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INSURANCE LAW

Philip K. Maxwell*
Tim Labadie*

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

A. WHO CAN SUE AND WHO CAN BE SUED

1. *Standing to Sue*

SOME of the cases discussed in this section deny “standing” to sue under article 21.21 to so-called “third parties,” *i.e.* those not a party to an insurance contract. Use of the words “standing” and “third party,” however, are of doubtful application to a statutory cause of action.

The San Antonio Court of Appeals had the following to say about “standing” in a DTPA suit:

In order for any person to maintain a suit it is necessary that they have standing to litigate the matters in issue. Standing consists of some interest peculiar to the person individually and not as a member of the general public. This general rule of standing applies in all cases absent a statutory exception to the contrary. The DTPA provides us with just an exception.¹

The San Antonio court then noted that “[i]n *Riverside National Bank v. Lewis*, 603 S.W.2d 169, 173 (Tex. 1980), the court ruled that it is the statutory definition of *consumer* that delineates the class of persons that may maintain a private cause of action.”²

Since both the DTPA and article 21.21’s private damage remedies were passed as part of the same legislation in 1973, since the two statutes are clearly *in pari materia* by virtue of their express cross references to each other, since article 21.21 expressly provides that “any person” who is damaged may sue and article 21.21 defines “person” to include any person or entity and which, unlike the definition of “consumer,” does not require the actual or prospective purchase of anything, you would think it pretty clear that *anyone* and *everyone* injured by another’s engaging in unfair practices in the business of insurance can sue under the statute.

But as some of the article 21.21 cases discussed below show, plaintiffs damaged by unfair claims settlement practices have been pitched out of

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1. *Government Employees Credit Union v. Fuji Photo Film*, 712 S.W.2d 208, 213 (Tex. App.—San Antonio 1986, writ ref’d n.r.e.).

2. *Id.* at 213.

court even though they are within the statutory definition of "the class of person that may maintain a private cause of action" and even though they have suffered damage distinct from that suffered by the general public. Clearly, these decisions are not explained by traditional "standing" analysis.

The term "third party" is also suspect. The question is "third party" to what? Obviously, some of the cases discussed below testify that it is good advocacy to distance the plaintiff as far as possible from whatever agreement the wrongful acts or practices are being performed under, and "third party" is a good start. From there it won't be long before the plaintiff becomes a total "stranger" to the whole transaction and should be run out of town on a rail. The question is not whether use of the term "third party" makes good advocacy, but whether its use is intellectually defensible when dealing with a statutory cause of action that does not require that the plaintiff have a contract with the defendant. The source of the plaintiff's rights in an article 21.21 case derive from the statute itself, not from the law of contract. Indeed, it was the inadequacies of the common law of contract and fraud that led to the passage of article 21.21 and the DTPA in the first place.³

Section 16 of article 21.21 grants a cause of action to "any person who has sustained actual damages as a result of another's engaging in" conduct prohibited in section 4 of article 21.21, the rules and regulations adopted by the State Board of Insurance, or section 17.46 of the DTPA.⁴ Section 2, in turn, defines "person" as *any*⁵ individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agent, brokers, adjusters, and life insurance counselors.⁶ Inexplicably, even though the only statutory limitation placed on a person's standing to sue under article 21.21 is that such person must have sustained actual damages as a result of the other person's illegal conduct, some courts, as will be seen below, have required that the "person" also be an insured or beneficiary. Not all courts, however, engage in such judicial legislation, but instead apply the statute as written. For example, in *Maccabees Mutual Life Insurance Co. v. McNeil*,⁷ the court allowed a person to maintain an action under article 21.21 even though he was neither an insured nor a beneficiary of an insurance policy.

In *Maccabees* the Dallas County Hospital District (DCHD) sought to obtain group life insurance coverage for its employees through Maccabees. Whyburn, a Maccabees group sales representative, told DCHD that he had authority to bind coverage as a representative of Maccabees, and that cover-

3. See *Smith v. Baldwin*, 611 S.W.2d 611 (Tex. 1981).

4. TEX. INS. CODE ANN. art. 21.21, § 16(a) (Vernon Supp. 1993).

5. Texas courts have always interpreted the term "any" found in statutes as "equivalent to and ha[ving] the force of 'every' and 'all'." *Hime v. City of Galveston*, 268 S.W.2d 543, 545 (Tex. Civ. App.—Waco 1954, writ ref'd n.r.e.); accord *Branham v. Minear*, 199 S.W.2d 841, 846 (Tex. Civ. App.—Eastland 1947, writ ref'd n.r.e.); *Doherty v. King*, 183 S.W.2d 1004, 1007 (Tex. Civ. App.—Amarillo 1944, writ dism'd).

6. TEX. INS. CODE ANN. art. 21.21, § 2(a) (Vernon Supp. 1993) (emphasis added).

7. 836 S.W.2d 229 (Tex. App.—Dallas 1992, no writ).

age would be in force upon payment of \$15,000. DCHD paid the \$15,000 and Whyburn completed an application for DCHD on which he wrote: "All actively not at work will be insured and the non-active waiver clause will be waived."

About a month and a half after DCHD paid the \$15,000, Maccabees sent a letter to DCHD declining the application because lists of inactive employees were incomplete and did not indicate the reasons for inactive status. Prior to this, Vivien McNeil, an active employee of the hospital gift shop, died. Her beneficiary, Tom McNeil, presented DCHD with a claim for \$37,900. Maccabees did not pay because no policy had been issued by Maccabees. McNeil then demanded payment from DCHD and Maccabees. After a bench trial, a judgment was rendered against Maccabees and in favor of McNeil under article 21.21. Maccabees argued to the court of appeals that McNeil could not recover under article 21.21 because there was no privity between the parties as no insurance policy had ever been issued. The court disagreed, holding that "article 21.21, § 16 allows recovery by 'any person who has sustained actual damages' without imposing a requirement that the claimant be a policyholder."⁸

The court in *Benefit Trust Life Insurance Co. v. Littles*⁹ also refused to require that the plaintiff be an insured or beneficiary before maintaining suit under article 21.21. Leslie Littles sued Benefit Trust, the administrator of his employer's health plan, for its failure to pay medical bills incurred for treatment of second and third-degree burns he suffered. After a jury trial, Littles obtained a judgment against Benefit Trust.

Benefit Trust argued on appeal that Littles had no standing to sue under article 21.21 of the Insurance Code because he was not an intended third-party beneficiary of the administration contract between Benefit Trust and the City of Victoria, Littles' employer. The court held that there is a presumption against contracts creating the status of an intended third-party beneficiary. Before such status could be established, Littles had to prove that the contracting parties intended to create a third-party beneficiary and that such intent was clearly spelled out in the contract.¹⁰ Upon reviewing the administration contract, the court concluded that Littles was the intended third-party beneficiary of the contract.¹¹ Benefit Trust was given the responsibility of evaluating and paying claims under the City's health plan. The City did not participate in the handling of claims. The court concluded that the contract was entered into for the benefit of the plan participants, including Littles.

The court next held that even if Littles was not a third-party beneficiary, he still had standing to sue under article 21.21 because of the close relationship between Littles and Benefit Trust.¹² This close relationship was created

8. *Id.* at 235.

9. No. 04-91-00673-CV, 1993 WL 437192 (Tex. App.—San Antonio, Oct. 29, 1993, writ dismissed).

10. *Id.*, slip op. at 10-11.

11. *Id.*, slip op. at 13.

12. *Id.*, slip op. at 14.

by virtue of Benefit Trust's exclusive control over payment of the claims. According to the court, Littles was directly injured by Benefit Trust's refusal to pay a portion of his medical bills and knew its actions would directly affect Littles.¹³

A third case deciding that a person suing under article 21.21 does not need to be an insured is *Transport Insurance Co. v. Faircloth*.¹⁴ Judith and Marvin Kervin were killed when struck by a truck owned and operated by Allied Van Lines. Transport Insurance Company insured the Allied truck. At the time of the accident the daughter of Judith Kervin, Paula Faircloth, was fifteen years old and was left an orphan. About one month later, a settlement was entered into by and between Transport and Paula's court-appointed guardian, settling the claims of Paula for \$250,000.

After Paula reached the age of majority, she filed suit against Transport, the insurance adjuster, the guardian and others, alleging that the \$250,000 settlement was grossly inadequate. Based on the jury's verdict, the trial court entered judgment in favor of Paula under article 21.21 of the Insurance Code.

Transport argued to the court of appeals that Paula lacked standing to recover under article 21.21. The court held that Paula did not need to be an insured in order to assert a cause of action under article 21.21, but only needed to be a person who was injured by an act proscribed by article 21.21.¹⁵ Relying on § 16 of article 21.21, the court held that any person who has sustained actual damages as the result of another engaging in any act or practice declared to be unfair or deceptive in the rules or regulations of the State Board of Insurance, § 17.46 of the DTPA, or in the Insurance Code can maintain an action against the person or persons engaged in such acts or practices.¹⁶

The court concluded that Paula was entitled to recover under article 21.21 because she obtained findings that the defendants: (1) committed an unlisted deceptive trade practice under DTPA § 17.46(a); (2) committed an unfair claims settlement practice as defined in article 21.21-2 and 28 TEX. ADMIN. CODE § 21.203; (3) committed deceptive trade practices listed in DTPA § 17.46(b); (4) engaged in a trade practice determined by law to be unfair or deceptive (breach of the duty of good faith and fair dealing); and (5) engaged in fraud. According to the court, a common law fraud action can serve as the foundation for a violation of DTPA § 17.46 and article 21.21, § 16.¹⁷

Another example of the court giving a literal reading to the definition of "person" is *International Trucking Co. v. Employers Casualty Co.*¹⁸ A truck

13. *Id.*

14. 861 S.W.2d 926 (Tex. App.—Beaumont 1993, writ requested).

15. *Id.* at 939.

16. *Id.* at 939-40.

17. *Id.* at 941.

18. No. 04-90-00012-CV (Tex. App.—San Antonio, July 8, 1992, n.w.h.). This case is still on rehearing, most likely awaiting the supreme court's decision in *Watson v. Allstate Ins. Co.*, 828 S.W.2d 423 (Tex. App.—Fort Worth 1992), *rev'd*, 37 Tex. Sup. Ct. J. 408 (Jan. 12, 1994) which involves many of the same issues.

owned by International Trucking Company was involved in a wreck with a truck owned by Williams Drilling Company. International sued Williams for negligence. International also sued the insurers for Williams, Employers Casualty and Employers National, along with two claims adjusters, Page and Veale, for misrepresentations and unreasonable denial of the claim.

The trial court granted the insurers and individuals summary judgment on International's Insurance Code claims, and the parties proceeded to trial on the DTPA claim. The court granted directed verdicts for Page and Veale, but the jury found that the insurers had knowingly violated the DTPA and caused damages to International. The trial court rendered judgment on the verdict for treble damages against the insurers and rendered a take nothing judgment in favor of Page and Veale. The court of appeals reversed the summary judgment and rendered judgment for International on the article 21.21 claims. The court also affirmed the judgment on the DTPA claims.

The court first determined that International had standing to bring suit under article 21.21 even though it may not have been a "consumer." The only qualification required to bring suit under article 21.21 is that one must be a "person."¹⁹ Since International was a corporation it met the definition of "person" found in § 2 of article 21.21. Therefore, the court held that International could maintain an action under article 21.21 for violations of § 17.46 of the DTPA without being a "consumer."²⁰

Employers Casualty argued that a "person" under article 21.21 is limited to an insured or a beneficiary of the policy, relying on *Chaffin v. TransAmerica Insurance Co.*²¹ The court distinguished *Chaffin* since it did not involve third-party beneficiaries, nor were there allegations that the insurer made misrepresentations directly to the plaintiffs as Employers Casualty did in this case. Instead the court relied on *Watson v. Allstate Insurance Co.*²²

Watson was involved in a car wreck with Townsley, who was insured by Allstate. Without first getting a judgment against Townsley, or otherwise establishing his legal responsibility for the wreck, Watson tried to sue Allstate directly. She alleged claims for breach of the duty of good faith and fair dealing, DTPA violations, and unfair insurance practices, and she sought declaratory relief. The trial court granted summary judgment against her on all claims. The court of appeals agreed that Watson, as a potential third-party beneficiary under the automobile liability policy, did not have any claim for breach of the duty of good faith and fair dealing and that she was not entitled to sue as a "consumer" under the DTPA.²³ However, the court held that Watson was entitled to sue under article 21.21, § 16 as a "person" injured by Allstate's alleged unfair insurance practices.²⁴ Watson relied on the State Board of Insurance rule prohibiting unfair claim

19. *International Trucking*, slip op. at 6.

20. *Id.*

21. 731 S.W.2d 728 (Tex. App.—Houston [14th Dist.] 1987, writ ref'd n.r.e.).

22. 828 S.W.2d 423 (Tex. App.—Fort Worth 1992), *rev'd*, 37 Tex. Sup. Ct. J. 408 (Jan. 12, 1994).

23. 828 S.W.2d at 426-27.

24. *Id.* at 427-28.

settlement practices, specifically, failing to attempt to effectuate a prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.²⁵ Thus, the court reversed and remanded for consideration of Watson's claim under article 21.21.

The supreme court affirmed the judgment of the court of appeals with respect to the DTPA and common law bad faith claims. The supreme court, however, reversed the judgment as to the article 21.21 cause of action. The court held that a third-party claimant lacks standing under article 21.21 to directly sue the insurer of the tortfeasor for unfair claims settlement practices.²⁶ The court noted that to have a private cause of action for unfair claims settlement practices, such practices must be declared unfair or deceptive in § 4 of article 21.21, the rules or regulations adopted under article 21.21, or be defined as unlawful deceptive trade practices in DTPA § 17.46.²⁷ The court first determined that § 4 of article 21.21 does not define unfair claims settlement practices to be unfair or deceptive.²⁸

The court then looked to the State Board of Insurance regulations to see if they provided a private cause of action for unfair claims settlement practices. The court noted that Board Order 18663, which was promulgated under article 21.21, does not prohibit unfair claims settlement practices.²⁹ Instead, this regulation prohibits unfair or deceptive acts as defined by the provisions of the Insurance Code or other regulations of the State Board of Insurance. Even so, the court held that another regulation, namely Board Order 41454, which does prohibit unfair claims settlement practices, cannot form the basis of an article 21.21 action because this regulation was adopted pursuant to article 21.21-2, not article 21.21.³⁰ The court further concluded that the prohibitions against unfair claims settlement practices in article 21.21-2 cannot form the basis of an article 21.21 cause of action because there is no private cause of action under article 21.21-2.³¹ The court noted that the Legislature recently refused to amend article 21.21-2 so as to provide a private remedy. Next, the court concluded that only the practices defined in DTPA § 17.46 are actionable under article 21.21, and unfair claims settlement practices are not specifically mentioned.³²

The court also held that Watson had no standing to sue on the automobile liability policy as a third-party beneficiary.³³ Watson argued that the court in *Dairyland County Mutual Insurance Co. v. Childress*³⁴ held that an injured person is an intended third-party beneficiary of an insurance policy and is entitled to enforce the contract. The court held that, even so, this does not give the third-party claimant the right to sue to enforce extra-con-

25. 28 TEX. ADMIN. CODE § 21.203(4) (West 1988).

26. 37 Tex. Sup. Ct. J. at 408.

27. *Id.* at 409.

28. *Id.*

29. *Id.*

30. *Id.* at 410.

31. *Id.*

32. *Id.* at 411.

33. *Id.* at 411.

34. 650 S.W.2d 770 (Tex. 1990).

tractual obligations under article 21.21.³⁵

While closing to "third-party" liability claimants the door to the unfair claims settlement practice statute and regulation, the *Watson* majority stated that "we are particularly mindful of the duties imposed on insurers as to their insureds."³⁶ The opinion then cited, in addition to *Arnold*, page 136 of the *Vail*³⁷ opinion, where the *Vail* court summarized its holdings. The *Watson* majority also held that, "*Vail* remains the law as to claims for alleged unfair claim settlement practices brought by insureds against their insurers."³⁸

Justice Spector concurred in the judgment, stating, however, that "[o]nce Kathleen Watson has obtained a judgment or settlement against the insured, she is entitled to recover for any damages she has sustained as a result of Allstate's unfair or unlawful acts or practices."³⁹

Justice Doggett, joined by Justice Gammage, dissented, stating that "[b]y challenging the legitimacy of *Vail v Texas Farm Bureau Insurance Co.*, 754 S.W.2d 129 (Tex. 1988) . . . and implicitly adopting the regressive reasoning of the previously rejected writings of Justices Gonzalez and Phillips . . . , the majority has invited imminent attack on the most effective tool that Texas consumers possess to ensure that they have not paid premiums only to be subjected to abuse by their own insurers."⁴⁰ After reviewing the holdings in *Vail*, the dissent took issue with the court's holding that the conduct declared unlawful in article 21.21-2 was not actionable because that statute did not grant a private remedy. The dissent, as did the *Vail* court, saw this as presenting no impediment to an article 21.21 cause of action based on such conduct because article 21.21 provides a cause of action for every practice determined elsewhere in the Insurance Code to be unfair, something article 21.21-2 explicitly does.⁴¹

The dissent also took issue with the majority's statement that *Vail* was predicated upon the special relationship between the insurer and insured, the justification for limiting a cause of action for unfair claims settlement practices to insureds.⁴² Justice Doggett pointed out that the Legislature could have limited an article 21.21 cause of action to insureds or consumers, but instead granted such right to any person.⁴³ Moreover, *Vail's* focus was not on the common law duty, but was a case of statutory interpretation.

The dissent also criticized the majority's view that an insurer cannot owe a duty of good faith to both its insured and a third-party claimant. According to Justice Doggett, an insurer would not have to compromise the duties to its insured when attempting to settle third-party claims because it is in the

35. *Watson*, 37 Tex. Sup. Ct. J. at 411.

36. *Id.*

37. *Vail v. Texas Farm Bureau Ins. Co.*, 754 S.W.2d 129 (Tex. 1988).

38. *Watson*, 37 Tex. Sup. Ct. J. at 411.

39. *Watson*, 37 Tex. Sup. Ct. J. at 173 (Spector, J., concurring).

40. *Watson*, 37 Tex. Sup. Ct. J. at 173 (Doggett, J., dissenting).

41. *Id.* at 174.

42. *Id.* at 175.

43. *Id.*

insured's best interests to arrive at a fair and equitable settlement of the third-party claims.⁴⁴

Curiously, the majority opinion that Ms. Watson lacked "standing" under article 21.21 did not turn on the only "standing" question the statute asks: Is the plaintiff a "person?" Article 21.21, § 16 vests a cause of action in "[a]ny person who has sustained actual damages as a result of another's engaging in" the unlawful conduct. Section 2 defines "person" very broadly to include "any individual," which Ms. Watson clearly was. The court did not mention the definition of "person" in § 2(a) at all. And of the language in § 16 granting the cause of action to "any person" the court had only the following to say, "To be sure, art. 21.21, section 16 is worded as providing a cause of action to 'any person.' However, for Watson to assert her cause of action against Allstate for unfair claim settlement practices, she must do so through the reasoning of *Vail*."⁴⁵ In other words, it was not her lack of standing as a "person" that kept Ms. Watson from asserting her suit for unfair claims settlement practices against Allstate. It was because she had failed to "do so under the reasoning of *Vail*." Those familiar with *Vail* may find this startling because the supreme court in that case expressly held that both article 21.21-2 and Board Order 41454 (the statute and regulation prohibiting unfair claims settlement practices) were actionable under article 21.21.

The *Vail* court recognized: (1) that article 21.21-2 does not itself have a private cause of action; (2) that Board Order 41454 was issued under that article, not article 21.21; and (3) that only regulations issued under article 21.21 are actionable. The prohibitions in article 21.21-2 and Board Order 41454 were still actionable under article 21.21, ruled the *Vail* court, because Board Order 18663, which was issued under article 21.21, prohibits, *inter alia*, "any: . . . unfair or deceptive act or practice as defined by the provisions of the Insurance Code or as defined by these sections and other rules and regulations of the State Board of Insurance authorized by the Code."⁴⁶

Article 21.21-2 both defines certain settlement practices as "unfair" and is one of "the provisions of the [Insurance] Code". Similarly, Board Order 41454 both defines such practices as "unfair" and is one of the "other rules and regulations of the State Board of Insurance authorized by the Code." Accordingly, held *Vail*, a violation of either the statute or the regulation is a violation of Board Order 18663 and hence actionable under article 21.21.⁴⁷ *Vail* also held that an unfair claim settlement practice is prohibited as an unlisted deceptive trade practice under DTPA § 17.46, violations of which are expressly actionable under article 21.21, and that breach of the common law duty of good faith and fair dealing recognized by the court in *Arnold* and *Aranda* was also actionable because Board Order 18663 also prohibits unfair

44. *Id.* at 176.

45. *Watson*, 37 Tex. Sup. Ct. J. at 411.

46. 28 TEX. ADMIN. CODE § 21.3(a) (West 1988).

47. *Vail*, 754 S.W.2d at 134.

practices "determined pursuant [to] law."⁴⁸

How then did Ms. Watson fail to assert her claim "under the reasoning of *Vail*?" The supreme court answered this question with a reconstruction of the reasoning of *Vail* to render article 21.21 unavailable to a tort victim who has not yet received a judgment against the tortfeasor.

Plodding the same ground as the court in *Vail*, but without acknowledging that it was doing so, the *Watson* court "address[ed] each basis for art. 21.21 liability separately."⁴⁹ Though § 4 of article 21.21 was not a part of the "reasoning in *Vail*" or a basis of Ms. Watson's unfair claims settlement practices claim against Allstate, the court in *Watson* took this section on first. The court stated that the list in § 4 "does not define unfair claim settlement practices as an unfair or deceptive act or practice in the business of insurance."⁵⁰ The court "note[d] that unlike section 17.46 of the DTPA, discussed below, section 4 of art. 21.21 does not use the phrase 'includes, but is not limited to[,]'" that § 4 is an "exclusive list", and that, therefore, "[u]nfair claim settlement practices are not actionable under art. 21.21, section 16, by virtue of art. 21.21, section 4."⁵¹ Of course, there is no problem with this portion of the court's opinion because nobody has ever argued that the list in § 4 included unfair claims settlement practices.

The court next turned to the rules and regulations adopted under article 21.21. The court noted first that "Board Order 18663 does not declare unfair claim settlement practices to be an unfair or deceptive act or practice."⁵² Again, this is true and no one ever said it did. Well, almost no one. Chief Justice Phillips, dissenting from *Vail*'s holding that *Arnold* and *Aranda* were unfair trade practices adopted "pursuant by law" and thus incorporated by Board Order 18663, conceded that there was a role for the court in defining unfair practices prohibited by this regulation:

The court now holds "this court is empowered to determine whether conduct constitutes an unfair or deceptive act." *I agree with this statement in principle, but find it inapposite to the case before us.*

Undoubtedly, this court might be confronted with a case in which it is called upon to determine whether a particular trade practice is "an unfair or deceptive act or practice in the business of insurance" pursuant to Board Order 18663, § 4(b). Having made such a determination, the decision of this court could properly be relied upon by parties alleging a violation of Board Order 18663, § 4. *Chitsey* [which denied an

48. *Id.* at 135-36.

49. *Watson*, 37 Tex. Sup. Ct. J. at 409.

50. *Id.* (emphasis by the court).

51. *Id.*

52. *Id.* (emphasis by the court). Technically, referring to Board Order 18663 is not accurate, because that Order was supplanted with Board Order 41060 (which made only minor editorial changes in Board Order 18663) on June 4, 1982. With the advent of the Texas Administrative Code the regulations are no longer referred to as "Board Orders" and the "Source" note following each regulation does not even mention the Board Order numbers. For a discussion of the regulations issued under article 21.21, see D. BRAGG, P. MAXWELL, & J. LONGLEY, TEXAS CONSUMER LITIGATION § 7.04 (2d ed. 1983 & 1993 Supp.) and Kincaid, Actionable Conduct Under Insurance Board Regulations in STATE BAR OF TEXAS, ADVANCED DTPA/CONSUMER LAW COURSE (1990).

Article 21.21 recovery for an alleged violation of Board Order 41454 because of no evidence of "frequency"] would not foreclose such a result.⁵³

Thus, under the Phillips' view, the supreme court in *Watson* could have determined that "not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear," is "an unfair or deceptive act or practice in the business of insurance" and thus actionable directly under Board Order 18663 without any need to incorporate article 21.21-2 or Board Order 41454. We wonder whatever happened to this idea!

The *Watson* majority stated that ". . . like art. 21.21 of the Insurance Code [Board Order 18663] prohibits insurers from engaging in unfair or deceptive acts or practices as *defined elsewhere*."⁵⁴ This is absolutely correct, and just what *Vail* concluded. Thus, one looks to Board Order 41454 and article 21.21-2, right? Having laid out the rug to the unfair claims settlement regulation with its "*defined elsewhere*" language, the *Watson* majority abruptly pulled it out from under Ms. Watson: "This court held in *Vail*," the *Watson* majority said, "that an insured could not rely on Board Order 41454 because the definition of unfair or deceptive acts or practices required that such acts be committed with 'such frequency as to indicate a general business practice' [and therefore] *Vail* precludes Watson's claims under Board Order 41454."⁵⁵ The court recognized that the "frequency" requirement had been removed, but after Ms. Watson's claim arose and thus of no help to her.

The court was wrong in its conclusion that *Vail* "precluded" reliance on Board Order 41454. *Vail* did deny recovery under the regulation, but not because an insured never could prove frequency, but because the insureds in that case did not. The Vails proved the denial of only two claims, both theirs. The supreme court held that "[a]n insurer's denial of two claims made by a single insured does not constitute the 'frequency' required by the definition of an unfair claims settlement practice in Board Order 41454."⁵⁶ *Vail* was a *jury* trial and there was a failure of proof. *Watson* was a *summary judgment on the pleadings*. Allstate offered *no* summary judgment evidence that it did not commit unfair claims practices with "frequency." It is bed-rock law that where, as in *Watson*, a summary judgment movant offers no evidence, but instead attacks the pleadings as stating no cause of action, those pleadings and inferences must be accepted as true.⁵⁷ Ms. Watson *alleged* a violation of Board Order 41454 and the supreme court was obliged to assume it was true, including the required "frequency."

Any hope that a future Ms. Watson with proof of "frequency" might be able to rely on Board Order 41454 was extinguished, however, when the court went further to state that "[i]n any event, Board Order 41454 was

53. *Vail*, 754 S.W.2d at 140 (Phillips, C.J., dissenting) (emphasis added).

54. *Watson*, 37 Tex. Sup. Ct. J. at 409 (emphasis by the court).

55. *Id.* at 410.

56. *Vail*, 754 S.W.2d at 135.

57. *Trunkline LNG Co. v. Trane Thermal Co.*, 722 S.W.2d 722, 724 (Tex. App.—Houston [14th Dist.] 1986, writ ref'd n.r.e.).

adopted pursuant to art. 21.21-2, not art. 21.21 and, thus, cannot form the basis of a claim under art. 21.21, section 16.”⁵⁸

This holding makes absolutely no sense. The court just finished saying on the previous page that Board Order 18663, which *was* adopted under article 21.21, “prohibits insurers from engaging in unfair or deceptive acts or practices as *defined elsewhere*.” The “elsewhere” is, under the express language of this regulation, “*other* rules and regulations of the State Board” and other “provisions of the [Insurance] Code”. To reach its conclusion, the *Watson* court had to amend Board Order 18663 and disregard the holding in *Vail* that the “rules and regulations” referred to include all those promulgated by the Board, not just those promulgated under article 21.21. Clearly, if the Board had desired the limitation engrafted onto this regulation by the court, it would have done so itself. However, the Board, in the five years since *Vail* was decided, never changed this regulation.

It is this holding in particular that indicates Justice Enoch’s judicial philosophy. As late as last October, a dissenting Justice Enoch criticized the court for abrogating the family-member exclusion in automobile liability policies, an exclusion that had been approved by the State Board of Insurance. “With the stroke of a pen,” charged Justice Enoch, “the Court rips the family member exclusion endorsement out of every automobile liability insurance policy in this state.”⁵⁹ Enoch argued that since “[t]he Legislature amended the [Texas Motor Vehicle Safety Responsibility] Act in 1989 and 1991, after the family member exclusion was promulgated [by the Board of Insurance], and failed to address the family member exclusion[,] . . . the Texas Board of Insurance’s promulgation of Endorsement 575 should be given great deference.”⁶⁰

Justice Enoch in *Watson*, however, gave the Insurance Board no deference. In *Watson* Justice Enoch did not even mention that the Insurance Board filed two amicus curiae briefs *in support of Kathleen Watson* saying it agreed with the holding in *Vail*, that it had always interpreted article 21.21 and its own regulations consistent with Ms. Watson’s right to sue, and that strong private enforcement of article 21.21 was crucial to the overall regulatory scheme. The *Watson* Justice Enoch apparently forgot the holdings of the cases that the *Johnson* Justice Enoch cited for deferring to the Board. One was *Direlco, Inc. v. Bullock*,⁶¹ which held that “[a]lthough not bound by the agency construction, the court should give deference to the construction of the agency administering the statute [and that] once the statute is given a particular interpretation, a court is entitled to assume that the Legislature, by failing to amend the statute, indicated its approval of the interpretation.”

Vail was decided in 1988. The Legislature has met three times since then and never amended article 21.21 (except to remove the McCarran-Ferguson

58. *Watson*, 37 Tex. Sup. Ct. J. at 410.

59. *National County Mut. Fire Ins. Co. v. Johnson*, 37 Tex. Sup. Ct. J. 75, 79-80 (Oct. 27, 1993) (Enoch, J., dissenting).

60. *Id.* at 81.

61. 711 S.W.2d 360, 363 (Tex. App.—Austin 1986, writ ref’d n.r.e.).

reference that Allstate argued precluded third-party claimants from using article 21.21), though massively overhauling the Insurance Code in two of those sessions and eliminating the “frequency” requirement from article 21.21-2. The State Board of Insurance has met countless times since 1988 and never amended Board Order 18663. It has amended Board Order 41454 to remove the “frequency” requirement, which, under the rulings in *Chitsey* and *Vail*, hobbled its use by private litigants. If either the Legislature or the Board disagreed with the holdings in *Vail*, they have shown no indication of it.

Also, why did Chief Justice Phillips join in the majority opinion? In his dissent in *Vail*, the Chief Justice, while disagreeing that the court’s *Arnold* and *Aranda* decisions were adopted “pursuant by law” as used in Board Order 18663, had no problem with the incorporation of Board Order 41454. Agreeing with the dissent of Justice Gonzalez, the Chief Justice “believe[d] that *Chitsey v. National Lloyds Insurance Co.*, 738 S.W.2d 641 (Tex. 1987), forecloses a holding that Texas Farm’s denial of the Vails’ claim meets the ‘frequency’ requirements of both Board Order 41454 and Tex. Ins. Code, art. 21.21-2.”⁶²

Having jerked up the rug, the court then ripped the planks out of the floor, stating that article 21.21-2, the unfair claims settlement practices statute, was likewise unavailable through Board Order 18663. Said the court:

We will not construe art. 21.21, section 16 to permit, indirectly, a third-party claimant to sue an insurer for unfair claim settlement practices through Board Order 18663 where she may not do so directly and where the legislature has specifically refused to create such a cause of action for unfair claim settlement practices under art. 21.21, section 16 and art. 21.21-2.⁶³

Again, how does denying access to article 21.21-2 through Board Order 18663 square with the express language of the regulation incorporating practices declared unfair under other “provisions of the Code” and the *Watson* court’s acknowledgment that the regulation prohibits practices “as defined elsewhere”? Contrary to the court’s statement, it was not “construing”, nor was it being called upon to “construe”, article 21.21. Rather, it was being asked to enforce the plain language of the Board’s regulation. Moreover, the *Watson* court does not even mention that *Vail* expressly considered and rejected the “there is no express cause of action under article 21.21-2” argument. Said *Vail*: “The fact that article 21.21-2 itself does not confer a private cause of action does not preclude the incorporation of definitions contained in that article into rules and regulations promulgated by the State Board of Insurance.”⁶⁴ One would think an opinion which the *Watson* majority cites as the prime reason why Ms. Watson cannot recover would receive at least an honorable mention on this point.

Though closing the Board Order 18663’s door to the unfair claim settle-

62. *Vail*, 754 S.W.2d at 139 (Phillips, C.J., dissenting).

63. *Watson*, 37 Tex. Sup. Ct. J. at 410.

64. *Vail*, 754 S.W.2d at 134.

ment statute and regulation, the *Watson* court did not close its door to *Arnold* and *Aranda*. In fact, the majority simply does not mention *Arnold* and *Aranda* in its discussion of Board Order 18663's incorporation of unfair practices "defined elsewhere." In light of its unwillingness to recognize Board Order 18663's incorporation of the unfair claims settlement statute and regulation, as did *Vail*, the *Watson* majority's silence on the regulation's incorporation of *Arnold* and *Aranda*, which *Vail* recognized, is most puzzling. This is especially so, because Chief Justice Phillips, who joins the majority in *Watson*, so vigorously dissented from this holding in *Vail*, "find[ing] no basis whatsoever for the court's conclusion." Said the Chief Justice:

Moreover, our opinions in *Arnold v. National County Mut. Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987) and *Aranda v. Insurance Co. of North America*, 748 S.W.2d 210, 213 (Tex. 1988), do not amount to a "determination by law" that good faith failure to settle a claim is "an unfair or deceptive act or practice in the business of insurance." State Bd. of Ins., 28 Tex. Admin. Code § 21.3(b) (July 22, 1982) [Board Order 18663, § 4b]. In *Chitsey*, this court wrote: "The words 'determined by law' call for at least a state agency, if not legislative, determination and not just a jury finding." 738 S.W.2d at 643. The court now holds "this court is empowered to determine whether conduct constitutes an unfair or deceptive act." I agree with this statement in principle, but find it inapposite to the case before us.

* * *

Arnold and *Aranda* do no more than establish common law duties of good faith and fair dealing. They are not determinations of what comprises a deceptive act or practice pursuant to Board Order 18663, § 4(b). By holding that they are, this court elevates a general common law duty to a *per se* statutory violation subject to treble damages.⁶⁵

The *Watson* court also concluded that unfair settlement practices were not deceptive trade practices under DTPA § 17.46, the violations of which are expressly actionable under article 21.21, by stating:

While section 17.46 may not be a complete list of unlawful deceptive trade practices for purposes of asserting claims under the DTPA, art. 21.21 expressly makes actionable those acts or practices that, in fact, are defined in section 17.46 as unlawful deceptive trade practices. Unfair claims settlement practices are not listed and, therefore, they are not actionable under art. 21.21, section 16 of the Insurance Code.⁶⁶

The *Watson* court does not even mention that *Vail* held to the contrary. Said the *Vail* court "Article 21.21, § 16 of the Insurance Code makes actionable any violation of section 17.46 of the DTPA. Thus, section 16 of article 21.21 incorporates any unlisted practice that is determined to be false, misleading, or deceptive."⁶⁷

Watson cited with approval *Spradling v. Williams*,⁶⁸ an "unlisted" decep-

65. *Vail*, 754 S.W.2d at 140 (Phillips, C.J., dissenting).

66. *Watson*, 37 Tex. Sup. Ct. J. at 411.

67. *Vail*, 754 S.W.2d at 135 (emphasis by the courts) (internal citations omitted).

68. 566 S.W.2d 561, 564 (Tex. 1978).

tive trade practice case that was likewise cited with approval in *Vail*, and expressly recognized that in *Spradling* "this Court held that section 17.46 is not an exclusive list of deceptive acts or practices under the DTPA."⁶⁹ *Watson* attempts to avoid the effect of the breadth of section 17.46 by emphasizing what it perceives as the narrowness of § 16. Section 16, the *Watson* court reminds us, makes actionable only those acts defined by section 17.46. What *Watson* overlooks is that *Spradling* sets out the definition of "false, deceptive, or misleading acts or practices" that are not listed in § 17.46(b). Texas Pattern Jury Charges, Vol. 4, echoing the definition in *Spradling*, defines "false, misleading, or deceptive acts or practices" as follows: "False, misleading, or deceptive act or practice means an act or series of acts that have the tendency to deceive an average ordinary person, even though that person may have been ignorant, unthinking, or gullible."⁷⁰

Again, why is Chief Justice Phillips joining with the majority on this part of the *Watson* opinion? Chief Justice Phillips' quarrel with the "unlisted" deceptive trade practice holding in *Vail* was that the plaintiffs did not get a proper jury finding using the definition in *Spradling*. Said the Chief Justice:

To warrant recovery for an unlisted practice, there *must* be a finding that the act occurred and that it was deceptive. *Spradling v. Williams*, 566 S.W.2d 561, 564 (Tex. 1978). To meet this requirement, the court points to the jury's finding that Texas Farm intentionally failed to exercise good faith in the settlement of the Vails' claim. This is simply not a finding that Texas Farm's failure to exercise good faith was a deceptive act. To obtain such a finding, the jury must have been properly instructed as to what a deceptive act is, and it must have found that the act in question was deceptive. *Spradling v. Williams*, 566 S.W.2d at 564. In the absence of a finding that the failure to exercise good faith was deceptive, there can be no violation of an unlisted trade practice.⁷¹

Again, *Watson* is not an appeal from a jury verdict. It is a dismissal on the pleadings. Does not the Chief Justice still believe that a plaintiff is entitled to submit *Spradling* under article 21.21 as he said in *Vail*?

While closing to "third-party" liability claimants the door to the unfair claims settlement practice statute and regulation, the *Watson* majority stated that "we are particularly mindful of the duties imposed on insurers as to their insureds."⁷² The opinion then cites, in addition to *Arnold*, page 136 of the *Vail* opinion. On that page the *Vail* court summarized its holdings as follows:

We hold that the Vails stated and proved a cause of action for unfair claims settlement practices under section 17.50(a)(4) of the DTPA on any of three alternative grounds: (1) by incorporating article 21.21, § 16 of the Insurance Code, section 4(a) of Board Order 18663, and the definition of an unfair claims settlement practice in article 21.21-2, § 2(d) of the Insurance Code; (2) by incorporating article 21.21, § 16 of the In-

69. *Watson*, 37 Tex. Sup. Ct. J. at 409, n.3.

70. STATE BAR OF TEXAS, TEXAS PATTERN JURY CHARGES PJC 102.15 (1990).

71. *Vail*, 745 S.W.2d at 140 (Phillips, C.J., dissenting).

72. *Watson*, 37 Tex. Sup. Ct. J. at 411.

insurance Code, section 4(b) of Board Order 18663, and the determinations made by this court in *Arnold* and *Aranda*; and (3) by incorporating article 21.21, § 16 of the Insurance Code and section 17.46 of the DTPA.⁷³

The *Watson* majority also flatly stated: *Vail* remains the law as to claims for alleged unfair claim settlement practices brought by insureds against their insurers.⁷⁴ Thus the enigma. An opinion that so thoroughly rejects the "reasoning of *Vail*" warmly embraces it.

The majority's attempt to limit and make unavailing the holding of *Dairyland County Mutual Insurance Co. v. Childress*⁷⁵ also rings hollow. In *Childress* the court held that an injured person is a third party beneficiary of an automobile insurance policy and thus, is permitted to recover attorney's fees in enforcing the policy. The court stated that: "There is no question in our minds that the compulsory insurance requirement of the Texas motor vehicle safety laws implies that all potential claimants for damages resulting from automobile accidents are intended as beneficiaries of the statutorily required automobile liability coverage."⁷⁶

In *National County Mutual Fire Insurance Co. v. Johnson*,⁷⁷ the court, quoting this same passage from *Childress*, held that the public policy behind the Texas Safety Responsibility Act is to protect all potential claimants from damages resulting from automobile accidents. Thus, the court invalidated the family-member exclusion in automobile policies because this would leave some potential claimants unprotected by the mandatory insurance laws.

Watson argued, and the court of appeals held, in response to some courts requiring a person to be an insured or beneficiary to have standing to sue under article 21.21, that in light of *Childress*, she was an intended beneficiary of the Allstate policy, and thus could bring a suit under article 21.21. This argument seems to be lost on the *Watson* court as it found *Childress* inapplicable to this case. The reason perhaps is because the court refused to consider the whether Ms. *Watson* was a "person" with standing to sue under article 21.21.

As mentioned above, several courts have brushed aside the plain meaning of article 21.21 and imposed a requirement that a "person" be an insured or beneficiary before being able to maintain suit under this statute. These include *Shelton Insurance Agency v. St. Paul Mercury Insurance Co.*,⁷⁸ *Pineda v. PMI Mortgage Insurance Co.*,⁷⁹ *CNA Insurance Co. v. Scheffey*,⁸⁰ and *In re Burzynski*.⁸¹

In *Shelton*, Roberts, an insurance agent working for the Shelton Agency,

73. *Vail*, 754 S.W.2d at 136.

74. *Watson*, 37 Tex. Sup. Ct. J. at 411.

75. 650 S.W.2d 770 (Tex. 1983).

76. *Id.* at 775.

77. 37 Tex. Sup. Ct. J. 75 (Oct. 27, 1993).

78. 848 S.W.2d 739 (Tex. App.—Corpus Christi 1993, writ denied).

79. 843 S.W.2d 660 (Tex. App.—Corpus Christi 1992), writ denied per curiam, 851 S.W.2d 191 (Tex. 1993).

80. 828 S.W.2d 785 (Tex. App.—Texarkana 1992, writ denied).

81. 989 F.2d 733 (5th Cir. 1993).

sold a St. Paul policy to Frio Drilling Company insuring it against losses resulting from oil well blowouts. After one of Frio's wells blew out and St. Paul denied the claim, Frio sued Shelton Agency and St. Paul. St. Paul later settled the claims with Frio, but did not settle the claims against the Shelton Agency. St. Paul then hired an attorney to defend the Shelton Agency in the Frio suit under an errors and omissions policy. This lawsuit was eventually settled as well.

The Shelton Agency then sued St. Paul alleging that St. Paul was liable to pay damages under either the blowout policy or the errors and omissions policy because it wrongfully, and in bad faith, refused to timely pay either of the claims. The Shelton Agency sought to recover the premiums that it wrote off in settling the Frio suit plus commissions lost due to losing Frio as a customer. The jury found that St. Paul denied Frio's claim with no reasonable basis for the denial; failed to determine if there was a reasonable basis for denying Frio's claim; and failed to exercise good faith in the investigation, processing, and denial of Frio's claim. The trial court, however, granted judgment n.o.v. favorable to St. Paul, and ordered that the Shelton Agency take nothing.

The court of appeals affirmed the take-nothing judgment on the article 21.21 claims. According to the court, a cause of action under article 21.21 is available only to a "person" who is either an insured or intended beneficiary of the policy.⁸² Because the Shelton Agency was neither, the court held that it could not maintain an article 21.21 cause of action.⁸³

In *Pineda v. PMI Mortgage Insurance Co.*⁸⁴ Pineda executed a note payable to Houston First American Savings Association. The note was secured by a deed of trust covering certain real property in Harris County. In addition to the monthly payment under the note, Pineda paid the bank premiums on a mortgage insurance policy issued by PMI. This mortgage insurance policy insured the lender against loss of the mortgage loan to Pineda.

Pineda defaulted on the note and United Savings, the successor to Houston First American, foreclosed and purchased the property. After the foreclosure sale, there was deficiency and a claim was made by United Savings to PMI for payment on the mortgage insurance policy. This claim, which amounted to \$19,789.24, was paid to United Savings by PMI. PMI later filed suit against Pineda to recover the amount it had paid under the mortgage insurance policy to United Savings. Pineda filed a counterclaim alleging various causes of action including violations of article 21.21 of the Insurance Code. The trial court rendered a summary judgment in favor of PMI and the court of appeals affirmed.

The court held that Pineda did not have standing to sue under article 21.21 because he was not an insured or a beneficiary of the mortgage insur-

82. *Shelton*, 848 S.W.2d at 744.

83. *Id.* (noting also that the Shelton Agency was not a "consumer" under the DTPA because it did not seek or acquire the benefits of the Frio policy).

84. 843 S.W.2d 660 (Tex. App.—Corpus Christi 1992), *writ denied per curiam*, 851 S.W.2d 191 (Tex. 1993).

ance policy.⁸⁵ Even though Pineda paid the premiums for the mortgage insurance policy, the court held that this policy was purchased for the benefit of the lender and not Pineda.⁸⁶ Relying on *Chaffin v. TransAmerica Insurance Co.*⁸⁷ the court held that Pineda did not come within the definition of a "person" under article 21.21 because he was neither an insured nor a beneficiary under the mortgage insurance policy.⁸⁸

*CNA Insurance Co. v. Scheffey*⁸⁹ involved claims brought by Dr. Scheffey against CNA for failing to promptly and fairly pay Scheffey for medical treatment he gave to CNA insureds and that CNA disparaged Scheffey's professional reputation by making false and misleading representations. The DTPA claims were severed from the case so that only the article 21.21 and the common law claims were tried. CNA appealed the judgment for approximately \$34 million rendered against it arguing that Scheffey did not have standing to sue under article 21.21.

Relying solely on the statement in *Chaffin*⁹⁰ that there is no authority for extending the meaning of "person" found in article 21.21 beyond insureds or beneficiaries,⁹¹ the court held that Scheffey was not a "person" because he was neither the insured nor beneficiary.⁹²

In deciding *Burzynski*,⁹³ the Fifth Circuit also concluded that a "person" must be an insured or beneficiary to maintain an action under article 21.21.⁹⁴ Dr. Stanislaw Burzynski, the owner-operator of Burzynski Research Institute (BRI) sued Aetna Life Insurance Company alleging that during the course of an underlying lawsuit, Aetna and its attorneys committed various unfair practices in the business of insurance and fraudulent acts. BRI was engaged in the business of treating terminally ill cancer patients with a non-FDA approved treatment. BRI claimed the treatment was covered by its patients' health insurance policies. However, in the mid-1980's, Aetna allegedly began denying BRI patients' insurance claims to reduce its claims exposure. Following the death of a patient, Burzynski intervened as plaintiff-assignee in a suit against Aetna for the reimbursement of medical expenses. The underlying suit eventually ended in a summary judgment for both sides.

Burzynski then brought this lawsuit alleging violations of article 21.21, among other things. The district court dismissed the entire complaint on the grounds that Texas law afforded an absolute privilege to communications made in a court proceeding. Alternatively, the district court dismissed, without prejudice, each cause of action under FED. R. CIV. P. § 12(b)(6) for failure to state a claim. On appeal to the Fifth Circuit, the court rejected Aetna's discovery privilege defense due to the possibility of Aetna's "ulte-

85. *Id.* at 673.

86. *Id.*

87. 731 S.W.2d 728 (Tex. App.—Houston [14th Dist.] 1987, writ ref'd n.r.e.).

88. *Pineda*, 843 S.W.2d at 673.

89. 828 S.W.2d 785 (Tex. App.—Texarkana 1992, writ denied).

90. 731 S.W.2d 728 (Tex. App.—Houston [14th Dist.] 1987, writ ref'd n.r.e.).

91. *Id.* at 731.

92. *Scheffey*, 828 S.W.2d at 791.

93. 989 F.2d 733 (5th Cir. 1993).

94. *Id.* at 740.

rior, malicious motives," and remanded for the reassessment of each of Burzynski's causes of action.⁹⁵

On remand, the district court took no action on its prior dismissals without prejudice, failed to call for answers by Aetna, and simply dismissed all of Burzynski's causes of action. Burzynski petitioned for, and obtained, a writ of mandamus to direct the district court to reinstate all claims and call for answers thereto. The Fifth Circuit granted Burzynski's petition for rehearing to examine the viability of each cause of action.

Burzynski brought suit under article 21.21 of the Insurance Code, alleging that Aetna violated DTPA § 17.46(b)(8), which prohibits disparaging the goods, services, or business of another by false or misleading representations of facts. The court, reaffirming its holding in *Warfield v. Fidelity & Deposit Co.*,⁹⁶ held that only insureds or beneficiaries, those in contractual privity with the insurer, have standing to sue under article 21.21.⁹⁷ Those without contractual privity have standing only if they relied on the words or deeds of the insurer.⁹⁸ Because Burzynski was not an insured or beneficiary of an Aetna policy, and did not rely on Aetna's false representations, the court held that he had no standing under article 21.21. Thus, the court ordered this claim dismissed with prejudice.

The Fifth Circuit's discussion of standing under article 21.21 shows how far astray from the statute the courts have gone on this issue. Neither section 16 nor section 2 of Article 21.21 limit "person" to "insureds," "beneficiaries," those in contractual privity with the insurer, or those who rely upon the insurer's words or deeds.⁹⁹ Yet the courts mentioned above have abandoned the statutory language in order to follow *Chaffin v. TransAmerica Insurance Co.*¹⁰⁰ The court in *Chaffin* denied standing under article 21.21 to a "person" stating that it could "find no authority for extending the construction of 'person' beyond one who is either an insured or a beneficiary of the policy."¹⁰¹ Curiously, the court reached this conclusion immediately after quoting the broad definition of "person" in Section 2 of Article 21.21 of the Texas Insurance Code.

The Fifth Circuit's discussion of "person" in this case shows why such an interpretation of article 21.21 is so wrong. The court begins: "This is one of those cases in which the apparent plain meaning of the statute provides little guide to its meaning."¹⁰² There is nothing apparent about the plain meaning

95. See *Burzynski v. Aetna Life Ins. Co.*, 967 F.2d 1063 (5th Cir. 1992).

96. 904 F.2d 322 (5th Cir. 1990).

97. *Burzynski*, 989 F.2d at 741.

98. *Id.*

99. The legislature has shown itself entirely capable of using the words "policyholder" or "insured" whenever it has intended a more limited concept than "person". See TEX. INS. CODE art. 21.21 § 4(1) (prohibiting, inter alia, "making any misrepresentation to any *policyholder insured*") (emphasis added). "When the Legislature has carefully employed a term in one section of a statute, and has excluded it in another, it should not be implied where excluded." *Smith v. Baldwin*, 611 S.W.2d 611, 616 (Tex. 1981) (rejecting implication of intent in DTPA § 17.46(b)(5) because of presence of similar requirement in other sections of statute).

100. 731 S.W.2d 722 (Tex. App.—Houston [14th Dist.] 1987, writ ref'd n.r.e.).

101. *Id.* at 731.

102. *In re Burzynski*, 989 F.2d at 740.

of the definition of person, it is plain and clear. So plain and clear that some courts cannot believe it and feel compelled to severely restrict its meaning. But in order to accomplish this end, the court must rewrite the statute.

The Fifth Circuit continues: "Despite this broad statutory language which seems to give standing to "any person," under the proper interpretation, Burzynski and BRI do not have standing to bring an action under Insurance Code Art. 21.21."¹⁰³ The court's initial impression of the statute is correct, it does give standing to "any person." The only limitation imposed by the statute is that the person must have sustained actual damages as a result of another's engaging in conduct made actionable under § 16 of article 21.21. The court's desire to apply the "proper interpretation" to this clear and unambiguous statute runs afoul of the well-established rule that when a statute is not ambiguous, there is no need to resort to the rules of construction and the court must not construe the statute, but enforce it as written.¹⁰⁴

A person complaining about acts or practices that violate article 21.21 can also bring an action under the Deceptive Trade Practices Act. However, to do so the person must meet the definition of "consumer", which is one who seeks or acquires goods or services by purchase or lease.¹⁰⁵ The court in *3Z Corp. v. Stewart Title Guaranty Co.*¹⁰⁶ was faced with the issue of whether a prospective purchaser of title insurance is "consumer" with standing to sue under the DTPA. Several years after purchasing property, 3Z Corporation discovered that the property was subject to two liens, neither of which had been disclosed by the seller, title company or title insurer. In fact, 3Z Corporation specifically asked about these liens and was told that they did not affect the property being purchased.

3Z Corporation then brought suit against Stewart Title of Montgomery County and Stewart Title Guaranty Company under various theories, including violations of the DTPA and Insurance Code. Both defendants filed motions for summary judgment, which were granted. The court of appeals affirmed the judgment and award of attorney's fees as to Stewart Title Guaranty Company, but reversed the judgment as to Stewart Title of Montgomery County and remanded for trial.

The court of appeals first discussed whether 3Z Corporation was a consumer under the DTPA. 3Z Corporation argued that it was a consumer because it was seeking to purchase a title policy. Stewart Title argued that 3Z Corporation was not a consumer because it did not purchase the title policy within the life of the commitment. The court held that to be a consumer, one must seek or acquire goods or services by purchase or lease.¹⁰⁷ The court held that "the term 'services' includes the purchase of insurance policies and even though the transaction is not consummated, the prospec-

103. *Id.*

104. See *RepublicBank Dallas, N.A. v. Interkal, Inc.*, 691 S.W.2d 605, 612 (Tex. 1985), and *Cail v. Service Motors, Inc.*, 660 S.W.2d 814, 815 (Tex. 1983).

105. TEX. BUS. & COM. CODE ANN. § 17.45(4) (Vernon 1987).

106. 851 S.W.2d 933 (Tex. App.—Beaumont 1993, writ denied).

107. *Id.* at 937.

tive purchasers are considered consumers."¹⁰⁸ Because there was a question of fact as to whether 3Z Corporation intended to purchase a title policy or was merely obtaining what it thought was a free title examination until such time as the property could be sold, the court held that Stewart Title failed to establish, as a matter of law, that 3Z Corporation was not a consumer.

2. *Who Can Be Sued*

In *Great American Insurance Co. v. North Austin Municipal Utility District No. 1*¹⁰⁹ the court found that article 21.21 applies to commercial sureties. The North Austin Municipal Utility District No. 1 (MUD) advertised for bids to construct a waste-water lift station. MUD requested that the bidders provide alternative bids: one for a newly constructed dry well, and the other for the refurbishment and relocation of the existing dry well. Underground Utilities was awarded the contract for the refurbishment and relocation of the existing lift station. Great American issued a performance bond on behalf of Underground Utilities and in favor of MUD. The contract between MUD and Underground Utilities provided for a one-year correction period after MUD's acceptance of the project. This provision required Underground Utilities to correct or replace any defective work. In connection with Underground Utilities' obligation under this provision, Great American, as surety, issued a one-year maintenance bond in favor of MUD.

Within the first year of MUD's acceptance of the project, one of the sides of the dry well began to collapse. MUD concluded that the collapse resulted because the sides of the dry well were not of sufficient thickness for the depth of burial. MUD requested Underground Utilities to make repairs. Underground Utilities refused, claiming (1) that it had performed all work in accordance with the plans and specifications; (2) that the engineer approved the work; (3) that MUD accepted the work; and (4) that the subcontractor who refurbished the well was liable under his manufacturer's warranty for the deformity.

MUD then informed Great American that the dry well was suffering from a structural deformity and that Underground Utilities refused to make repairs. MUD demanded that Great American perform under the terms of its maintenance bond. Great American responded that the structural defect was the result of a design defect for which Underground Utilities was not liable under the terms of the contract. Therefore, Great American refused to perform under the maintenance bond.

MUD filed suit, asserting various claims against Underground Utilities, the engineer, the subcontractor, and Great American. The jury found that all four defendants were liable and that Great American had engaged in unfair or deceptive acts or practices. Great American appealed the judgment against it, arguing that article 21.21 of the Insurance Code does not apply to commercial sureties. Great American maintained that a commer-

108. *Id.*

109. 850 S.W.2d 285 (Tex. App.—Austin 1993, writ requested).

cial surety is not engaged in the "business of insurance" for the purposes of article 21.21. The court disagreed,¹¹⁰ looking to article 1.14-1 of the Insurance Code, which defines "the business of insurance" as including: "The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business activity of the guarantor or surety."¹¹¹

Great American countered by asserting that the definition of the "business of insurance" in article 1.14-1 should not apply to article 21.21 because neither article refers to, or incorporates, the other's definitions. The court held, however, that neither article excludes the definitions of the other and if the legislature had intended to exclude sureties from article 21.21, it could have done so, as was done in article 21.55 of the Insurance Code.¹¹²

Great American next argued that the definition in article 1.14-1 should not apply to article 21.21 because the purposes of the statutes are different. According to Great American, article 1.14-1 defines the general business activities that are subject to the overall jurisdiction for the State Board of Insurance, while article 21.21 regulates specific activities relating to the "business of insurance," which the legislature has deemed to be unfair or deceptive. The court rejected this argument because it "would allow sureties to be 'regulated' as entities engaged in the business of insurance, yet would make it impossible to prohibit them from engaging in unfair or deceptive practices while conducting this business."¹¹³

Great American also argued that federal case law should control the interpretation of "business of insurance" found in article 21.21. The court held that its analysis was not inconsistent, either with the purpose of the Insurance Code as expressed in article 21.21 or with the intent of Congress, expressed in the McCarran-Ferguson Act.¹¹⁴

In *Ayoub v. Baggett*¹¹⁵ Ayoub sued his insurer, Truck Insurance, and Baggett, the employee responsible for the handling of his claim, under article 21.21 for the unreasonable delay in investigating and adjusting his claim. Truck Insurance, a California corporation, removed the case to federal court claiming that Baggett, a Texas citizen, was fraudulently joined as a defendant in order to defeat diversity jurisdiction. The court noted that a remand was required unless Baggett was included as a defendant without a plausible legal basis.

Ayoub argued that because section 2 of article 21.21 includes in the class of "persons" who can be sued insurance adjusters, he alleged a viable cause of action against Baggett, the claims adjuster for Truck Insurance. The court felt that article 21.21 is designed to regulate the business entities that provide insurance, not the employees of those providers.¹¹⁶ Thus, the court

110. *Id.* at 288.

111. TEX. INS. CODE ANN. art. 1.14-1, § 2(a)(2) (Vernon Supp. 1993).

112. *Great American Ins. Co.*, 850 S.W.2d at 289.

113. *Id.*

114. *Id.*

115. 820 F. Supp. 298 (S.D. Tex. 1993).

116. *Id.* at 299.

concluded that Ayoub could not maintain an action under article 21.21 against Baggett for his conduct committed while adjusting Ayoub's claims.¹¹⁷

Here again, a court refuses to enforce the statutory language as written. As mentioned above, section 16 of article 21.21 permits any person to sue another *person* who engages in conduct prohibited by the statute. Section 2 of article 21.21 clearly and simply defines a "person" so as to include "*any individual, . . . and any other legal entity engaged in the business of insurance, including . . . adjusters, . . .*" This definition clearly shows that insurance companies are not the only one that can be sued under article 21.21. Moreover, prior to 1985, section 16 permitted suit to be brought against the "company or companies" engaging in the wrongful conduct. The 1985 amendments to article 21.21 substituted the words "person or persons" for "company or companies", clarifying the legislature's intent to subject insurance company employees to the regulation of the statute.

If the statute wasn't clear enough, any uncertainty the court had could have been dispelled by looking to the regulations promulgated under article 21.21 by the Department of Insurance. The purpose of these regulations is as follows:

It is the purpose of these sections to further define and state the standards that are necessary to prohibit deceptive acts or deceptive practices by insurers and insurance agents *and other persons* in their conduct of the business of insurance or in connection therewith, whether done directly or indirectly, and irrespective of whether the person is acting as insurer, principal, agent, employer, *or employee*, or in other capacity or connection with such insurer.¹¹⁸

Thus, the court was simply wrong when it said there is nothing in article 21.21 to suggest "that private claims against individual employees are part of the Texas scheme" of regulating insurance.¹¹⁹

In contrast to *Ayoub* is *Transport Insurance Co. v. Faircloth*,¹²⁰ where the court affirmed a judgment under article 21.21 against the insurer, its adjusting company, the adjusting company's employee, an attorney, and a person who had been appointed guardian over Faircloth when she was a minor. Faircloth sued all these parties under article 21.21 for conduct that led to her receiving a grossly inadequate settlement when she was 15 years old for the death of her mother and step-father.

After concluding that Paula had standing to recover under article 21.21, the court held that Paula was entitled to recover from Transport, the insurer, and the other defendants. The court, relying on the regulation quoted

117. *Id.* at 300. Compare *Herman v. Millicovsky*, 834 F. Supp. 182 (S.D. Tex. 1993) where a different judge from the Southern District remanded a case against an insurer and its adjuster, concluding that article 21.21 "arguably provides a cause of action against individuals," such as adjusters.

118. 28 TEX. ADMIN. CODE § 21.1 (West 1988) (emphasis added).

119. *Ayoub*, 820 F. Supp. at 300.

120. 861 S.W.2d 926 (Tex. App.—Beaumont 1993, writ requested).

above,¹²¹ held that because these other defendants were connected with Transport, they were all prohibited from engaging in deceptive acts or practices in the business of insurance.¹²² Additionally, the court held that all defendants were liable to Faircloth because the jury found that they had joined in a civil conspiracy to defraud her.¹²³

B. PRE-SUIT NOTICE OF COMPLAINT

Article 21.21 provides that at least thirty days before a lawsuit is filed the person seeking damages must give the alleged wrongdoer written notice of the specific complaint including the amount of actual damages, expenses and attorney's fees.¹²⁴

In *State Farm Fire & Casualty Co. v. Price*¹²⁵ Price sued State Farm under the DTPA, article 21.21 and for breach of the duty of good faith and fair dealing as a result of State Farm's refusal to pay under Price's homeowners policy for damage to his house. After the initial inspection of the damages, a claims adjuster for State Farm told Price the claim would be paid because the plumber determined the damage was caused by a plumbing break. State Farm then had an engineer inspect the house. Based on this inspection, State Farm determined the damage was caused by the settling of the house over a period of years, and the claim was denied.

The jury found that the damage to the house was caused by accidental discharge, breakage, or overflow of water from within a plumbing, heating, or air conditioning system, and that State Farm engaged in unfair or deceptive acts or practices in the business of insurance. The jury found actual damages of \$102,500 and the trial court awarded additional damages of \$205,000.

State Farm argued that Price did not give notice of his claims under the DTPA and Insurance Code prior to filing suit. When Price filed suit he alleged only a breach of contract action. Price then gave notice and waited thirty days before amending in claims under the DTPA and Insurance Code.¹²⁶ State Farm argued that this procedure subverted the purpose of the notice requirements.

The court held that State Farm waived any complaint about notice because it did not file a plea in abatement until ten days before trial and twenty-eight months after the DTPA and Insurance Code actions had been filed.¹²⁷ The court held that for a plea in abatement to be timely, it must be

121. 28 TEX. ADMIN. CODE §§ 21.1-3 (West 1988).

122. *Faircloth*, 861 S.W.2d at 940. See also *Allstate Ins. Co. v. Carter*, 855 S.W.2d 97 (Tex. App.—Corpus Christi), writ *dism'd*, 859 S.W.2d 367 (Tex. 1993); *Perez v. Kirk & Carrigan*, 822 S.W.2d 261 (Tex. App.—Corpus Christi 1991, writ denied).

123. *Faircloth*, 861 S.W.2d at 941.

124. TEX. INS. CODE ANN. art. 21.21, § 16(e) (Vernon Supp. 1993). The DTPA has an almost identical provision, the only difference being the DTPA requires sixty days notice rather than thirty. TEX. BUS. & COM. CODE ANN. § 17.505 (Vernon Supp. 1993).

125. 845 S.W.2d 427 (Tex. App.—Amarillo 1992, writ *dism'd* by agr.).

126. At the time notice was given the DTPA also had a thirty day notice period. This was changed to sixty days in 1989. TEX. BUS. & COM. CODE ANN. § 17.505 (Vernon Supp. 1993).

127. *Price*, 845 S.W.2d at 432-33.

filed while settlement and avoidance of litigation expense remain viable. That is, when the answer is filed or soon thereafter.¹²⁸

The court concluded that Price did nothing improper by filing suit for breach of contract, sending notice, waiting the requisite time, and then adding the DTPA and Insurance Code causes of action.¹²⁹

The court's conclusion that State Farm had waived any complaint about notice for failure to file a timely plea in abatement is based upon the Texas Supreme Court's decision in *Hines v. Hash*.¹³⁰ Hash, without ever filing a plea in abatement, complained at trial that Hines had not given proper notice of his claim under the DTPA. The court of appeals held that notice had not been given and remanded for a new trial after the case had been abated for sixty days. The supreme court reversed.

The court determined that if a DTPA suit is filed without first giving notice and the defendant timely requests an abatement, the trial court must abate the proceedings.¹³¹ However, to be timely, the request for an abatement must be made with the filing of the answer, or very soon thereafter.¹³² The court reasoned that an immediate request for an abatement must be made since the purpose of the notice provision is to encourage settlement and avoid litigation expense.¹³³ Failure to make a timely request for abatement waives all complaints about lack of notice.¹³⁴

C. ACTIONABLE CONDUCT

Section 16 of article 21.21 makes actionable conduct prohibited by section 4 of article 21.21, conduct prohibited in the rules and regulations adopted by the Department of Insurance, and conduct prohibited by section 17.46 of the DTPA.¹³⁵

In *First Title Co. of Waco v. Garrett*¹³⁶ the court addressed the issue of whether a title insurer made a misrepresentation actionable under the DTPA when the title policy contained a representation that there were no restrictive covenants on the property when there was one. Garrett contracted to purchase nine acres from Jenkins and Dameron for use as an automobile salvage yard. Jenkins and Dameron, however, did not tell Garrett that there was a restrictive covenant on the property that prevented it from being used as a salvage yard. First Title Company of Waco conducted a title search, but failed to discover the restrictive covenant that was actually listed within its files. Alamo Title Company issued a title commitment affirmatively representing that no restrictive covenants appeared in the county deed records.

As a result, Garrett finalized the purchase and began to prepare the prop-

128. *Id.*

129. *Id.* at 433.

130. 843 S.W.2d 464 (Tex. 1992).

131. *Id.* at 469.

132. *Id.*

133. *Id.*

134. *Id.*

135. *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 132-33 (Tex. 1988).

136. 860 S.W.2d 74 (Tex. 1993).

erty for use as an auto salvage yard. A neighboring landowner soon complained and eventually obtained an injunction against Garrett. Garrett sued Jenkins and Dameron for misrepresentations and eventually settled with them. Garrett filed this lawsuit against First Title and Alamo Title alleging negligence and violations of the DTPA. The jury found that the title companies were negligent and made misrepresentations. The court of appeals affirmed.¹³⁷ The supreme court affirmed as to liability for negligence and DTPA violations.

The title companies argued that the contract entered into with Garrett was one of indemnity, not of guaranty — so, any incorrect representation as to the status of the property should subject them to liquidated damages under insurance policy, not damages for misrepresentation under the DTPA. The court disagreed holding that when a seller makes an affirmative representation, the law imposes a duty to know whether that statement was true.¹³⁸ In this case, the title commitment contained the representation that there were no restrictive covenants in the county deed records. There was also evidence that Garrett relied on this representation before deciding to purchase the property.

The title companies also argued that a disclaimer in the title commitment protected it from liability. The disclaimer read:

The policy to be issued pursuant to this commitment does not guarantee that the insured property has adequate title to allow it to be used, sold, transferred, leased, or mortgaged for any purpose intended by the purchaser nor will it provide coverage for possible loss of opportunity or economic expectation.¹³⁹

The title companies argued that this disclaimer was similar to the one found in *Stewart Title Guaranty Co. v. Cheatham*¹⁴⁰ to relieve a title company from liability. That disclaimer provided that the policy was:

. . . to show the results of the Company's title search "upon which only the Company may rely." None of the information contained herein, or the absence of other information, constitutes a representation to any party, other than the Company, as to the status of the title.¹⁴¹

The court distinguished *Cheatham* because there was no evidence in that case that the purchasers had even relied on the statements of the title report.¹⁴² Moreover, the court held that when representations are made, a consumer cannot waive DTPA protection.¹⁴³

An identical result was reached in *3Z Corporation v. Stewart Title Guaranty Co.*¹⁴⁴ In August 1984, Stewart Title of Montgomery County issued a commitment for a policy of title insurance to 3Z Corporation covering Lots

137. *First Title Co. of Waco v. Garrett*, 802 S.W.2d 254 (Tex. App.—Waco 1990), *aff'd in part, rev'd on other grounds*, 860 S.W.2d 74 (Tex. 1993).

138. *Garrett*, 860 S.W.2d at 76.

139. *Id.*

140. 764 S.W.2d 315 (Tex. App.—Texarkana 1988, writ denied).

141. *Id.* at 320.

142. *Garrett*, 860 S.W.2d at 77.

143. *Id.* at 77.

144. 851 S.W.2d 933 (Tex. App.—Beaumont 1993, writ denied).

one and 35 in a subdivision in Montgomery County. At that time, title was vested in Anchor Financial Corporation and the commitment actually covered other lots in the subdivision. Certain exceptions were noted in the policy, including a vendor's lien in favor of Lambright, covering six lots in the subdivision, including Lots one and 35. Also noted was a deed of trust in favor of First City Bank that covered four lots, but did not include Lots one and 35.

In September 1984, 3Z Corporation received a deed of conveyance to Lots one and 35 from Anchor. The conveyance was expressly subject to a lien in favor of First City, but in view of the policy of commitment reflecting that the subject property was not covered by the lien, 3Z Corporation was not concerned. The grantor had always represented that the subject property was not affected by the Lambright vendor's lien.

Again, 3Z Corporation ordered a policy of title insurance for Lots one and 35 from Stewart Title of Montgomery County, and a policy of commitment was issued on January 20, 1986. The list of exceptions did not include the vendor's lien in favor of Lambright and the deed of trust in favor of First City Bank. In August 1986, another policy of commitment for Lots one and 35 was issued and it read identical to the policy of commitment dated in January 1986.

After receiving the January 1986 commitment, 3Z Corporation called Stewart Title to make sure that the Lambright vendor's lien and the First City Bank lien did not apply to the property. The president of 3Z Corporation spoke to Keller, an assistant vice-president at Stewart Title, who allegedly told him that the policy of commitment was absolutely right and that there were only three liens against lots, none of which were the Lambright or First City Bank liens.

Near the end of 1989 or beginning of 1990, 3Z Corporation noticed that it had not received any tax statements on the property. The tax collector informed 3Z Corporation that the lots were no longer in the name of 3Z Corporation, but in the name of a third-party. When 3Z Corporation called Stewart Title, it was informed that First City Bank had foreclosed on their lien covering the property and that it had been sold at a trustee sale.

3Z Corporation brought suit against Stewart Title of Montgomery County and Stewart Title Guaranty Company under various theories, including violations of the DTPA and Insurance Code, common law fraud, and negligent misrepresentation. Both defendants filed motions for summary judgment, which were granted. The trial court held that 3Z Corporation's claims were groundless and brought in bad faith or for the purpose of harassment and awarded \$1,500 as reasonable attorneys' fees to each defendant. The court of appeals affirmed the judgment and award of attorney's fees as to Stewart Title Guaranty Company, but reversed the judgment as to Stewart Title of Montgomery County and remanded for trial.

Stewart Title argued that it had no duty to disclose the title defects to 3Z Corporation. The court held that while a title company does not owe a duty to the insured to discover and disclose a title defect, it does have a duty to

know if its representations are true.¹⁴⁵ Therefore, a title insurer can be liable under the DTPA for affirmatively misrepresenting that a title defect does not exist.¹⁴⁶ Thus, the alleged misrepresentation that the property was not subject to the Lambright and First City liens was actionable under the DTPA.

The court held, however, that Stewart Title Guaranty Company could not be liable for the misrepresentations of Stewart Title because the individual making the statement was the agent of Stewart Title, not Stewart Title Guaranty. Because a title policy was never issued, Stewart Title Guaranty never became an indemnitor. The court, therefore, affirmed the judgment in favor of Stewart Title Guaranty.

In *Lawyers Surety Corp. v. Royal Chevrolet, Inc.*¹⁴⁷ the court addressed the issue of whether the refusal to pay under a surety bond issued to a car dealer for his bad checks was actionable under the Insurance Code and the DTPA. Don Lancaster, the car dealer, posted a \$25,000 bond before receiving a dealer's license in accordance with statute.¹⁴⁸ This bond was issued by Lawyers Surety. After the checks Lancaster wrote to purchase a number of used cars from Royal Chevrolet were returned for insufficient funds, Royal Chevrolet sued him and recovered a judgment in excess of \$25,000. Lawyers Surety refused to pay the claim submitted by Royal Chevrolet claiming that it was a surety only for Lancaster's bad bank drafts, not bad checks.

Royal Chevrolet then sued Lawyers Surety alleging violations of the DTPA and the Insurance Code. At trial, the parties stipulated to \$25,000 in actual damages. The jury found in favor of Royal Chevrolet and the trial court rendered judgment for Royal Chevrolet. The court of appeals affirmed.

Lawyers Surety argued that no evidence supported the jury's findings that it engaged in conduct prohibited by the DTPA and Insurance Code. The evidence showed, however, that after Royal Chevrolet initially notified Lawyers Surety that Lancaster purchased automobiles with bank drafts backed by insufficient funds, Lawyers Surety replied that it would not consider the claim until Royal Chevrolet obtained a judgment against Lancaster. Royal Chevrolet reduced its action against Lancaster to judgment and demanded that Lawyers Surety pay the bond. Lawyers Surety denied the claim asserting that the bond covered only the failure to pay a bank draft and not a bad check. Royal Chevrolet also provided evidence that Lawyers Surety litigated this very issue in the past and that judgments were obtained against Lawyers Surety that bank drafts include checks. The court found that this evidence supported the jury's finding that Lawyers Surety failed to attempt to effectuate a prompt, fair, and equitable settlement of the claim when liability had become reasonably clear and that it had done so knowingly.¹⁴⁹

In *St. Paul Insurance Co. v. Rakkar*¹⁵⁰ Rakkar owned a rental house that

145. *Id.* at 937.

146. *Id.*

147. 847 S.W.2d 624 (Tex. App.—Texarkana 1993, writ denied).

148. TEX. REV. CIV. STAT. ANN. art. 6686(a)(1-A)(vii) (Vernon Supp. 1993).

149. *Lawyers Surety*, 847 S.W.2d at 628-29.

150. 838 S.W.2d 622 (Tex. App.—Dallas 1992, no writ).

was destroyed by fire. The fire started when Rakkar lit a hibachi on the kitchen floor and then passed out. When he awoke, the cabinets were on fire, and there was no water at the house. By the time a fire truck arrived, the house was engulfed in flames. The next day St. Paul was notified of the loss. Rakkar waited almost two months before receiving a proof of loss form, which he timely filed with St. Paul. After much delay, St. Paul denied his claim accusing him of intentionally setting the fire. Even so, St. Paul promised to pay off the mortgage, but never did. Rakkar paid the mortgage company himself and took an assignment from the mortgage company of its rights to the insurance payment. When St. Paul learned that Rakkar had an assignment from the mortgagee for the insurance proceeds, St. Paul still refused to pay Rakkar.

St. Paul argued on appeal that the trial court erred in awarding treble damages because Rakkar failed to establish entitlement to recovery under article 21.21. The court rejected this argument, noting that the jury found that St. Paul had breached its duty of good faith and fair dealing. As such conduct amounts to a unfair or deceptive act, the court held that Rakkar had prevailed under his article 21.21 cause of action.¹⁵¹

In *Transport Insurance Co. v. Faircloth*¹⁵² Faircloth brought suit under article 21.21 against Transport and others alleging unfair practices and fraud committed in connection with their obtaining a settlement from her after the death of her mother and her husband. Based on the jury's verdict, the trial court entered judgment in favor of Paula.

The court of appeals concluded that Paula was entitled to recover under article 21.21 because she obtained findings that the defendants committed an unlisted deceptive trade practice under DTPA § 17.46(a); committed an unfair claims settlement practice as defined in article 21.21-2 and 28 TEX. ADMIN. CODE § 21.203; committed deceptive trade practices listed in DTPA § 17.46(b); engaged in a trade practice determined by law to be unfair or deceptive (breach of the duty of good faith and fair dealing).¹⁵³ The court also determined that a common law fraud action can serve as the foundation for a violation of DTPA § 17.46 and article 21.21 § 16.¹⁵⁴

In *Commonwealth Lloyds Insurance Co. v. Downs*¹⁵⁵ the jury found, inter alia, that Commonwealth Lloyds committed violations of the DTPA and article 21.21 of the Insurance Code in the manner in which it handled Downs' claim for the death of five horses caused when the roof of his horse arena collapsed due to a severe winter storm. Commonwealth argued that the evidence was insufficient to support the jury's finding that it violated the Insurance Code and the DTPA. According to the court, these causes of action focused on the conduct of Commonwealth during the procurement phase of the policy.¹⁵⁶ It was undisputed that Downs desired insurance cov-

151. *Id.* at 628. See *Vail*, 754 S.W.2d at 135.

152. 861 S.W.2d 926 (Tex. App.—Beaumont 1993, writ requested).

153. *Id.* at 940-41.

154. *Id.* at 941.

155. 853 S.W.2d 104 (Tex. App.—Fort Worth 1993, writ denied).

156. *Id.* at 117.

erage on his property that corresponded with the insurance clause in the lease he had with his tenant. Downs testified that he provided Commonwealth with a copy of the lease that required Downs to insure the building against loss or damage by fire, explosion, or other hazards and contingencies. The court found no evidence that Commonwealth engaged in any unfair or deceptive act or practice because the insurance coverage that was provided by Commonwealth satisfied the requirements of the lease.¹⁵⁷ Furthermore, there was no evidence that Commonwealth made any representations to Downs about the extent of the insurance coverage except that the coverage provided satisfied the requirements of the lease.¹⁵⁸

The article 21.21 cause of action in *Jerry v. Kentucky Central Insurance Co.*¹⁵⁹ was based on the alleged failure of the insurer to attempt to effectuate settlement of the claim once liability became reasonably clear, conduct defined to be an unfair claims settlement practice in both article 21.21-2¹⁶⁰ and the Department of Insurance regulations.¹⁶¹ This conduct is actionable under section 16 of article 21.21 as conduct declared unlawful by Board Order 41060 through its incorporation of conduct defined as unfair or deceptive in other portions of the Insurance Code and other regulations.¹⁶²

The court found two reasons why the Jerrys could not recover under article 21.21. First, the court held that the Jerrys did not introduce any evidence of other claims and did not prove that Kentucky Central acted in accordance with a general business practice.¹⁶³ Secondly, the court held that since there was no breach and no liability under the contract, Kentucky Central's liability never became reasonably clear, and it could not be accused of an unfair failure to settle.¹⁶⁴

It is not clear from the court's opinion that the Jerrys were required to prove "frequency" in order to establish Kentucky Central's liability under article 21.21. The Jerrys had two options under article 21.21 for bringing an action for Kentucky Central's failing to effectuate a settlement once liability became reasonably clear, either as a violation of 28 Tex. Admin. Code § 21.3 or 28 Tex. Admin. Code § 21.203(4). The court does not mention the route chosen by the Jerrys. If the Jerrys had gone through § 21.3, which incorporates violations of article 21.21-2, they would not have been required to prove frequency.¹⁶⁵ However, if the Jerrys were alleging a violation of § 21.203(4), they would have had to prove frequency.¹⁶⁶

"Frequency," however, is no longer an element of proof under either of these regulations nor under article 21.21-2. As of September 1, 1991, the legislature deleted from article 21.21-2 the requirement to show that the in-

157. *Id.* at 118.

158. *Id.*

159. 836 S.W.2d 812 (Tex. App.—Houston [1st Dist.] 1992, writ denied).

160. TEX. INS. CODE ANN. art. 21.21-2, § 2(b)(4) (Vernon Supp. 1993).

161. 28 TEX. ADMIN. CODE § 21.203(4) (West 1988).

162. *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 133 (Tex. 1988).

163. *Jerry*, 836 S.W.2d at 816.

164. *Id.*

165. *Vail*, 754 S.W.2d at 134.

166. *Chitsey v. National Lloyds Ins. Co.*, 738 S.W.2d 641, 643 (Tex. 1987).

surer was committing unfair claim settlement practices with such frequency as to indicate a general business practice. This same language was also deleted from 28 Tex. Admin. Code § 21.203 by the State Board of Insurance in July 1992.

In *Love of God Holiness Temple Church v. Union Standard Insurance Co.*¹⁶⁷ the Love of God Holiness Temple Church sued Union Standard under article 21.21 after it denied the church's claim for water damage to its building. The trial court granted Union Standard's motion for instructed verdict on the article 21.21 claim, and the jury found that the church's damage was not caused by an event covered by the policy. The trial court, therefore, rendered a take-nothing judgment. The court of appeals affirmed.

The church argued that the trial court should not have granted Union Standard's motion for instructed verdict on its claim under article 21.21. The church alleged that Union Standard committed an unfair claim settlement practice by compelling it to institute a suit to recover amounts due under the policy by offering substantially less than the amount ultimately recovered in the suit brought by the church. According to the court, when an insurer has a reasonable basis for denying a claim, the insurer does not violate any provision of article 21.21-2.¹⁶⁸ Because the jury found there was no coverage under the policy, the court held that the denial of the claim could not have been an unfair claim practice.

The court made a grave mistake in stating that, "[a]s long as there exists a reasonable basis for the insurer to deny the insured's claim, the insurer does not violate *any* provision of Article 21.21-2."¹⁶⁹ Most of the conduct listed in article 21.21-2 as unfair claims settlement practices are not dependent on coverage. For example, article 21.21-2, § 2(b)(1) prohibits knowing misrepresentations of pertinent facts or policy provisions relating to coverages at issue. Thus, if the insurer represents that a provision allows coverage for a certain loss, but in fact coverage is excluded, there can be liability without contractual coverage.

Additionally, a finding of coverage is not necessary to establish a violation of article 21.21-2, § 2(b)(4), which prohibits refusing to pay a claim "in which liability has become reasonably clear." If the Legislature intended to require a finding of coverage, the language would have been supplanted with "where it is proven that liability exists under a policy of insurance."

The court in *McCracken v. United States Fire Insurance Co.*¹⁷⁰ could find no evidence of misrepresentations and thus granted a summary judgment in favor of the insurer. While driving his stepfather's power boat, McCracken accidentally ran over and killed his friend, Doug Swafford, who had been water skiing behind the boat. Williams, the stepfather, had watercraft insurance through State Farm and an umbrella policy through U.S. Fire. Following the accident, the Swafford family filed a wrongful death and survival

167. 860 S.W.2d 179 (Tex. App.—Texarkana 1993, writ requested).

168. *Id.* at 182.

169. *Id.* (emphasis added).

170. 802 F. Supp. 30 (W.D. Tex. 1992).

statute lawsuit against McCracken and Williams. However, U.S. Fire notified McCracken that he was not covered under Williams' umbrella policy because he did not fit the policy's definition of an "insured."

United States Fire then filed a declaratory judgment action concerning coverage under the policy. After a trial on the merits, the court found (1) the umbrella policy's definition of "insured" to be ambiguous; and (2) McCracken was an "insured" under the policy because such ambiguities must be resolved in favor of recovery for the insured. The Swaffords eventually agreed to a \$550,000 settlement, \$350,000 of which was paid by U.S. Fire. McCracken then filed this lawsuit against U.S. Fire for violations of the Insurance Code and DTPA, and breach of the duty of good faith and fair dealing. McCracken sought to recover past and pending attorney's fees as well as damages for emotional distress.

United States Fire moved for summary judgment on McCracken's claim of misrepresentation under the DTPA and Insurance Code. The court granted this motion because it could find no evidence of a misrepresentation of coverage. The evidence showed that United States Fire never represented that McCracken would be covered because it was unaware of McCracken's existence when the policy was sold. The court disregarded, as mere opinion and conclusory, Williams' controverting affidavit stating that he believed, and was led to believe, that the U.S. Fire policy expressly covered McCracken and anyone else who operated the boat.¹⁷¹

D. DAMAGES

1. Actual Damages

Article 21.21 provides that any plaintiff who prevails thereunder may obtain his or her actual damages.¹⁷² The DTPA also uses the term "actual damages" and courts have construed this term to encompass all damages caused by the unfair or deceptive act or practice to ensure that the injured person is made whole.¹⁷³ Thus, the damages cannot be limited to a specific measure of damages, but the court should allow the measure of damages which affords the greatest recovery.¹⁷⁴

a. Mental Anguish

i. Is a "Knowing" Violation Required?

In *Beaston v. State Farm Life Insurance Co.*¹⁷⁵ Heaton, an agent with State Farm, sold Terri and David Beaston graduated-premium whole life policies. The monthly payment on David Beaston's policy, due on December 28, 1983, was not paid. The thirty-one-day grace period ran from December 28, 1983 to January 28, 1984. On January 31, 1984, David Beaston

171. *Id.* at 35.

172. TEX. INS. CODE ANN. art. 21.21, § 16(b)(1) (Vernon Supp. 1993).

173. *Henry S. Miller Co. v. Bynum*, 836 S.W.2d 160, 162 (Tex. 1992).

174. *Id.*; *Kish v. Van Note*, 692 S.W.2d 463, 466-67 (Tex. 1985).

175. 861 S.W.2d 268 (Tex. App.—Austin 1993, writ requested).

was killed in a one-car accident. When Terri Beaston called on State Farm to pay the life insurance policy benefits, State Farm refused, contending that David Beaston's policy had lapsed on January 28, three days before his death.

Terri Beaston filed suit against State Farm and Heaton asserting claims for breach of contract, violations of article 21.21, and the DTPA. The jury found that State Farm engaged in unfair or deceptive acts prohibited by article 21.21 and that such conduct was a producing cause of damages to Terri Beaston. However, the jury made no finding as to "knowing" conduct. With respect to damages, the jury awarded \$200,000 for Terri Beaston's mental anguish. Unaware that the trial court had found coverage as a matter of law, the jury did not award Terri Beaston the policy benefits as damages.

Based on an earlier instructed verdict, the trial court awarded the policy benefits of \$250,000. The court's judgment, however, did not include the jury's mental anguish award. The court held that these damages were not recoverable without a finding that the defendants acted "knowingly." Additionally, the trial court refused to treble Beaston's actual damages. The court of appeals modified the judgment of the trial court, and as modified, affirmed.

Beaston first argued that the judgment should have included the jury's award of mental anguish damages because a finding of "knowing" conduct is not essential to a recovery of such damages. The trial court refused to allow these damages without proof of "knowing" conduct based on *Luna v. North Star Dodge Sales, Inc.*¹⁷⁶ In *Luna*, the court held that mental anguish damages are recoverable under the DTPA when there is a showing that the defendant acted "knowingly."¹⁷⁷ This decision was reached at a time when the law permitted recovery of mental anguish damages only when there was a physical injury or physical manifestation of the mental anguish. As an exception to the physical-injury rule, the law recognized that mental anguish was recoverable when there was proof of intentional, willful, or grossly negligent conduct. The court in *Luna* held that "knowingly" was a mental state that lay between gross negligence at the bottom, and intentional at the top,¹⁷⁸ therefore, mental anguish damages were recoverable where there was a finding of "knowing" misconduct.

The physical-injury or physical-manifestation requirement, however, was abolished several years after *Luna* in *St. Elizabeth Hospital v. Garrard*.¹⁷⁹ Following *Garrard*, the Austin Court of Appeals, on two occasions, questioned whether a finding of "knowing" misconduct was still a prerequisite for recovering mental anguish damages under the Insurance Code.¹⁸⁰ Addi-

176. 667 S.W.2d 115 (Tex. 1984).

177. *Id.* at 117.

178. *Id.* at 118.

179. 730 S.W.2d 649 (Tex. 1987).

180. *State Farm Fire & Cas. Co. v. Gros*, 818 S.W.2d 908, 915 (Tex. App.—Austin 1991, no writ); *HOW Ins. Co. v. Patriot Fin. Serv., Inc.*, 786 S.W.2d 533, 541 (Tex. App.—Austin 1990, writ denied).

tionally, in *Milt Ferguson Motor Co. v. Zeretzke*¹⁸¹ the San Antonio Court of Appeals expressly held that a finding of "knowingly" was not necessary to recover mental anguish damages in a DTPA case in light of *Garrard*.

State Farm argued, however, that the supreme court has reverted back to the *Luna* decision by virtue of its opinion in *Boyles v. Kerr*.¹⁸² In the *Boyles* case, the Texas Supreme Court overruled the portion of *Garrard* authorizing a cause of action for negligent infliction of emotional distress. The *Boyles* court, however, upheld and reaffirmed the *Garrard* decision that abolished the physical-injury or physical-manifestation requirement for recovery of mental anguish damages, but in dicta stated that mental anguish damages may not be recovered under the DTPA absent proof of a willful or grossly negligent violation.¹⁸³ The *Beaston* court rejected this argument.

First, the court stated that *Luna* is controlling authority only for DTPA claims.¹⁸⁴ *Beaston*, however, recovered under article 21.21 of the Insurance Code. State Farm argued that there was no substantial difference between the DTPA and the Insurance Code so as to justify a different result than that found in *Luna*. The court disagreed. According to the court, while the DTPA and article 21.21 are interrelated and have a common history, the general scope and purpose of the statutes are very different.¹⁸⁵ Generally, violations of article 21.21 occur from conduct that is proscribed by statutes, rules, and regulations of the State Board of Insurance. These proscriptions involve the entire insurance industry. According to the court, insurance companies and their personnel are presumed to know the legal parameters of the rules of the Insurance Code, unlike businesses affected by the DTPA, which are not regulated by any state agency. "Therefore, it is difficult for an insurance company to argue that its violation of article 21.21 is just an 'innocent mistake.'"¹⁸⁶

Another reason that the court decided *Luna* was not applicable was that it was decided prior to the supreme court's decision in *Garrard*, which abolished the physical injury requirement.¹⁸⁷ The court acknowledged that the supreme court in *Boyles v. Kerr* held that mental anguish damages can no longer be recovered for negligent infliction of emotional distress, but noted that the supreme court made clear that its decision did not affect a claimant's right to recover mental anguish damages caused by the defendant's breach of some other legal duty.¹⁸⁸ In this case, the other legal duty was established by article 21.21, which "forbids any person in the business of insurance from engaging in unfair insurance practices."¹⁸⁹

The court also noted that in *Boyles v. Kerr* the supreme court recognized

181. 827 S.W.2d 349 (Tex. App.—San Antonio 1991, no writ).

182. 855 S.W.2d 593 (Tex. 1993).

183. *Id.* at 598.

184. *Beaston*, 861 S.W.2d at 274.

185. *Id.*

186. *Id.* at 275.

187. *Id.*

188. *Id.*

189. *Id.*

that a special relationship between the parties may give rise to a duty, which, if breached, would support mental anguish damages.¹⁹⁰ The court held that because the relationship between the insurer and insured is a "special relationship" giving rise to a duty of good faith and fair dealing, when that duty is breached, mental anguish damages are recoverable without proof of "knowing" conduct.¹⁹¹

ii. *What Is Compensable Mental Anguish?*

Mental anguish has been defined by the courts as a "mental sensation of pain resulting from such painful emotions as grief, severe disappointment, wounded pride, shame, despair, and public humiliation."¹⁹² In *Beaston*, State Farm argued that there was insufficient evidence to support the jury's finding of mental anguish damages. The court disagreed in view of the evidence that Terri Beaston experienced depression, was much upset, and had been subjected to State Farm's attacks on her character and extensive inquiry into alleged marital difficulties and discord. The court held that mental anguish damages are uniquely the province of jurors who are best suited to determine, by reference to their own experiences, the degree to which the plaintiff has suffered compensable mental anguish.¹⁹³ The court, thus, did not disturb the jury's finding regarding mental anguish damages.

The court in *Benefit Trust Life Insurance Co. v. Littles*¹⁹⁴ was also asked to review the evidence supporting the jury's finding of mental anguish damages. Like the Austin court in *Beaston*, the *Littles* court held that jurors are best suited to determine, by reference to their own experience, whether and to what extent the defendant's conduct caused compensable mental anguish.¹⁹⁵ The evidence revealed that Benefit's failure to pay the medical bills caused Littles embarrassment to the point that he did not have additional necessary treatment because Littles could not pay the bills, and Littles knew Benefit would not pay them. This resulted in some scarring remaining on his lip and neck that caused Littles to withdraw from his wife, son, and friends and to feel insecure. The court held that this evidence was sufficient to support the judgment for mental anguish damages.¹⁹⁶

b. Policy Benefits

In *Vail v. Texas Farm Bureau Mutual Insurance Co.*¹⁹⁷ the court held that

190. *Id.*

191. *Id.*

192. *Benefit Trust Life Ins. Co. v. Littles*, No. 04-91-00653-CV, 1993 WL 437192 (Tex. App.—San Antonio, Oct. 29, 1993, writ dismissed) (quoting *GAB Business Serv., Inc. v. Moore*, 829 S.W.2d 345, 350 (Tex. App.—Texarkana 1992, no writ)).

193. *Beaston*, 861 S.W.2d at 275-76. Interestingly, the court noted that the evidence of mental anguish included that caused by the aggressive defense tactics used by State Farm during the course of the litigation.

194. No. 04-91-00653-CV, 1993 WL 437192 (Tex. App.—San Antonio, Oct. 29, 1993, writ dismissed).

195. *Id.*, slip op. at 29.

196. *Id.*

197. 754 S.W.2d 129 (Tex. 1988).

the amount of the policy benefits wrongfully withheld are damages as a matter of law. Accordingly, Beaston argued that the jury's finding of \$0 as policy benefits was immaterial and the trial court should have considered the \$250,000 policy benefits as actual damages subject to trebling under article 21.21. The court of appeals acknowledged that *Vail* did support Beaston's position, but felt constrained by the jury's verdict and thus, refused to treble the policy benefits.¹⁹⁸ Unlike the Austin court, the Texarkana court followed *Vail* on this issue in *Davis v. Twin City Fire Insurance Co.*¹⁹⁹ In *Davis* the court held that, as a matter of law, the damages for breach of the duty of good faith and fair dealing are the amount of the benefits wrongfully withheld and entitled Davis to recover exemplary damages even though there was no finding of any other element of actual damages.²⁰⁰ Furthermore, the jury did not need to be asked whether the insurer's conduct was a proximate cause of damages in the amount of the benefits wrongfully withheld.²⁰¹

2. Treble (or Additional) Damages

Article 21.21 provides that a person who prevails shall recover in addition to his or her actual damages, two times the amount of the actual damages if the trier of fact determines that the defendant "knowingly" committed the acts complained.²⁰² "Knowingly" is defined as "actual awareness of the falsity, unfairness, or deception of the act or practice made the basis for the claim. . ."²⁰³ The award of additional damages is mandatory under article 21.21 upon a finding of a "knowing" violation. The DTPA also has a provision for additional damages which differs somewhat from article 21.21. Under the DTPA, the first \$1000 of actual damages are automatically doubled as additional damages upon a showing of a violation of the statute.²⁰⁴ A prevailing consumer is entitled to these mandatory additional damages even in the absence of a "knowing" violation. If the conduct was committed knowingly, the trier of fact has the discretion to award additional damages not to exceed three times the amount of actual damages.²⁰⁵

In *State Farm Fire & Casualty Co. v. Price*²⁰⁶ State Farm argued that the procedure for assessing additional damages under article 21.21 was unconstitutional because it provides for mandatory imposition of treble damages against insurance companies for acts committed knowingly, whereas the DTPA provides for discretionary treble damages against any other defendant for the same type of conduct. State Farm contended that this differentia-

198. *Beaston*, 861 S.W.2d at 278.

199. 865 S.W.2d 231 (Tex. App.—Texarkana 1993, writ requested).

200. *Id.* at 236.

201. *Id.*; see 4 STATE BAR OF TEXAS, TEXAS PATTERN JURY CHARGE PJC 110.18.

202. TEX. INS. CODE ANN. art. 21.21, § 16(b)(1) (Vernon Supp. 1993).

203. *Id.* at § 2(c).

204. TEX. BUS. & COM. CODE ANN. § 17.50(b)(1) (Vernon Supp. 1993). See also *Nationwide Mut. Ins. Co. v. Holmes*, 842 S.W.2d 335, 342 (Tex. App.—San Antonio 1992, writ denied).

205. *Id.*

206. 845 S.W.2d 427 (Tex. App.—Amarillo 1992, writ dism'd by agr.).

tion in the treatment of insurance companies, as compared to other defendants, is a violation of due process and equal protection.

Price sued State Farm under the DTPA, article 21.21 and for breach of the duty of good faith and fair dealing as a result of State Farm's refusal to pay under his homeowners policy for damage to his house. After the initial inspection of the damages, a claims adjuster for State Farm told Price the claim would be paid because the plumber determined that the damage was caused by a plumbing break. State Farm then had an engineer inspect the house. Based on this inspection, State Farm determined that the damage was caused by the settling of the house over a period of years, and the claim was denied.

The jury found that the damage to the house was caused by accidental discharge, breakage, or overflow of water from within a plumbing, heating, or air conditioning system, and that State Farm engaged in unfair or deceptive acts or practices in the business of insurance. The jury found actual damages of \$102,500 and the trial court awarded additional damages of \$205,000.

The court rejected State Farm's constitutional attack holding that State Farm had not overcome the historical presumption of the validity of the statutes.²⁰⁷ The court held that whether the constitutional provisions of due process and equal protection are offended depends on the subject on which a statute operates and the character of rights affected by the statute.²⁰⁸ The constitutional guarantees do not forbid the state from adjusting its legislation to differences and situations.

With respect to the DTPA, the court held that it was designed to protect consumers against false, misleading, and deceptive business practices and to provide efficient and economical procedures to secure such protection. To further these goals, the statute provides the possibility of treble damages in order to deter violations of the act. The court held that the treble damage provision of the DTPA does not violate due process.²⁰⁹

Turning to the Insurance Code, the court held that its purpose is to regulate trade practices in the business of insurance. The statute applies to any individual or legal entity engaged in the business of insurance and, according to the court, it applies equally to all so engaged. In providing for treble damages for knowing conduct, the legislature proportioned damages in relation to the plaintiff's actual loss to deter the knowing commission of prohibited acts or practices. The court, therefore, concluded that the damage provision rationally relates to the interest of the state and does not violate the constitutional inhibition of being so severe and oppressive as to be wholly disproportionate to the prohibited acts or practices and unreasonable.²¹⁰

The court concluded that the legislature addressed different subjects by enacting the DTPA and Insurance Code. All those within the class regu-

207. *Id.* at 439.

208. *Id.*

209. *Id.*

210. *Id.* at 440.

lated by the DTPA are treated alike, as are those within the class subject to the Insurance Code. The court held, therefore, that "the fact that State Farm's knowing violation of the Insurance Code subjected it to mandatory treble damages, [was] no basis for saying the Code's damage provision [was] a violation of due process and equal protection since the DTPA violators are exposed only to discretionary treble damages."²¹¹

This different treatment of additional damages between the two statutes is also revealed in *Lawyers Surety Corp. v. Royal Chevrolet, Inc.*²¹² Don Lancaster, doing business as Lancaster Motors, purchased wholesale a number of used cars from Royal Chevrolet. Lancaster paid for these cars by checks, which were returned for insufficient funds. When Lancaster did not cover the bad checks, Royal Chevrolet sued him and recovered a judgment in excess of \$25,000.

In accordance with statute,²¹³ Lancaster posted a \$25,000 bond before receiving a dealer's license. This bond was issued by Lawyers Surety. Lawyers Surety refused to pay the claim submitted by Royal Chevrolet claiming that it was a surety only for Lancaster's bad bank drafts, not bad checks.

Royal Chevrolet then sued Lawyers Surety alleging violations of the DTPA and the Insurance Code. At trial, the parties stipulated to \$25,000 in actual damages. The jury found that Lawyers Surety engaged in one or more deceptive acts or practices, that such acts were committed knowingly, and that Lawyers Surety's failure to act fairly and in good faith amounted to such an entire want of care as to indicate a conscious indifference to the rights of Royal Chevrolet. The jury assessed \$40,000 in exemplary damages. The trial court extended judgment of the jury's verdict but, rather than awarding the exemplary damages found by the jury, awarded \$50,000 as exemplary damages. The court of appeals affirmed.

One of the arguments made by Lawyers Surety was that the trial court should have awarded \$40,000 in additional damages rather than \$50,000 since treble damages are not mandatory under the Deceptive Trade Practices Act. The court held that while treble damages are not mandatory under the DTPA, the trial court may have awarded the mandatory additional damages under article 21.21 of the Insurance Code, therefore, the \$50,000 in additional damages was proper.²¹⁴

As mentioned, the mental state needed to justify additional damages is "knowing" conduct. In *St. Paul Insurance Co. v. Rakkar*²¹⁵ the court reversed the award of additional damages because the court found that while the promises and representations of St. Paul were proven to be false, there was no evidence that the people making the representations had actual awareness that they were false.²¹⁶ The court thought that, at worst, St. Paul was grossly negligent or reckless in its handling of Rakkar's claim. A find-

211. *Id.*

212. 847 S.W.2d 624 (Tex. App.—Texarkana 1993, writ denied).

213. TEX. REV. CIV. STAT. ANN. art. 6686(a)(1-A)(vii) (Vernon Supp. 1993).

214. *Lawyers Surety*, 847 S.W.2d at 629.

215. 838 S.W.2d 622 (Tex. App.—Dallas 1992, no writ).

216. *Id.* at 629. See also *William H. McGee & Co. v. Schick*, 792 S.W.2d 513, 520-21 (Tex.

ing of conscious indifference, however, was found to be sufficient to support an award of additional damages in *Allied General Agency, Inc. v. Moody*.²¹⁷ In light of the supreme court's holding in *Luna*²¹⁸ that "knowing" conduct lies in between conscious indifference and intentional conduct, it would seem that a finding of conscious indifference, or gross negligence, would not rise to the level required for additional damages.

Whether a measure of recovery is actual damages impacts the amount of additional damages recoverable under article 21.21 and the DTPA since under both statutes additional damages are a multiple of actual damages. In *Beaston* the trial court refused to consider prejudgment interest as actual damages subject to trebling. The court of appeals, relying on its decisions in *Celtic Life Insurance Co. v. Coats*²¹⁹ and *Paramore v. Nehring*,²²⁰ held that prejudgment interest is an element of actual damages subject to trebling.²²¹ The San Antonio court, however, has taken issue with the Austin court's position on this issue, holding that prejudgment interest is not subject to trebling. The more recent of these cases is *Benefit Trust Life Insurance Co. v. Littles*.²²²

Littles sued Benefit Trust after it refused to pay medical bills Littles incurred in connection with treatment for second and third-degree burns over his face, head, and body. Benefit Trust was the company that wrote, administered, and partially funded the group insurance plan provided by Littles' employer, the City of Victoria. After a jury trial, Leslie Littles obtained a judgment against Benefit, which included the trebling of prejudgment interest. The court of appeals found this to be error, based on the prohibition of awarding prejudgment interest on punitive damages found in *Vail v. Texas Farm Bureau Mutual Insurance Co.*²²³ The court felt that trebling prejudgment interest was not permissible because this would yield the same amount as awarding prejudgment interest on punitive damages.²²⁴

The Austin court addressed this argument in *Celtic Life*, where the court held that although the amount of damages is the same for trebling prejudgment interest and applying prejudgment interest to punitive damages, the processes are distinguishable.²²⁵ The focus is thus on the method not the result. The court held that because prejudgment interest is an element of actual damages as recognized at common law, it can be trebled even though prejudgment interest does not accrue on punitive damages.

App.—Eastland 1990), writ *dism'd*, 843 S.W.2d 743 (Tex. 1992), where the court held that a finding of gross negligence did not support an award of additional damages.

217. 788 S.W.2d 601, 604 (Tex. App.—Dallas 1990, writ denied).

218. 667 S.W.2d at 118.

219. 831 S.W.2d 592 (Tex. App.—Austin 1992), *rev'd on other grounds*, 36 Tex. Sup. Ct. J. 1259 (Sept. 10, 1993).

220. 792 S.W.2d 210 (Tex. App.—Austin 1990, no writ).

221. *Beaston*, 861 S.W.2d at 278.

222. No. 04-91-00653-CV, 1993 WL 437192 (Tex. App.—San Antonio, Oct. 29, 1993, writ *dism'd*).

223. 754 S.W.2d 129 (Tex. 1988).

224. *Littles*, slip op. at 39.

225. *Celtic Life*, 831 S.W.2d at 599.

The other case in which the San Antonio court refused to treble prejudgment interest is in *Southern Life & Health Insurance Co. v. Alfaro*.²²⁶ Without any analysis, the court concluded in *Alfaro* that *Vail* prohibits the trebling of prejudgment interest.²²⁷

When the prejudgment interest issue is closely examined it is clear that the Austin court is correct and the San Antonio court is wrong. Courts have held that "actual damages" recoverable under the DTPA are those recoverable at common law.²²⁸ At common law, prejudgment interest is recoverable as damages for the loss of use of money between the time of the injury and the judgment.²²⁹ This form of interest is commonly referred to as "interest as damages" (as opposed to interest *eo nomine*) and is awarded at common law to insure complete recovery for the detention of that which is due on account of the injury inflicted.²³⁰

Moreover, interest on indebtedness, which is not conceptually different from prejudgment interest, is an element of actual damages recoverable under the DTPA.²³¹ Thus, if an insured borrows money to pay the medical bills that an insurer refuses to pay, the insured would clearly be entitled to recover the interest incurred on this debt. Furthermore, this interest would be subject to trebling under the DTPA, which is exactly what happened in *Smith v. Baldwin*²³² and *Kold-Serve Corp. v. Ward*.²³³

When a jury finds that the defendant has violated article 21.21 knowingly, the trial court, following the mandate of the statute, is required to award, in addition to actual damages, statutory punitive damages in an amount equal to "two times the amount of actual damages."²³⁴ Because prejudgment interest is an element of actual damages, the trial court, in calculating the amount of statutory punitive damages, should multiply by two the amount of prejudgment interest, just as it multiplies by two every other element of actual damages suffered by the plaintiff. The failure of the San Antonio court to treble prejudgment interest sacrifices article 21.21's policy of deterrence by automatically reducing in all cases the amount of additional, or punitive, damages assessed against knowing law violators.

Section 16(b)(1) of article 21.21 expressly grants to the prevailing plaintiff the following recovery: "*the amount of actual damages plus court costs and reasonable and necessary attorneys' fees. If the trier of fact finds that the defendant knowingly committed the acts complained of, the court shall*

226. No. 4-91-470-CV, 1993 WL49785 (Tex. App.—San Antonio, Feb. 26, 1993, writ *dism'd*).

227. *Id.*, slip op. at 16-17.

228. *Brown v. American Transfer & Storage, Co.*, 601 S.W.2d 931, 939 (Tex.), *cert. denied*, 449 U.S. 1015 (1980).

229. *Cavnar v. Quality Control Parking, Inc.*, 696 S.W.2d 549, 552 (Tex. 1985).

230. *Id.* at 551-52.

231. *Henry S. Miller Co. v. Bynum*, 836 S.W.2d 160, 164 (Tex. 1992) (Phillips, C.J., concurring).

232. 611 S.W.2d 611, 617 (Tex. 1980).

233. 736 S.W.2d 750, 755 (Tex. App.—Corpus Christi 1987), *writ dismiss'd*, 748 S.W.2d 227 (Tex. 1988).

234. TEX. INS. CODE ANN. art. 21.21, § 16(b)(1) (Vernon Supp. 1993) (emphasis added).

award, in addition, *two times the amount of actual damages*[.]”²³⁵

Thus the same phrase, “the amount of actual damages,” describes both the award required to fully compensate the plaintiff for his losses and the unit of measurement the court must use in calculating the amount of additional or punitive damages to be assessed against a knowing law violator. The purpose of the additional damage award is not to compensate the plaintiff, but rather “to deter violations of the Insurance Code.”²³⁶

In removing the actual damage award of prejudgment interest from the additional damage calculation in the instant case, the San Antonio court has frustrated article 21.21’s policy of deterrence. Mistakenly relying on the role of prejudgment interest in compensating the plaintiff, the court has ignored the role that prejudgment interest and all other elements of actual damages play in accomplishing the goal of deterrence through the additional damage calculation. The error in emphasis is plainly seen in the following excerpt from the court’s opinion.

The purpose of awarding prejudgment interest is to compensate the injured plaintiff for lost use of money due as damages between the accrual of the claim and the judgment. That objective is achieved when prejudgment interest is added to the amount of actual damages before they are trebled. Thereafter, the measure of actual damages, without including prejudgment interest, is trebled in accordance with article 21.21 to punish the defendant for a knowing violation of the Insurance Code.²³⁷

Obviously, eliminating the amount of prejudgment interest from the additional damage calculation does not threaten the goal of compensation. That goal is, in the court’s words, “sufficiently maintained” by a single award of interest. But eliminating the prejudgment interest award from the additional damage calculation clearly frustrates the policy of deterrence because it automatically reduces the amount of deterrence. Fear of frustrating article 21.21’s policy of deterrence by reducing the amount of damages subject to trebling was the reason the Supreme Court refused to permit that amount to be reduced by a pretrial payment the plaintiff had received from a settling defendant.²³⁸ If the policy of deterrence prevents the amount of actual damages subject to trebling to be reduced by the portion of plaintiff’s damages for which he *has* been compensated, by what reason or logic can it be reduced by a portion of his damages — prejudgment interest — for which he *has not* been compensated? The point is that compensation of the plaintiff is not germane to the assessment of additional damages, the sole purpose of which is deterrence, and that to fully achieve the policy of deterrence no amount of actual damages should be excluded from the additional damage calculation.

The foregoing argument is unaffected by the statement in *Vail* that “[p]rejudgment interest may not be awarded on punitive damages.”²³⁹ As

235. *Id.*

236. *Stewart Title Guaranty Co. v. Sterling*, 822 S.W.2d 1, 9 (Tex. 1991).

237. *Littles*, slip op. at 38-39 (citations omitted).

238. *Stewart Title*, 822 S.W.2d at 9.

239. *Vail*, 754 S.W.2d at 137.

authority for this proposition, the court in *Vail* cited its opinion in *Cavnar v. Quality Control Parking, Inc.*²⁴⁰ In *Cavnar* a common law wrongful death case, the court denied prejudgment interest on punitive damages because such an award was not needed to fully compensate the plaintiff for his actual losses. Said the court in *Cavnar*, “[Punitive damages] are assessed over and above the amount of damages necessary to indemnify the plaintiff. The plaintiff can thus be made whole even if prejudgment interest is not awarded on punitive damages.”²⁴¹

But the deterrence of wrongdoers, not the compensation of the plaintiff, that is the objective of article 21.21’s additional damage award. That the plaintiff is “made whole” without the doubling of prejudgment interest as part of the additional damage award is irrelevant. A statutory cause of action establishes a precise mechanism, two times the amount of actual damages, for determining the amount of punitive damages. The court is not being asked to award prejudgment interest on an amount of punitive damages that had otherwise already been determined. Instead the court is asked to properly determine the amount of punitive damage in the first place by adherence to the statutory formula the Legislature has so clearly and unambiguously provided.

Another issue presented in *Littles* was when to start the accrual of prejudgment interest. Benefit Trust argued that to be entitled to prejudgment interest Littles had to establish precisely when each element of his damages was incurred. The court looked to *Cavnar v. Quality Control Parking, Inc.*²⁴² for assistance in resolving this issue. In *Cavnar* the court recognized that in some cases it is very difficult to establish an exact time when each element of damage occurred.²⁴³ Thus, the court devised an equitable rule that prejudgment interest would begin to accrue six months after the occurrence of the incident giving rise to the cause of action.²⁴⁴ The *Littles* court, following *Cavnar*, thus held that the trial court was correct to start the accrual of prejudgment interest six months from the date of the occurrence giving rise to his cause of action, which the court determined was the day Benefit transferred his claims to “large case management” because the claim was approaching \$50,000, the level at which Benefit would become liable under the excess policy.²⁴⁵

In *Commonwealth Lloyd’s Insurance Co. v. Thomas*²⁴⁶ the insurer argued that Thomas was not entitled to prejudgment interest because there was no evidence establishing the date Thomas suffered his actual damages, including mental anguish. The court held that while it was difficult to determine exactly when the injuries occurred, as they were suffered intermittently, this

240. 696 S.W.2d 549 (Tex. 1985).

241. *Id.* at 556.

242. 696 S.W.2d 549 (Tex. 1985).

243. *Id.* at 555.

244. *Id.*

245. *Littles*, slip op. at 40.

246. 825 S.W.2d 135, 150 (Tex. App.—Dallas 1992), *writ granted*, 843 S.W.2d 486 (Tex. 1993).

was not fatal to a recovery of prejudgment interest.²⁴⁷ Like the *Littles* court, the *Thomas* court looked to *Cavnar* for assistance and held that prejudgment interest should be calculated starting at six months after the cause of action accrued.²⁴⁸

Benefit Trust also argued that prejudgment interest should not have been compounded daily as per *Cavnar* because the legislature abrogated *Cavnar* when it amended article 5069-1.05 to allow for prejudgment interest computed as simple interest. The court noted, however, that article 5069-1.05²⁴⁹ applies only to wrongful death, personal injury, and property damage²⁵⁰ cases. Thus, *Cavnar*, not the statute, determines how prejudgment interest will be calculated in a cause of action under article 21.21.²⁵¹

3. One-Satisfaction Rule

In *First Title Co. of Waco v. Garrett*²⁵² the court determined that when a plaintiff suffers an indivisible injury, the nonsettling defendant is entitled to a credit for settlements made with the other defendants. Garrett contracted to purchase nine acres from Jenkins and Dameron for use as an automobile salvage yard. Jenkins and Dameron, however, did not tell Garrett that there was a restrictive covenant on the property that prevented use as a salvage yard. First Title Company of Waco conducted a title search, but failed to discover the restrictive covenant that was actually listed within its files. Alamo Title Company issued a title commitment affirmatively representing that no restrictive covenants appeared in the county deed records.

After Garrett purchased the property and began to prepare it for use as an auto salvage yard a neighboring landowner complained and eventually obtained an injunction against Garrett. Garrett then sued Jenkins and Dameron for misrepresentations and received \$69,000 in settlement of the claims. Garrett filed this lawsuit against First Title and Alamo Title alleging negligence and violations of the DTPA. The jury found that the title companies were negligent and made misrepresentations. First Title and Alamo Title requested the trial court to give them a credit for the \$69,000 settlement Garrett had received from Jenkins and Dameron. The trial court refused to do so. The court of appeals affirmed the trial court's decision in all respects and held that the title companies were not entitled to a credit because they

247. *Id.*

248. *Id.* But see *Thompson v. Trinity Universal Co.* 708 S.W.2d 45, 48-49 (Tex. App.—Houston [1st Dist.] 1986, writ ref'd n.r.e.), and *Campion v. Hochheim Prairie Farm Mut. Ins. Ass'n*, 644 S.W.2d 795, 797 (Tex. App.—Corpus Christi 1982, writ ref'd n.r.e.), where the courts held that prejudgment interest begins to accrue when the insurance company denies the claim.

249. TEX. REV. CIV. STAT. ANN. art. 5069-1.05, § 6 (Vernon Supp. 1993).

250. "Property damage" entails physical destruction of property and not economic loss. *Associated Tel. Directory Publishers, Inc. v. Five D's Publishing Co., Inc.*, 849 S.W.2d 894, 900 (Tex. App.—Austin 1993, no writ) (claims of conversion and unfair competition did not involve property damage). *Ciba-Geigy Corp. v. Stephens*, No. 11-92-197-CV (Tex. App.—Eastland, Feb. 24, 1994, n.w.h.) (claim for damage to crops involves property damage).

251. *Littles*, slip op. at 41.

252. 860 S.W.2d 74 (Tex. 1993).

had not established that Jenkins and Dameron were joint tortfeasors.²⁵³

The Texas Supreme Court affirmed as to liability for negligence and DTPA violations, but held that the title companies were entitled to a credit for the settlement. The court, utilizing the one-satisfaction rule discussed in *Stewart Title Guaranty Co. v. Sterling*,²⁵⁴ held that when a plaintiff suffers an indivisible injury — one that was caused by distinct actors, but is so singular in character as to make apportionment of fault impossible — the judgment should be reduced by the amount of any settlements to prevent a double recovery.²⁵⁵ However, the party seeking the benefit of a settlement credit has the burden of establishing that it is entitled to such reduction in the amount of the judgment.²⁵⁶ The court found it sufficient that the title companies placed into the record the settlement agreement from the lawsuit involving Jenkins and Dameron and the order of dismissal from that case without an actual adjudication that Jenkins and Dameron were joint tortfeasors.²⁵⁷

E. ATTORNEYS' FEES

Any plaintiff who prevails in a suit brought under article 21.21, § 16 is entitled to recover reasonable and necessary attorney's fees.²⁵⁸ The amount of attorney's fees is a question of fact and must be a reasonable amount under the particular circumstances of the case. Evidence that a contingent fee is reasonable will support an award of attorney's fees under article 21.21.²⁵⁹

The question of attorney's fees can be submitted to the jury in two ways: one question to be answered in dollars based upon testimony of the hours worked and the hourly rate of the attorney, and the other question to be answered as a percentage of the plaintiff's total recovery.²⁶⁰ In *State Farm Fire & Casualty Co. v. Price*²⁶¹ the court approved of this alternative submission and held that the jury's answers as to a percentage and a dollar figure were not conflicting since the jury was instructed to answer without considering which sum would actually be awarded by the court. According to the court, "Reasonable attorney's fees may be evidenced by a dollar amount or

253. *First Title Co. of Waco v. Garrett*, 802 S.W.2d 254, 257 (Tex. App.—Waco 1990), *rev'd*, 860 S.W.2d 74 (Tex. 1993).

254. 822 S.W.2d 1 (Tex. 1991).

255. *Garrett*, 860 S.W.2d at 78.

256. *Id.*

257. *Id.* at 79.

258. TEX. INS. CODE ANN. art. 21.21, § 16(b)(1) (Vernon Supp. 1993). A person prevails under article 21.21 if the jury finds that the defendant engaged in conduct actionable thereunder even though the jury does not award all the damages sought. *Id.* See *Barnes v. Western Alliance Ins. Co.*, 844 S.W.2d 264, 273 (Tex. App.—Fort Worth 1992, writ *dism'd* by agr.).

259. *Great Am. Ins. Co. v. North Austin Mun. Util. Dist. No. 1*, 850 S.W.2d 285, 290 (Tex. App.—Austin 1993, writ requested).

260. 4 STATE BAR OF TEXAS, TEXAS PATTERN JURY CHARGES PJC 110.15, 110.16 (1990).

261. 845 S.W.2d 427, 436 (Tex. App.—Amarillo 1992, writ *dism'd*).

by a percentage of the recovery."²⁶² Moreover, if both alternatives are submitted this allows the plaintiff to elect the alternative providing for the greatest relief that the verdict will support.

When the jury finds that the attorney's fees are a certain percentage of the plaintiff's recovery, the court, in rendering judgment, should calculate the fees as a percentage of the total recovery, *including attorney's fees*, instead of just the damages. In *Great American Insurance Co. v. North Austin Municipal Utility District No. 1*²⁶³ the court held that the proper method of calculating attorney's fees that have been found to be a percentage of the recovery is to first determine the total recovery so that after the attorney's fees are subtracted therefrom the remaining sum equals the damages. Thus, if the non-attorney fee recovery is \$100,000 and the fees are forty percent (40%) of the recovery then the \$100,000 non-attorney fee recovery must be sixty percent (60%) of the total recovery. Therefore, the total recovery is \$166,666.67, the attorney's fees are \$66,666.67, and the plaintiff's net recovery is \$100,000.00.

Any other method of calculating attorney's fees, said the court, would result in awarding the plaintiff either attorney's fees less than the percentage found by the jury or damages less than those found by the jury.²⁶⁴ For example, if attorney's fees are calculated as forty percent (40%) of \$100,000.00, or \$40,000, the plaintiff's total recovery would be \$140,000.00. The plaintiff would then have to pay his attorney forty percent (40%) of \$140,000, causing him to use \$16,000.00 of the awarded damages to pay for attorney's fees. This would defeat the fee-shifting provision of article 21.21.

A similar result was reached in *Barnes v. Western Alliance Insurance Co.*²⁶⁵ although the recovery was for damages in the forms of fees to be paid to an appraiser. Claiming that the roofs of two of his buildings were damaged by hail, Barnes filed an insurance claim with Western. Barnes and Western could not agree on the amount of the loss, so Barnes demanded that an appraisal be made and an award given based on that appraisal pursuant to terms of the insurance contract. Before initiating the appraisal process, Barnes hired Softline Services to investigate and document his claims for presentation to Western.

In accordance with the policy, Barnes and Western each appointed an appraiser. The court then appointed an umpire to whom the appraisals were

262. *Id.*; see also *Benefit Trust Life Ins. Co. v. Littles*, No. 04-91-00673-CV, 1993 WL 437192, slip op. at 34 (Tex. App.—San Antonio, Oct. 29, 1993, writ dismissed).

263. 850 S.W.2d 285, 291 (Tex. App.—Austin 1993, writ requested). The Austin court reaffirmed this method of calculating attorney's fees in *Beaston v. State Farm Life Ins. Co.*, 861 S.W.2d 268, 279 (Tex. App.—Austin 1993, writ requested). Additionally, the San Antonio court adopted this method in *Benefit Trust Life Ins. Co. v. Littles*, No. 04-91-00673-CV, 1993 WL 437192, slip op. at 35-36 (Tex. App.—San Antonio, Oct. 29, 1993, writ dismissed). See also *Aetna Casualty & Sur. Co. v. Taff*, 502 S.W.2d 903 (Tex. Civ. App.—Waco 1973, writ refused n.r.e.). But see *The Goodyear Tire & Rubber Co. v. Portilla*, 836 S.W.2d 664, 671-72 (Tex. App.—Corpus Christi 1992, writ granted on other grounds); *Berry Prop. Mgmt., Inc. v. Bliskey*, 850 S.W.2d 644 (Tex. App.—Corpus Christi 1993, writ dismissed).

264. *Great American Ins. Co.*, 850 S.W.2d at 291.

265. 844 S.W.2d 264 (Tex. App.—Fort Worth 1992, writ dismissed by agreement).

to be submitted. The umpire and Barnes' appraiser signed an appraisal award for more than \$400,000 over the objection of Western's appraiser. Barnes filed this suit after Western failed to pay or challenge the award, alleging violations of the Insurance Code, Deceptive Trade Practices Act, and breach of the duty of good faith and fair dealing.

The jury found that Barnes had suffered hail damage in the amount of approximately \$68,000 and that the appraisal award should be set aside because of fraud, accident, or mistake. The jury also found that Western had knowingly violated the Insurance Code and the DTPA. The trial court entered judgment for Barnes for treble damages, attorney's fees, and pre- and postjudgment interest. The judgment also provided for Softline to recover twenty percent (20%) of Barnes' actual damages and prejudgment interest.

Softline argued to the court of appeals that the trial court improperly limited its recovery to twenty percent (20%) of Barnes' actual damages and prejudgment interest. The contract between Barnes and Softline provided that Softline was to be paid an amount equal to twenty percent (20%) of the gross amount recovered by Barnes from Western. Softline argued that gross recovery meant the overall total amount Barnes was awarded, not just actual damages and prejudgment interest. The court agreed and held that Softline was entitled to recover twenty percent (20%) of the actual damages, treble damages, attorney's fees, prejudgment interest, and postjudgment interest awarded to Barnes.²⁶⁶

F. JURY QUESTIONS/INSTRUCTIONS

The issue addressed by the court in *Spencer v. Eagle Star Insurance Co. of America*²⁶⁷ was whether a jury question was immaterial or merely defective. Charles and Sharon Spencer sued Eagle Star for delaying payment of benefits owed under business interruption coverage. The Spencers suffered a fire loss at their business on February 19, 1986, but Eagle Star did not unconditionally tender payment of the benefits until March 10, 1987.

The jury found in favor of the Spencers in response to the following Question 1(A): "[Was the] handling of the Spencers' claim for loss of earnings by Eagle Star . . . an, unfair practice in the business of insurance?"²⁶⁸ "Unfair practice" was defined as any act, or series of acts, that is arbitrary, without justification, or takes advantage of a person to the extent that an unjust or inequitable result is obtained.

The jury also found this conduct was a producing cause of damages to the Spencers. The trial court granted Eagle Star's motion for judgment notwithstanding the verdict on the basis that Question 1(A) "does not support a judgment against the Defendant under our law," and rendered a take-nothing judgment. The Spencers appealed. The court of appeals affirmed, hold-

266. *Id.* at 272.

267. 37 Tex. Sup. Ct. J. 519 (Feb. 9, 1994).

268. *Id.* at 520.

ing that the question was immaterial and defective.²⁶⁹ The Texas Supreme Court reversed and remanded for a new trial.

The supreme court agreed with the lower courts that the question and instruction were defective because the instruction did not specify the conduct made unlawful by the statutes and regulations. The court, citing *Brown v. American Transfer & Storage Co.*,²⁷⁰ held that, "When liability is asserted based upon a provision of a statute or regulation, a jury charge should track the language of the provision as closely as possible."²⁷¹ The court found the instruction too broad and ill-defined as it allowed the jury to find an unfair insurance practice based on action that took advantage of the Spencers and resulted in an inequitable result.²⁷²

Even so, the court concluded that the question was not immaterial as it submitted liability under article 21.21 — the heart of the Spencers' case.²⁷³ Accordingly, the court held that the trial court should not disregard the jury's answer to Question 1(A) and remanded a judgment n.o.v. Instead, the trial court should have granted a new trial.

The Spencers argued that Eagle Star waived any objection to Question 1(A) and judgment should be rendered in their favor based on the jury's verdict. The court disagreed. Because the defect was with an instruction, the court — focusing on Rule 274 rather than Rule 278 — held that Eagle Star was required to object, rather than request a proper instruction.²⁷⁴ The court determined that Eagle Star properly objected to the instruction and thus, a new trial was in order.

One of the issues in *Commonwealth Lloyds Insurance Co. v. Downs*²⁷⁵ was the propriety of the questions submitting DTPA and article 21.21 liability to the jury. Downs sued his insurance company after it failed to pay for the death of five horses caused by the collapse of the roof of his horse arena after a severe winter storm. The jury found that the loss was covered by the policy, that Commonwealth breached its duty of good faith and fair dealing and violated the DTPA and article 21.21 of the Insurance Code. The court of appeals reversed and rendered a take-nothing judgment, finding no coverage under the policy.

Even so, the court addressed Commonwealth's argument that the questions relating to the article 21.21 and DTPA causes of action were so vague and incomprehensible as to violate its right to due process. These questions read as follows:

Jury Question No. 4:

Do you find from a preponderance of the evidence that Defendant engaged in any unfair or deceptive act or practice that was a producing

269. *Spencer v. Eagle Star Ins. Co.*, 780 S.W.2d 837 (Tex. App.—Austin 1989), *rev'd*, 37 Tex. Sup. Ct. J. 579 (Feb. 9, 1994).

270. 601 S.W.2d 931, 937 (Tex.), *cert. denied*, 449 U.S. 1015 (1980).

271. *Spencer*, 37 Tex. Sup. Ct. J. at 521.

272. *Id.*

273. *Id.*

274. *Id.*

275. 853 S.W.2d 104 (Tex. App.—Fort Worth 1993, writ denied).

cause of damages to Plaintiff?²⁷⁶

You are instructed that “unfair or deceptive act or practice” means any of the following:

(A) [e]ngaging in any false, misleading, or deceptive acts or practices. “False, misleading, or deceptive act or practice” means an act or series of acts that have the tendency to deceive an average ordinary person, even though that person may have been ignorant, unthinking or gullible;²⁷⁷ or

(B) [m]aking or causing to be made any statement misrepresenting the terms, benefits, or advantages of an insurance policy;²⁷⁸ or

(C) [m]aking, directly or indirectly causing to be made, any assertion, representation, or statement with respect to insurance that was untrue, deceptive, or misleading.²⁷⁹

Jury Question No. 13:

Do you find from a preponderance of the evidence that Defendant engaged in any “false, misleading, or deceptive act or practice” that was a producing cause of damages to Plaintiff?²⁸⁰

“False, misleading, or deceptive act or practice” means any of the following:

(A) [r]epresenting that goods or services had or would have characteristics or benefits that they did not have;²⁸¹ or

(B) [r]epresenting that goods or services are or will be of a particular standard, quality or grade if they were of another;²⁸² or

(C) [r]epresenting that an agreement confers or involves rights and remedies it did not have or involve;²⁸³ or

(D) [f]ailing to disclose information about goods or services that was known at the time of the transaction with the intention to induce another into a transaction;²⁸⁴ or

(E) [f]ailing to attempt in good faith to investigate, process and pay the claim promptly, fairly, and equitably when liability has become reasonably clear.²⁸⁵

The court held that the questions were properly worded.²⁸⁶ Question 4(A) was taken from *Spradling v. Williams*²⁸⁷ which was cited with approval in *Vail v. Texas Farm Bureau Mutual Insurance Co.*²⁸⁸ Additionally, Question 4(B) was taken from article 21.21, section 4(1);²⁸⁹ Question 4(C) was taken from article 21.21, section 4(2);²⁹⁰ and Question 13(A)-(D) tracked the statutory language of the DTPA section 17.46(b)(5), (7), (12), and (23) re-

276. See 4 STATE BAR OF TEXAS, TEXAS PATTERN JURY CHARGES PJC 102.14 (1990).

277. *Id.* at 102.15.

278. *Id.* at 102.16.

279. *Id.* at 102.17.

280. *Id.* at 102.01.

281. *Id.* at 102.02.

282. *Id.* at 102.03.

283. *Id.* at 102.04.

284. *Id.* at 102.05.

285. *Id.* at 102.20.

286. *Downs*, 853 S.W.2d at 116.

287. 566 S.W.2d 561 (Tex. 1978).

288. 754 S.W.2d 129 (Tex. 1988).

289. TEX. INS. CODE ANN. art. 21.21, § 4(1) (Vernon Supp. 1993).

290. TEX. INS. CODE ANN. art. 21.21, § 4(2) (Vernon Supp. 1993).

spectively.²⁹¹ The court did not address whether question 13(E) was properly worded because it had found that the damage to the arena was not covered under the terms of the insurance policy. Therefore, there could be no award of damages under Question 13(E).

The San Antonio court also had the opportunity to pass judgment on jury questions submitting a cause of action under article 21.21 in *Benefit Trust Life Ins. Co. v. Littles*.²⁹² The question asked of the jury in this case was as follows: "Did Benefit Trust Life Insurance Company engage in any unfair or deceptive act or practice that resulted in damages to Leslie Littles or the City of Victoria?"²⁹³ "Unfair or deceptive act or practice" was defined as:

1. Engaging in any false, misleading, or deceptive acts or practices; "False, misleading, or deceptive acts or practices" means an act or series of acts that have the tendency to deceive an average ordinary person, even though that person may have been ignorant, unthinking, or gullible;²⁹⁴
2. Making, or directly or indirectly causing to be made, any assertion, representation, or statement with respect to insurance that was untrue, deceptive or misleading;²⁹⁵ or
3. Omitting any information or making any false implication or impression that was either misleading or deceptive or had the capacity to be misleading or deceptive;²⁹⁶ or
4. Not attempting in good faith to effectuate a prompt, fair, and equitable settlement of a claim if liability has become reasonably clear.²⁹⁷

Benefit Trust claimed that subparts one and two of Question No. 1 were similar to the questions that the court held to be immaterial in *William H. McGee & Co., Inc. v. Schick*.²⁹⁸ The court held that *Schick* was distinguishable because the question involved in that case did not specify the conduct constituting unfair or deceptive acts or practices as found in the above question.²⁹⁹ The court found this question proper because subsection 1 originated from section 17.46(a) of the DTPA,³⁰⁰ subsection 2 was taken from section 4 of article 21.21;³⁰¹ subsection 3 was taken from the regulations promulgated by the State Board of Insurance;³⁰² and subsection 4 from article 21.21-2 of the Insurance Code.³⁰³

291. TEX. BUS. & COM. ANN. §§ 17.46(b) (5, 7, 12 & 23) (Vernon 1987).

292. No. 04-91-00653-CV, 1993 WL 437192 (Tex. App.—San Antonio, Oct. 29, 1993, writ *dism'd*).

293. See 4 STATE BAR OF TEXAS, TEXAS PATTERN JURY CHARGES PJC 102.14 (1990).

294. *Id.* at 102.15.

295. *Id.* at 102.17.

296. *Id.* at 102.18.

297. *Id.* at 102.20.

298. 792 S.W.2d 513 (Tex. App.—Eastland 1990), writ *dism'd*, 843 S.W.2d 473 (Tex. 1992).

299. *Littles*, slip op. at 18.

300. In *Vail*, the court held that § 16 of article 21.21 incorporates and makes actionable all of § 17.46 of the DTPA, even the prohibition against unlisted deceptive trade practices in § 17.46(a) which are no longer actionable to a consumer suing directly under the DTPA. See *Vail*, 754 S.W.2d at 135.

301. TEX. INS. CODE ANN. art. 21.21, § 4(2) (Vernon Supp. 1993).

302. 28 TEX. ADMIN. CODE § 21.112 (West 1993).

303. TEX. INS. CODE ANN. art. 21.21-2, § 2(b)(4) (Vernon Supp. 1993).

G. DEFENSES

1. Limitations

An action brought under article 21.21, as well as the DTPA, must be brought within two years after the date on which the unfair or deceptive act or practice occurred.³⁰⁴ Both statutes incorporate the "discovery rule" and allow an action to be brought within two years after the unfair or deceptive act or practice was discovered or, in the exercise of reasonable diligence, should have been discovered.³⁰⁵ Because the discovery rule is a plea of confession and avoidance, the plaintiff has the burden to plead and prove its application once the defendant has raised a limitations defense.³⁰⁶ The burden is somewhat different for purposes of summary judgment. Before a defendant will be entitled to a summary judgment on his affirmative defense of limitations, he must not only plead and prove that limitations bar the plaintiff's cause of action, he also must negate the discovery rule.³⁰⁷ The discovery rule is negated by establishing, as a matter of law, the precise date on which the plaintiff discovered or should have discovered facts giving rise to the cause of action.³⁰⁸ In *3Z Corporation v. Stewart Title Guaranty Co.*³⁰⁹ the court held that a summary judgment on limitations should not have been granted because the evidence revealed that, although the misrepresentation occurred more than two years prior to suit being filed, the defendant did not establish as a matter of law that the plaintiff knew or should have known that the representation was false at the time it was made.

*P.G. Bell Co. v. United States Fidelity & Guaranty Co.*³¹⁰ was an action brought by Bell after USF&G refused to pay a judgment Bell obtain against one of USF&G's insureds. The trial court granted a summary judgment in favor of USF&G on its limitation defense. USF&G contended that limitations began to run when it refused to defend its insured. The court of appeals disagreed and reversed the summary judgment. According to the court, limitations did not start to run until Bell obtained a judgment against USF&G's insured, for it was at that time that the insured's obligation to pay was finally determined.³¹¹ Because Bell's lawsuit was filed within two years after obtaining judgment against the insured, the court held that suit was timely filed.

A different result on similar facts was reached in *Abe's Colony Club, Inc. v. C & W Underwriters, Inc.*³¹² This suit was brought by Abe's against its liability insurers, C & W and Mt. Hawley, because they refused to defend

304. TEX. INS. CODE ANN. art. 21.21, § 16(d) (Vernon Supp. 1993). See also TEX. BUS. & COM. CODE ANN. § 17.565 (Vernon 1987).

305. *Id.*

306. *Woods v. William M. Mercer, Inc.*, 769 S.W.2d 515, 517 (Tex. 1989).

307. *3Z Corp. v. Stewart Title Guar. Co.*, 851 S.W.2d 933, 938 (Tex. App.—Beaumont 1993, writ denied). See also *Burns v. Thomas*, 786 S.W.2d 266, 267-68 (Tex. 1990).

308. *3Z Corp.*, 851 S.W.2d at 938. See also *Eshelman v. Shield*, 764 S.W.2d 776, 777 (Tex. 1989).

309. 851 S.W.2d 933, 938 (Tex. App.—Beaumont 1993, writ denied).

310. 853 S.W.2d 187 (Tex. App.—Corpus Christi 1993, no writ).

311. *Id.* at 192.

312. 852 S.W.2d 86 (Tex. App.—Fort Worth 1993, writ denied).

Abe's in a lawsuit brought against it by a person who was injured by an intoxicated patron of Abe's. Bot's insurers refused to provide a defense based upon a liquor liability exclusion in the policy. The insurers obtained a summary judgment that Abe's causes of action under article 21.21 and the DTPA were barred by limitations.

Abe's argued to the court of appeals that limitations did not begin to run until the judgment against it in the underlying suit became final. The court disagreed, holding that limitations began when the insurers denied a defense because it was then that Abe's began incurring damages in the form of defense costs.³¹³ The lawsuit was not timely because it was filed almost four years after the defense was denied.

2. "Unlawful Act" Rule

In *Rodriguez v. Love*³¹⁴ Rodriguez purchased an automobile insurance policy from Northwestern National County Mutual through Joan Love, its recording agent. On March 18, 1990, Northwestern informed Rodriguez that her first premium payment was overdue and that the policy would be canceled if the premium was not paid on or before March 28, 1990. On March 20, 1990, Rodriguez went to Love's office and paid the insurance premium.

One month later Northwestern sent Rodriguez's check back to her and told her that the policy was canceled because it had not received the premium prior to the March 28th deadline. Northwestern also notified the Texas Department of Public Safety (DPS) of the cancellation of Rodriguez's policy. Thereafter, Rodriguez's driving privileges were suspended by the DPS. Rodriguez, however, continued to tender premium payments and asserted that she was advised by persons in Love's office that she was still insured. In addition, Rodriguez was given insurance identification cards by Love's office as proof of insurance coverage. According to these cards, Rodriguez was afforded insurance coverage until November 8, 1990. Nevertheless, the DPS failed to reinstate Rodriguez's driving privileges and arrested her on July 7, 1990, and October 11, 1990, for the offense of driving with a suspended license. Rodriguez never received notice from the DPS that her license was reinstated.

After her arrest, Rodriguez filed suit against Northwestern and Love alleging causes of action for violations of the DTPA, article 21.21, breach of the duty of good faith and fair dealing, negligence, and fraud. Northwestern and Love moved for summary judgment asserting that Rodriguez could not recover because her causes of action were predicated on her own unlawful act of driving with a suspended license. The trial court granted summary judgment in the favor of Northwestern and Love. The court of appeals affirmed in part and reversed and remanded in part.

Initially, the court affirmed the summary judgment to the extent that Rod-

313. *Id.* at 91.

314. 860 S.W.2d 541 (Tex. App.—El Paso 1993, no writ).

riguez's causes of action in damages are based on, and stemmed from, her arrests for the offense of driving with a suspended license. The court held that Rodriguez could not maintain these causes of action because of the "unlawful act" rule.³¹⁵ This rule provides that no action can be based on an admittedly unlawful act of the party asserting it. The evidence showed that Rodriguez continued to drive despite receiving notice from the DPS that her license had been suspended. This unlawful act caused Rodriguez arrest. Thus, the court held that Rodriguez could not maintain a cause of action to the extent it was based on her arrest for the offense of driving while her license was suspended. The court held, however, that not all of Rodriguez's causes of action were based on her arrest and, in fact, became viable before she was ever arrested.³¹⁶ The court, therefore, reversed the summary judgment as to the causes of action independent of the arrest and remanded those for trial.

The court incorrectly applied the "unlawful act" rule to the facts of this case. Historically, courts have refused to allow a party to recover or benefit from an illegal transaction. For example, in *Langford v. Pickens*³¹⁷ Langford turned over to Pickens his wholesale drug and liquor business to pay off his indebtedness to Pickens. Wartime regulations, in effect at the time, set certain prices for the sale of beer and whiskey. Langford complained that Pickens was charging more than the law allowed and not crediting Langford's indebtedness with the amounts received. The court refused to divide the profits of these illegal transactions.

In *Stevens v. Hallmark*³¹⁸ Stevens attempted to recover 129 cases of beer seized by the sheriff. Stevens, however, lived in a dry county and had intended to sell the beer in that county. The court held that Stevens' possession of the beer violated the law and could not serve as the basis for his cause of action. Additionally, the court noted that if the beer were returned to Stevens, he would again be in violation of the law.

The legal principle precluding recovery in these two cases has no relevance to Ms. Rodriguez's causes of action. Her claims were neither based on an unlawful transaction in which she participated nor on her own unlawful acts. Rather, she was complaining that the defendant's wrongful acts caused the suspension of her license and her arrest. Furthermore, neither the DTPA nor article 21.21 mention this doctrine as a defense. Thus, this defense should not be imposed on a cause of action under the DTPA or article 21.21.

In *Smith v. Baldwin*³¹⁹ the supreme court held that common law defenses may not be used to defeat a claim under the DTPA. *Smith v. Baldwin* involved a builder's statement to a prospective purchaser of a custom built home that the house, when completed, would meet V.A.-standards, thereby

315. *Id.* at 544.

316. *Id.*

317. 288 S.W.2d 568 (Tex. Civ. App.—Austin 1956, writ ref'd n.r.e.).

318. 109 S.W.2d 1106 (Tex. Civ. App.—Austin 1937, no writ).

319. 611 S.W.2d 611 (Tex. 1980).

enabling the purchaser to obtain permanent financing. Because of numerous construction defects, the V.A. refused to approve the house. The builder sued the purchaser on the building contract and interim construction note. The purchaser counterclaimed under the DTPA. The court of appeals denied the purchaser relief under the Act, holding that the builder's defense of "substantial performance" was good.³²⁰ The supreme court, however, disagreed:

Baldwin [the builder] argues that to hold builders liable for treble damages and attorneys' fees notwithstanding a substantial performance of the building contract places an unreasonable burden on the builder. Whether this is so or not, the Legislature in the DTPA did not provide that substantial performance is a defense to an action under the statute.³²¹

The court further held that:

The DTPA does not represent a codification of the common law. A primary purpose of the enactment of the DTPA was to provide consumers a cause of action for deceptive trade practices without the burden of proof and numerous defenses encountered in a common law fraud or breach of warranty suit.³²²

The court, throughout the years, has consistently applied this principle and has rejected attempts to imply into the DTPA defenses not found within the statute. For example in *Cameron v. Terrell & Garrett, Inc.*,³²³ supreme court held that a person bringing suit under the DTPA need not be in contractual privity with the person being sued.³²⁴ Thus, the court allowed the purchaser of a house to bring suit against the seller's agent for misrepresenting the number of square feet in the house even though the purchaser had not sought or acquired services from the agent.³²⁵

In *Weitzel v. Barnes*³²⁶ the court held that oral representations were not only admissible but could serve as the basis for a DTPA action.³²⁷ The court refused to apply the oral evidence rule, which would have barred proof of oral representations in a contract action, because in a DTPA suit "traditional contractual notions do not apply."³²⁸ Relying on *Weitzel*, the court held in *Kennemore v. Bennett*³²⁹ that the contractual defenses of waiver and estoppel were not controlling in a statutory DTPA action.³³⁰ Other common law defenses that have been determined to be inapplicable to a DTPA

320. *Baldwin v. Smith*, 568 S.W.2d 624, 630-31 (Tex. Civ. App.—Tyler 1979), *rev'd sub nom*, *Smith v. Baldwin*, 611 S.W.2d 611 (Tex. 1981).

321. *Smith v. Baldwin*, 611 S.W.2d at 616.

322. *Id.*

323. 618 S.W.2d 535, 541 (Tex. 1981).

324. *Id.* at 541.

325. *Id.*

326. 691 S.W.2d 598 (Tex. 1985).

327. *Id.* at 600.

328. *Id.*

329. 755 S.W.2d 89 (Tex. 1988).

330. *Id.* at 90-91.

action are: (1) doctrine of merger by deed;³³¹ (2) cemetery abandonment;³³² (3) constructive notice provided by a recording statute;³³³ (4) impossibility of performance;³³⁴ (5) contractual limitation of damages (at least, as to misrepresentation claims);³³⁵ (6) "as is" clauses in the contract;³³⁶ and (7) bona fide error or good faith.³³⁷

H. GROUNDLESS & BROUGHT IN BAD FAITH OR FOR THE PURPOSE OF HARASSMENT

Article 21.21, like the DTPA, provides that the defendant can recover attorney's fees and court costs if the court finds that the plaintiff's action "was groundless and brought in bad faith or brought for the purpose of harassment . . ."³³⁸ Whether an action satisfies these requirements is for the court, not the jury, to decide.³³⁹ To succeed on such a claim, the defendant must meet a two-pronged test: the suit must be (1) groundless and (2) brought in bad faith or for the purpose of harassment.³⁴⁰ An action is groundless when it has no basis in law or fact and is not warranted by a good faith argument for the extension, modification, or reversal of existing law.³⁴¹

In *Transport Indemnity Co. v. Orgain, Bell & Tucker*³⁴² an insurer's DTPA action against its attorneys was found to be groundless or brought in bad faith because the insurer admitted it was not a consumer, yet maintained a DTPA action for another year and one-half.³⁴³ In this case, a truck owned by Allied Van Lines collided with a car, resulting in the death of a man and woman who were in the car. Allied Van Lines was insured by Transport Indemnity and Transport Insurance Company ("Transport"). Transport hired the law offices of Orgain, Bell & Tucker and two of its attorneys to represent it in connection with the settlement of a wrongful death suit threatened by Paula Trippell in 1984. Soon thereafter, Trippell's claim was settled for \$250,000 and paid by Transport. About four years after the settlement, Trippell, no longer a minor, filed suit against Transport seeking to

331. *Alvarado v. Bolton*, 749 S.W.2d 47, 48 (Tex. 1988); *ECC Parkway Joint Venture v. Baldwin*, 765 S.W.2d 504 (Tex. App.—Dallas 1989, writ denied).

332. *Haney v. Purcell Co.*, 770 S.W.2d 566, 567 (Tex. 1989).

333. *Ojeda de Toca v. Wise*, 748 S.W.2d 449, 451 (Tex. 1988).

334. *Hurst v. Sears, Roebuck & Co.*, 647 S.W.2d 249, 251 (Tex. 1983).

335. *American Transfer & Storage Co. v. Brown*, 584 S.W.2d 284, 291 (Tex. Civ. App.—Dallas 1979), *rev'd on other grounds*, 601 S.W.2d 931 (Tex.), *cert. denied*, 449 U.S. 1015 (1980).

336. *Prudential Ins. Co. of Am. v. Jefferson Assocs., Ltd.*, 839 S.W.2d 866, 873 (Tex. App.—Austin 1992, writ granted); *Wyatt v. Petrila*, 752 S.W.2d 683, 685 (Tex. App.—Corpus Christi 1988, writ denied).

337. *Miller v. Soliz*, 648 S.W.2d 734, 739 (Tex. App.—Corpus Christi 1983, no writ).

338. TEX. INS. CODE ANN. art. 21.21, § 16(c) (Vernon Supp. 1993). *See also* TEX. BUS. & COM. CODE ANN. § 17.50(c) (Vernon 1987).

339. *Transport Indem. Co. v. Orgain, Bell & Tucker*, 846 S.W.2d 878, 882 (Tex. App.—Beaumont), *writ denied per curiam*, 856 S.W.2d 410 (Tex. 1993).

340. *McCain v. NME Hosp., Inc.*, 856 S.W.2d 751, 758 (Tex. App.—Dallas 1993, no writ).

341. *Id.* at 757; *Transport Indem.*, 846 S.W.2d at 882.

342. 846 S.W.2d 878 (Tex. App.—Beaumont), *writ denied per curiam*, 856 S.W.2d 410 (Tex. 1993).

343. *Id.* at 883.

overturn the settlement, contending that it was too low. Transport then hired another attorney to defend the Trippell action and was advised that Trippell had no standing to assert the previously settled wrongful death claim due to the fact that she was not the natural or legally adopted child of the persons who died in the accident.

Transport filed this suit against Orgain, Bell & Tucker, claiming that they committed malpractice and violated the Deceptive Trade Practices Act. Orgain, Bell & Tucker counterclaimed that Transport's DTPA claim was brought in bad faith or for the purpose of harassment. Orgain, Bell & Tucker was granted summary judgment on the ground that Transport's DTPA claim was brought in bad faith or for the purpose of harassment. The judgment was affirmed by the court of appeals.³⁴⁴

Transport argued that the trial court erred in holding that its DTPA claim was brought in bad faith or for the purpose of harassment. The court of appeals rejected this argument noting that Transport admitted in response to requests for admissions that it had assets of \$25 million or more, precluding it from maintaining consumer standing under § 17.45(4) of the DTPA.³⁴⁵ Transport had continued to maintain its DTPA action for more than one and one-half years after making the admission. Transport argued that while the DTPA claim may have been groundless, there was no evidence that it acted in bad faith or with an intent to harass. The court borrowed from the law of negotiable instruments a definition of "bad faith" as acting in willful disregard of, and refusal to learn available facts.³⁴⁶ Under this definition, the court held that Transport did act in bad faith because it knew that it did not qualify as a consumer under the DTPA, disregarded this information, and continued to assert a DTPA claim after such an admission.³⁴⁷

In *McCain v. NME Hospitals, Inc.*³⁴⁸ the court used a somewhat different definition of "bad faith" than was used in *Transport Indemnity*. Here the court held that to prove bad faith, it must be shown that the "motivation for filing suit was malicious, discriminatory, or with a reckless disregard for the defendant's rights."³⁴⁹ The court also concluded that before a trial court can determine whether a suit is brought in bad faith or for the purpose of harassment the court must hear evidence about the motives and credibility of the plaintiff.³⁵⁰

McCain arose out of the discharge of Cathey Wright, an incompetent adult, from the Dallas Rehabilitation Institute (DRI). After Wright assigned her rights to insurance benefits to DRI, it negotiated a settlement with the insurance companies for payment of Wright's medical expenses.

344. *Id.*

345. *Id.* at 883.

346. *Id.*

347. *Id.*

348. 856 S.W.2d 751 (Tex. App.—Dallas 1993, no writ.).

349. *Id.* at 758. Other courts so defining "bad faith" include *Selig v. BMW of N. Am., Inc.*, 832 S.W.2d 95, 103 (Tex. App.—Houston [14th Dist.] 1992, no writ); *Kazmir v. Suburban Homes Realty*, 824 S.W.2d 239 (Tex. App.—Texarkana 1992, writ denied).

350. *Id.* at 757-58.

DRI discharged Wright from its care when Wright exhausted her insurance benefits. Wright sued DRI, the insurance companies, and various lawyers and their law firms, alleging that the defendants entered into a civil conspiracy to misrepresent her insurance benefits and wrongfully discharged her from DRI.

Wright nonsuited the insurance companies after they were placed in receivership. The remaining defendants filed Rule 13 motions requesting a dismissal with prejudice and attorney's fees. The court granted these motions and dismissed the cause of action with prejudice. The trial court also imposed Rule 13 sanctions against Wright's attorneys. DRI then filed a counterclaim under DTPA § 17.50(c) alleging that Wright's DTPA claim was groundless and brought in bad faith. The trial court granted summary judgment for DRI and assessed attorneys' fees against Wright. The court of appeals reversed and remanded.³⁵¹

The court of appeals agreed with the trial court that Wright's petition, which alleged violations of article 21.21 of the Insurance Code, was groundless.³⁵² According to the court, article 21.21 applies only to persons or entities engaged in the business of insurance.³⁵³ Since none of the defendants were engaged in the business of insurance, the court found the petition groundless.³⁵⁴ However, DRI also had to prove that the suit was brought in bad faith or for the purpose of harassment.³⁵⁵ To make such a determination, the court held, the trial court was required to hold an evidentiary hearing to determine the motive and credibility of the person signing the alleged groundless petition.³⁵⁶ In this case, the trial court did not hear evidence on the circumstances surrounding the filing of the pleading and the signer's credibility and motives and thus had no evidence to determine that Wright or her attorneys filed the pleading in bad faith or to harass. Therefore, the court of appeals held that the trial court abused its discretion in assessing sanctions under Rule 13 and in granting the summary judgment under DTPA section 17.50(c).³⁵⁷

The court does not disclose the exact nature of the article 21.21 cause of action alleged against the defendants, nor does it present any analysis of whether these people were engaging in the business of insurance. Thus, the court's cursory treatment of this issue is disturbing.

The focus of article 21.21 is not on a certain type of person, but a certain type of conduct. Section 1 declares that the purpose of article 21.21 "is to regulate trade practices in the business of insurance"³⁵⁸ Section 3 provides that, "No person shall engage . . . in any . . . unfair or deceptive act or

351. *Id.* at 759.

352. *Id.* at 757.

353. *Id.*

354. *Id.*

355. *Id.*

356. *Id.*

357. *Id.* at 757-58.

358. TEX. INS. CODE ANN. art. 21.21, § 1(a) (Vernon Supp. 1993).

practice in the business of insurance."³⁵⁹

In Section 4, article 21.21 defines various acts to be unfair and deceptive.³⁶⁰ But this is not the only conduct regulated by article 21.21, as Section 16 makes actionable conduct declared to be unfair or deceptive by the DTPA Section 17.46 and by the Department of Insurance rules and regulations.³⁶¹ One such regulation is Board Order 41060,³⁶² which states as its purpose:

. . . to further define and state the standards that are necessary to prohibit deceptive acts or deceptive practices by insurers and insurance agents *and other persons* in their conduct of the business of insurance *or in connection therewith, whether done directly or indirectly, and irrespective of whether the person is acting as insurer, principal, agent, employer, or employee, or in other capacity or connection with such insurer.*³⁶³

The business of insurance is defined in article 1.14-1 of the Insurance Code and, as recognized in *Vail*, includes the investigation and adjustment of claims and losses.³⁶⁴ Thus, if an attorney (or any other person) assists the insurer in investigating and adjusting a claim or loss and engages in conduct defined as unfair or deceptive, that person, just like the insurer, is subject to liability under article 21.21.³⁶⁵

Thus, resolving the issue of whether a person is subject to liability under article 21.21 requires a look at the conduct engaged in, rather than the person committing the conduct. In this case, the court did not make such an analysis.

I. MISCELLANEOUS

In *Testoni v. Blue Cross & Blue Shield of Texas, Inc.*³⁶⁶ Testoni's wife received private nursing care during the last seven months of her life. Testoni had insurance with Blue Cross pursuant to his membership in the Employees Retirement System (ERS). Blue Cross denied coverage for the private nursing care, claiming lack of medical necessity. Testoni filed an administrative appeal with ERS. After ERS denied the claim, Testoni moved for rehearing. ERS took no action, and the motion was eventually overruled by operation of law. Testoni filed suit in the Travis County District Court seeking judicial review of the agency ruling and asserting, for the first time, causes of action against Blue Cross based on breach of warranty,

359. TEX. INS. CODE ANN. art. 21.21, § 3 (Vernon 1981).

360. TEX. INS. CODE ANN. art. 21.21, § 4 (Vernon Supp. 1993).

361. *Id.* § 16(a). See also *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 132 (Tex. 1988).

362. 28 TEX. ADMIN. CODE §§ 21.1-21.5 (West Supp. 1993) (Tex. Dept. of Ins. Trade Practices).

363. *Id.* § 21.1 (emphasis added).

364. TEX. INS. CODE ANN. art. 1.14-1, § 2 (Vernon Supp. 1993); *Vail*, 754 S.W.2d at 132.

365. See *Allstate Ins. Co. v. Carter*, 855 S.W.2d 97, 101 (Tex. App.—Corpus Christi 1993), writ granted; judgment set aside, 859 S.W.2d 367 (Tex. 1993); *Perez v. Kirk & Carrigan*, 822 S.W.2d 261, 268 (Tex. App.—Corpus Christi 1991, writ denied). Compare *Pennington v. Singleton*, 606 S.W.2d 682, 686 (Tex. 1980) (holding that a person can be subject to DTPA liability even if he is a one-time seller of goods or services and not a merchant).

366. 861 S.W.2d 387 (Tex. App.—Austin 1992, n.w.h.).

breach of the duty of good faith and fair dealing, and violations of the DTPA and Insurance Code. ERS filed a plea to the jurisdiction, asserting sovereign immunity and that Testoni's motion for rehearing lacked the specificity required by the Administrative Procedure and Texas Register Act (APTRA) to preserve his error for review. The trial court granted the plea to the jurisdiction with respect to ERS. Later, Testoni requested discovery from Blue Cross. In response, Blue Cross filed a motion to quash, claiming that the extra-contractual claims would be barred if the ERS decision on the coverage claim was upheld. Blue Cross also filed a plea to the jurisdiction and asserted that Testoni failed to properly exhaust his administrative remedies. The district court granted the motion to quash, partially granted the plea to the jurisdiction by dismissing the administrative appeal, and rendered a final judgment that *res judicata* barred the extra-contractual claims.

The court of appeals reversed the district court's judgment based on *res judicata* because Blue Cross did not raise this affirmative defense in an answer, motion for summary judgment, or motion for judgment on the pleadings.³⁶⁷ The court, however, did not remand for a new trial, holding that the trial court lacked jurisdiction over the extra-contractual claims as well as the review of the administrative agency decision.³⁶⁸ According to the court, coverage and the right of reimbursement under ERS policies were created by the Legislature, not common law.³⁶⁹ Citing *Texas Catastrophe Property Insurance Association v. Council of Co-Owners of Saida II Towers Condominium Association*,³⁷⁰ the court held that a claimant must follow the strict procedures of APTRA to resolve all disputes arising from a denial of payment for a claim.³⁷¹ Finding that when the Legislature creates a right, it can also restrict the remedies available and the means of determining their enforcement, the court held that all statutory causes of action arising on a legislatively created claim must be brought before the agency as part of a contested hearing.³⁷² Therefore, Testoni was required to file all of his claims for relief related to the insurance coverage denial at the agency level before pursuing review in the district court.³⁷³ Because he failed to do this with his extra-contractual claims against Blue Cross, the court held that those claims were barred for failure to exhaust administrative remedies and the district court did not have jurisdiction.³⁷⁴

The court held that Testoni did not exhaust his administrative remedies because he did not assert his extra-contractual claims in the proceeding before the ERS.³⁷⁵ The ERS does not have jurisdiction over these claims.³⁷⁶

367. *Id.* at 390.

368. *Id.*

369. *Id.* at 389.

370. 706 S.W.2d 644 (Tex. 1986).

371. *Testoni*, 861 S.W.2d at 390.

372. *Id.*

373. *Id.*

374. *Id.*

375. *Id.*

376. *Id.*

Thus, it would have been fruitless to ask the ERS for a determination on these claims.

The Texas Employees Uniform Group Insurance Benefits Act establishes a plan for the purchase of group life, accident, and health insurance for State employees.³⁷⁷ Section 4 of the Act gives to the Board of Trustees of the ERS the sole power to administer and implement the Act.³⁷⁸ As an agency created by statute, the Board has no inherent authority, but can exercise only those powers conferred upon it by the clear and express language of the statute.³⁷⁹ Moreover, no additional authority can be implied by judicial construction.³⁸⁰

Section 4B of article 3.50-2 gives the Board authority to adjudicate questions which relate to the "payment of claims arising from programs or coverages provided *under authority of this Act . . .*"³⁸¹ Thus, by the clear and express language of the statute, the Board is limited to adjudicating only those legal rights authorized by the terms of the Act; that is, whether the insured has a right to insurance benefits.³⁸² This issue was the subject of Testoni's administrative appeal and the ERS determined that the claims should not be paid. Even if the ERS had determined that Blue Cross was wrong to deny coverage, the only remedy that the Board could grant would be payment of the claim.

However, Testoni still had legal causes of action for Blue Cross & Blue Shield's unfair practices in the business of insurance. These claims for damages are not created by article 3.50-2, but by article 21.21 of the Insurance Code, the Deceptive Trade Practices Act and common law. *Natividad v. Alexsis, Inc.*³⁸³ recognized that a claims administrator owes an insured a common law duty of good faith and fair dealing.³⁸⁴ The court reasoned that when insurers delegate the duty of handling claims to third-party adjusters, those claims adjusters are under the same duty of good faith and fair dealing.³⁸⁵ Otherwise, the duty to handle claims fairly and promptly could be abrogated by the insurer by delegating the claims handling responsibilities to another entity.³⁸⁶

Because these causes of action are not created by article 3.50-2, the Board has no jurisdiction to adjudicate them.³⁸⁷ In *Beyer*, a case cited by the court

377. TEX. INS. CODE ANN. art. 3.50-2 (Vernon 1981 & Supp. 1994).

378. TEX. INS. CODE ANN. art. 3.50-2, § 4 (Vernon Supp. 1994).

379. *City of Sherman v. Public Utility Comm'n of Tx.*, 643 S.W.2d 681, 686 (Tex. 1983); *Sexton v. Mount Olivet Cemetery Ass'n*, 720 S.W.2d 129, 137 (Tex. App.—Austin 1986, writ ref'd n.r.e.).

380. *Sexton*, 720 S.W.2d at 137.

381. TEX. INS. CODE ANN. art. 3.50-2, § 4B(a) (Vernon Supp. 1993) (emphasis added).

382. *Beyer v. Employees Retirement Sys.*, 808 S.W.2d 622, 627 (Tex. App.—Austin 1991, writ denied).

383. 833 S.W.2d 545 (Tex. App.—El Paso 1992, writ granted).

384. *Id.* at 547-48.

385. *Id.*

386. *Id.* See also *Benefit Trust Life Ins. Co. v. Littles*, No. 04-91-00673-CV (Tex. App.—San Antonio, Oct. 29, 1993, writ dismissed).

387. *Beyer*, 808 S.W.2d at 626-27. See also *Beaver Express Serv., Inc. v. Railroad Comm'n*, 727 S.W.2d 768, 773 (Tex. App.—Austin 1987, writ denied) (holding jurisdiction of

as authority for its holding that all disputes must be brought before the ERS, the court held that the Board, in adjudicating a claim for insurance benefits, does not have jurisdiction to award penalties and attorney's fees under article 3.62 of the Insurance Code because nothing in article 3.50-2 authorizes such a recovery.³⁸⁸ The *Beyer* court never determined that remedies beyond those provided in article 3.50-2 can never be recovered in another forum, such as the courts.³⁸⁹ Instead, the court held that *Beyer* was not entitled to the relief provided under article 3.62 because that relief is available only in court proceedings — a class to which administrative proceedings do not belong.³⁹⁰

The court also incorrectly held that the district court had no jurisdiction because Testoni did not file a sufficiently specific motion for rehearing with the ERS.³⁹¹ Because the Board lacks jurisdiction to adjudicate the extra-contractual claims asserted by Testoni, the doctrine of exhaustion of administrative remedies is not applicable.³⁹² Clearly, it would be futile to seek remedies from an administrative agency that has no authority to grant those remedies.

Many questions were raised by the court's decision. For example, must the ERS hold a contested hearing on the causes of action asserted under common law, the DTPA, and article 21.21? How can it do so when it has jurisdiction only to decide the contractual issue? If the ERS can pass on these causes of action, can the insured demand a jury trial? If not, would this impinge upon the insured's constitutional right to a jury trial? Will it ever be possible for an insured to recover damages under these extra-contractual causes of action, or is the court implying that article 3.50-2 preempts these laws? Is article 3.50-2 the Texas equivalent of ERISA for members of the Employees Retirement System?

The answer most consistent with article 3.50-2, article 21.21 and the DTPA is that the ERS has jurisdiction only over the contract issue, while the district courts have jurisdiction over all claims not created specifically by article 3.50-2.

II. THE DUTY OF GOOD FAITH AND FAIR DEALING

A. NATURE OF THE DUTY

1. *Who Owes the Duty/To Whom Is the Duty Owed*

In *Benefit Trust Life Insurance Co. v. Littles*³⁹³ the court held that the administrator of a health plan, having exclusive control over the claims han-

an administrative agency means the power to hear and determine a matter committed to the agency's discretion by statute).

388. *Beyer*, 808 S.W.2d at 627.

389. *Id.*

390. *Id.*

391. *Id.*

392. *Texas Educ. Agency v. Cypress-Fairbanks I.S.D.*, 830 S.W.2d 88, 90 (Tex. 1992); *City of Sherman*, 643 S.W.2d at 683.

393. No. 04-91-00673-CV (Tex. App.—San Antonio, Oct. 29, 1993, writ dismissed). See also *Natividad v. Alexis, Inc.*, 833 S.W.2d 545, 547 (Tex. App.—El Paso 1992, writ granted).

dling process, owes a common law duty of good faith and fair dealing to the insured.³⁹⁴ Leslie Littles almost burned to death in a gasoline fire at his home. Over the next thirty-eight days, Littles underwent five surgeries in an attempt to treat the second and third-degree burns over his face, head, and body. This care was provided by the doctors at Burn Care Associates in San Antonio's St. Luke's Hospital. Soon after Littles was released from St. Luke's, a claim for the bill of Burn Care Associates in the amount of \$23,669.01 was submitted to Benefit Trust Life Insurance Company (Benefit). Benefit was the company that wrote, administered, and partially funded the group insurance plan provided by Littles' employer, the City of Victoria. Eight months later, Littles returned to St. Luke's for additional treatment and incurred another \$13,473.24 in medical bills. At that time, Benefit had neither paid the initial claims, nor given any reason for nonpayment. Eventually, Benefit paid \$12,028.60 of the \$37,142.25 owed to Burn Care Associates stating in a letter to Littles, that the remaining charges were not payable under the plan because they were for services not medically necessary or because the charges were above the usual and customary charge. Following various efforts of the physicians to persuade Benefit to approve payment of Littles' doctor bills, the physicians brought suit against Leslie Littles and Benefit for payment. Following lengthy litigation, the physicians obtained summary judgment against Leslie Littles for \$67,290.36, representing the outstanding medical bills along with attorney's fees and prejudgment interest. Leslie Littles in turn brought an action against Benefit and the City of Victoria for payment of the judgment taken against him by the physicians, as well as for mental anguish, temporary disfigurement, and other elements of damages. The City of Victoria then sued Benefit as its administrator and excess-risk carrier, for various causes of action in connection with its claims handling. The physicians resolved all their differences with the City of Victoria and Benefit prior to trial; however, their judgment against Leslie Littles remained unsatisfied.

After a jury trial, Leslie Littles obtained a judgment against Benefit in the amount of \$1,674,132.80, and a judgment against the City of Victoria for \$250,308.36. The City of Victoria obtained a judgment for contribution and indemnity against Benefit, as well as a money judgment in the amount of \$153,767.31. The court of appeals modified the judgment and, as modified, affirmed.³⁹⁵

Benefit argued that it did not owe Littles the common law duty of good faith and fair dealing because there was no contract of insurance between Benefit and Littles. The court held, however, that there was a special relationship between Benefit and Littles by virtue of the administration contract between it and the City of Victoria, which gave Benefit exclusive control over the claims handling process.³⁹⁶ The potential for abuse was revealed in this case as it was to Benefit's advantage to deny the claims once the total

394. Littles, slip op. at 21.

395. *Id.* at 22.

396. *Id.* at 21.

payout reached \$50,000 because it was at that point that Benefit became liable under the excess policy. Additionally, Littles had unequal bargaining power compared with Benefit as shown by his inability to get Benefit to pay the claims. Moreover, the court noted that this duty has been imposed on insurers even when there is no contractual relationship with the person.³⁹⁷

In *Hopkins v. Highlands Insurance Co.*³⁹⁸ Magnolia Coca-Cola Bottling Company, Hopkins' employer, purchased liability insurance from Highlands. This insurance was to cover losses resulting from accidents involving trucks owned and operated by Magnolia. Shortly after the insurance became effective, Highlands elected to exclude Hopkins from policy coverage. As a result, Magnolia fired Hopkins. Hopkins then brought suit against Highlands alleging, among other things, breach of the duty of good faith and fair dealing. The trial court granted a summary judgment on all causes of action in favor of Highlands. The court of appeals reversed the summary judgment in favor of Highlands concerning the cause of action for breach of the duty of good faith and fair dealing.³⁹⁹ The court rejected the argument that since Magnolia purchased the insurance contract, there was no contract with Hopkins from which the duty of good faith and fair dealing flowed.⁴⁰⁰ The court found that the insurance policy defined insured to include the truck drivers employed by Magnolia, of which Hopkins was one.⁴⁰¹ Therefore, Highlands owed Hopkins a duty of good faith and fair dealing as he was an intended third-party beneficiary of the policy.⁴⁰²

In *Jackson v. City of Galveston*⁴⁰³ Jackson contended he injured his back while in the course and scope of his employment as a waste collector with the City of Galveston, a self-insured municipality. The City, unwilling to abide by a decision of the Industrial Accident Board awarding benefits to Jackson, filed suit to set aside the award. Jackson counterclaimed alleging that the City had violated its duty to deal with him fairly and in good faith, and he sought exemplary damages for the City's negligence and gross negligence in denying his claim for benefits. In response to the City's special exceptions, the trial court held, as a matter of law, the doctrine of sovereign immunity shielded the City from Jackson's claim of breach of the duty of good faith and fair dealing. The court of appeals affirmed.⁴⁰⁴

The court recognized that worker's compensation carriers have a duty to deal fairly and in good faith with injured employees and the processing of

397. *Id.*, slip op. at 21-22, (citing *Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210 (Tex. 1988) (which held that a workers' compensation carrier owes a duty to an employee even though the insurance contract is with the employer); *St. Paul Guardian Ins. Co. v. Luker*, 801 S.W.2d 614 (Tex. App.—Texarkana 1990, no writ) (holding insurer owes duty to son of policyholder for whose benefit the policy was purchased); and *Natividad v. Alexis, Inc.*, 833 S.W.2d 545 (Tex. App.—El Paso 1992, writ granted) (independent claims adjuster owes duty to claimants).

398. 838 S.W.2d 819 (Tex. App.—El Paso 1992, no writ).

399. *Id.* at 825-26.

400. *Id.* at 826.

401. *Id.*

402. *Id.*

403. 837 S.W.2d 868 (Tex. App.—Houston [14th Dist.] 1992, writ granted).

404. *Id.* at 869.

compensation claims.⁴⁰⁵ However, the legislature has shielded municipalities from tort liability when performing a governmental, rather than a proprietary, function.⁴⁰⁶ The court concluded that a city engages in a governmental function when it self-insures in order to provide worker's compensation coverage since the city is required to provide such coverage by state law.⁴⁰⁷ Although article 8309h⁴⁰⁸ gives a city three different options in providing worker's compensation coverage, the court held that since the city has no discretion to decline coverage to its employees, it performs a governmental function in fulfilling the requirements of this statute.⁴⁰⁹ Furthermore, the court held that there was no indication in the Worker's Compensation Act that the legislature intended, by giving cities several options to meet the requirement, to waive governmental immunity.⁴¹⁰

Jackson, however, argued that even when a municipality acts in a governmental function, it can be liable for personal injury caused by a condition or use of tangible personal or real property. Jackson argued that the City failed to carefully review his medical records and negligently refused to process his claims for benefits, thus invoking the tangible property exception. The court held, however, that Jackson failed to amend his pleadings to allege that his medical records were used in a negligent manner, much less that they proximately caused him injury.⁴¹¹ Therefore, the court found that Jackson had failed to allege specific facts that would have brought his claim under the tangible property exception.⁴¹²

The majority held that there is no indication in the Worker's Compensation Act that the legislature intended to waive governmental immunity when a city becomes a self-insurer.⁴¹³ However, article 8308-10.42 provides:

In an action against an *insurance carrier* for breach of the duty of good faith and fair dealing, recovery of exemplary damages is limited to the greater of four times the amount of actual damages or one-quarter of one million dollars. Such an action against a *governmental entity or unit* or an employee of a governmental entity or unit is governed by the Texas Tort Claims Act . . . (emphasis added).⁴¹⁴

Insurance carrier is defined by the Act as:

- (A) a person authorized and admitted by the State Board of Insurance to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance;
- (B) a certified self-insurer for workers' compensation insurance as authorized by law; or
- (C) a governmental entity that self-insures, either individually or

405. *Id.* at 870 (citing *Aranda*, 748 S.W.2d at 210).

406. *Id.*

407. *Id.* at 870-71.

408. TEX. REV. CIV. STAT. ANN. art. 8309h, § 2(a) (Vernon Supp. 1993) (repealed effective Sept. 1, 1993).

409. *Jackson*, 837 S.W.2d at 871.

410. *Id.*

411. *Id.*

412. *Id.*

413. *Id.*

414. TEX. REV. CIV. STAT. ANN. art. 8308-10.42 (Vernon Supp.) (repealed).

collectively.⁴¹⁵

If the legislature had intended not to waive governmental immunity and except cities from this duty, it would have used the terms "insurance company" and "certified self-insurer" in article 8308-10.42 rather than "insurance carrier." Furthermore, the legislature would not have made a claim against a governmental entity for breach of this duty subject to the Tort Claims Act.

The majority opinion, thus treats article 8308-10.42 meaningless and contradictory. By providing a cause of action against a city that self-insures under the Worker's Compensation Act, the legislature took away governmental immunity.

In *Charter Roofing Co. v. Tri-State Insurance Co.*⁴¹⁶ the court determined that a general liability insurer does not owe a duty of good faith and fair dealing to its policyholder.⁴¹⁷ Charter purchased a general comprehensive liability policy from Tri-State. Soon thereafter, Charter contracted with Weingarten to repair the roof of a shopping center in Louisiana. Charter subcontracted the work to another contractor who, in turn, subcontracted the work to another company. When the property was damaged by a windstorm, Weingarten requested payment from Charter for the damages. Charter, in turn, filed a claim with Tri-State to cover the damages caused by the windstorm. Tri-State hired Newman, a claims adjuster, to handle the Weingarten claim. Upon completing his investigation, Newman recommended that Tri-State deny the claim because the work was not supervised by Charter; because the damage was not caused by property in the care, custody, or control of Charter; and because the damages were not caused by Charter's workmanship. Tri-State followed Newman's advice and denied the claim. Charter eventually paid Weingarten for the damages and then brought suit against Tri-State alleging breach of the duty of good faith and fair dealing. The trial court granted Tri-State's motion for summary judgment and entered a take-nothing judgment against Charter. The court of appeals affirmed.⁴¹⁸

The court held that Tri-State did not owe a duty of good faith and fair dealing to Charter because it was Weingarten, and not Charter, that made the claim against Tri-State.⁴¹⁹ The court held that the comprehensive general liability policy purchased by Charter covered claims made against Charter, not claims made by Charter.⁴²⁰ The court noted that the duty of good faith and fair dealing was recognized in *Arnold v. National County Mutual Fire Insurance Co.*⁴²¹ a first-party case, and thus, does not extend to liability insurance.⁴²²

415. TEX. REV. CIV. STAT. ANN. art. 8308-1.03(28) (Vernon Supp. 1993).

416. 841 S.W.2d 903 (Tex. App.—Houston [14th Dist.] 1992, writ denied).

417. *Id.* at 905.

418. *Id.* at 904.

419. *Id.* at 905-06.

420. *Id.*

421. 725 S.W.2d 165 (Tex. 1987).

422. *Charter Roofing Co.*, 841 S.W.2d at 905.

The court's decision that a general liability carrier does not owe its insured a duty of good faith and fair dealing in third-party claims is wrong. Apparently, the court did not understand that the duty of good faith actually grew out of third-party liability insurance and only later was extended to first-party insurance. The duty arose in third-party liability insurance because of the particular relationship between the insurer and insured and the tremendous potential for abuse by the insurer. Typically, liability policies provide that the insurer will defend and indemnify the insured against the right of liability the insurer may incur to a third-party. The insurer is given complete and exclusive control of the claim and lawsuit brought against the insured, and the insured is prohibited from making any settlement, except at his own expense, without the consent of the insurer. Thus, in *G.A. Stowers Furniture Co. v. American Indemnity Co.*,⁴²³ the court stated that "[a]ll [cases] acknowledge a liability for . . . lack of good faith, in refusing to settle."⁴²⁴ The question presented to the court in *Stowers* was whether, in addition to its duty of good faith, a liability insurer also had the duty to exercise ordinary care and prudence in settling claims.⁴²⁵

With the duty of good faith's doctrinal foundations so firmly established in the liability insurance context, no one, until the court in the instant case, ever questioned that a liability insurer owed the duty to its insured. The only real question was whether the duty would be extended to first-party insurance. Some courts, in fact, disfavored the duty in first-party cases, believing that the unique relationship that gives rise to the special duty of liability insurers to settle within policy limits is not present when an insurer is called upon to pay an insured for a casualty.⁴²⁶ Texas, of course, recognized the duty of good faith and fair dealing in first-party casualty insurance in *Arnold*.⁴²⁷ In light of these historical considerations, *Arnold* cannot be read as limiting the duty of good faith to first-party insurers.⁴²⁸

In *P.G. Bell Co. v. United States Fidelity & Guaranty Co.*⁴²⁹ the court held that although a third-party judgment creditor can maintain a breach of contract action against an insurer, the insurer does not owe a duty of good faith and fair dealing to the third-party judgment creditor.⁴³⁰ Bell, a general contractor, entered into a subcontract agreement with Superior Cranes to help

423. 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved).

424. *Id.* at 547.

425. *Id.*

426. See Santilli v. State Farm Life Ins. Co., 562 P.2d 965, 969 (Ore. 1977). See also 16A John A. Appleman, INSURANCE LAW AND PRACTICE § 48878.15 at 424 (1981); Mathew E. Karanian, *California Casualty General Insurance Co. v. Superior Court: Bad Faith for All*, 18 PAC. L.J. 307, 317 (1986).

427. *Arnold v. National County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987). See also David S. Lill, *Arnold v. National County Mutual Fire Insurance Co.: Texas Adopts First-Party Bad Faith*, 39 BAYLOR L. REV. 835 (1987) (noting that *Stowers* recognized a third-party liability insurer's duty of good faith and *Arnold* held that there is an implied duty of good faith in all contracts of insurance.)

428. For a more detailed discussion of the historical development of the duty see Stephen S. Ashley, *Bad Faith Actions, Liability and Damages*, Chapter 2 (Supp. 1991).

429. 853 S.W.2d 187 (Tex. App.—Corpus Christi 1993, no writ).

430. *Id.* at 190.

build a shopping center. Superior was to erect precast concrete slabs that formed the structures of the buildings. The subcontract required Superior to secure a general liability policy with property damage limits of \$100,000 per accident. This insurance was provided to Superior by USF&G. While working on the project, Superior cracked one of the slabs and refused to pay Bell for the resulting damages. Bell sued Superior alleging breach of contract and negligence. USF&G did not defend Superior in the case. Superior failed to appear at trial and a default judgment was taken against Superior in the amount of approximately \$150,000 in actual damages, \$150,000 in pre-judgment interest, and \$10,000 in attorney's fees. After USF&G refused to pay this judgment, Bell sued for breach of contract, breach of the duty of good faith and fair dealing, and for violations of the DTPA. USF&G filed a motion for summary judgment contending that Bell could not maintain any causes of action against USF&G because USF&G did not have a contract with Bell, it did not owe a duty of good faith and fair dealing to Bell, the terms of the insurance policy were not complied with, and the statute of limitations barred the claims. The trial court granted this motion and rendered judgment in favor of USF&G. The court of appeals reversed and remanded for trial.⁴³¹

USF&G argued that Bell could not maintain an action for breach of contract because there was no contract between USF&G and Bell. However, Bell was a third-party judgment creditor bound by the rights, duties, and obligations of the insured under the terms and conditions of the contract between the insurance company and the insured.⁴³² The court, therefore, held that once Bell acquired a default judgment against Superior for damages done to property covered by the USF&G policy, Bell had a cause of action against USF&G for payment of those damages up to the policy limits.⁴³³

The court held, however, that Bell, even as a third-party judgment creditor, was not owed a duty of good faith and fair dealing by USF&G.⁴³⁴ The court reasoned that the duty to deal fairly and in good faith arises from the special relationship between the insured and the insurer.⁴³⁵ In this case, the insured was Superior, not Bell. Bell argued that this duty did extend to it because the insurance policy was created for its benefit. The court found this case very similar to *Chaffin v. TransAmerican Insurance Co.*⁴³⁶ in that the subcontractor was the only person named on the policy and thus, it could not be concluded that the general contractor was a beneficiary under the policy.⁴³⁷ Moreover, the court held that the duty of good and fair dealing should extend only to the insured because it is the primary beneficiary of the policy, even though third-parties ultimately benefit from the existence of the

431. *Id.* at 188.

432. *Id.* at 190.

433. *Id.*

434. *Id.*

435. *Id.*

436. 731 S.W.2d 728 (Tex. App.—Houston [14th Dist.] 1987, writ ref'd n.r.e.).

437. *Id.* at 731-32.

policy.⁴³⁸

In *Shelton Insurance Agency v. St. Paul Mercury Insurance Co.*⁴³⁹ the court determined that an insurer does not owe a duty of good faith and fair dealing to an insurance agency.⁴⁴⁰ John Roberts, an insurance agent working for the Shelton Agency, sold Frio Drilling Company a St. Paul policy that insured it against losses resulting from oil well blowouts. After one of Frio's wells blew out and St. Paul denied the claim, Frio sued the Shelton Agency and St. Paul. St. Paul later settled with Frio, but did not settle the claims against the Shelton Agency. St. Paul then hired an attorney to defend the Shelton Agency in the Frio suit under an errors and omissions policy. The Shelton Agency later dropped its claim against Frio for \$40,000 in unpaid premiums as part of a settlement of the Frio suit. The Shelton Agency then sued St. Paul alleging that St. Paul was liable to pay damages under either the blowout policy or the errors and omissions policy because it wrongfully, and in bad faith, refused to timely pay either of the claims. The Shelton Agency sought to recover the premiums that it wrote off in settling the Frio suit plus commissions lost due to losing Frio as a customer.

The jury found that St. Paul denied Frio's claim with no reasonable basis for the denial; failed to determine if there was a reasonable basis for denying Frio's claim and failed to exercise good faith in the investigation, processing, and denial of Frio's claim. The trial court, however, granted judgment n.o.v. favorable to St. Paul, and ordered that the Shelton Agency take nothing. The court of appeals affirmed in part and reversed and rendered in part.⁴⁴¹

The court held that St. Paul could not be liable to the Shelton Agency for breach of the duty of good faith and fair dealing because the Shelton Agency was not an insured or intended beneficiary under the policy issued to Frio.⁴⁴² The court noted that the Shelton Agency did not request jury questions on whether St. Paul breached any duty owed directly to it, but merely asked whether St. Paul was liable for the manner in which it handled the Frio claim. Thus, according to the court, the "Shelton Agency waived any claim it might have had for breach of a duty running between St. Paul and itself."⁴⁴³

The court did hold that the Shelton Agency could recover from St. Paul under a breach of contract theory.⁴⁴⁴ St. Paul agreed to indemnify the Shelton Agency against all claims that the Shelton Agency might become obligated to pay as a result of any loss caused directly by St. Paul's error in processing or handling policies. Here, the jury found that St. Paul denied Frio's claims without a reasonable basis, thus establishing a breach of St. Paul's contractual obligation to indemnify the Shelton Agency.⁴⁴⁵ The dam-

438. *P.G. Bell Co.*, 853 S.W.2d at 190.

439. 848 S.W.2d 739 (Tex. App.—Corpus Christi 1993, writ denied).

440. *Id.* at 743.

441. *Id.* at 741.

442. *Id.* at 743.

443. *Id.* at 744.

444. *Id.* at 745.

445. *Id.*

ages that the Shelton Agency suffered were the amount of premiums that Frio owed, but were written off by the Shelton Agency. St. Paul argued that the evidence did not support the finding that it denied the claim without a reasonable basis for doing so. The evidence, however, showed that several people, including those hired by St. Paul, informed St. Paul that the loss Frio suffered was due to a blowout. Furthermore, St. Paul obtained a legal opinion that stated it would be very difficult to maintain that the damages suffered were not caused by a blowout, especially in view of the lack of a definitive definition of the term "blowout" in the policy. Thus, the court held there was sufficient evidence to support the jury's finding that St. Paul had no reasonable basis for denying Frio's claim.⁴⁴⁶

In *Central Savings and Loan Ass'n v. Stemmons Northwest Bank, N.A.*⁴⁴⁷ Central Savings purchased thirty mortgage loans from TriTexas. After a dispute arose over the availability of private mortgage insurance on some of the loans, the two entered into a settlement agreement wherein TriTexas agreed to act as the mortgage insurer. TriTexas delivered to Central Savings a letter of credit, issued by Stemmons, to secure TriTexas's obligations. When Stemmons told Central Savings it would not renew the letter of credit, Central Savings demanded that TriTexas comply with its obligations under the settlement agreement. TriTexas refused to do so and thus, Central Savings presented the letter of credit to Stemmons. Stemmons refused to honor it. Central Savings then sued Stemmons and TriTexas alleging, inter alia, that each breached a duty of good faith and fair dealing. The trial court granted summary judgment against Central Savings on these causes of action. The court of appeals affirmed.⁴⁴⁸

With respect to Stemmons, Central Savings argued that the two had a special relationship by virtue of the letter of credit giving rise to a common law duty of good faith and fair dealing. The court found that the requisite "special relationship" has been found only between an insurer and its insured and has never been found to exist between the issuer of a letter of credit and the beneficiary.⁴⁴⁹ The court thus viewed this duty as existing in very limited circumstances, none of which were present in this case.⁴⁵⁰ The court further held that parties to a transaction governed by the Uniform Commercial Code owe each other a duty of good faith and fair dealing, but a breach thereof is not a tort, but gives rise to a breach of contract cause of action.⁴⁵¹

With respect to TriTexas, Central Savings argued that because the settlement agreement provided that TriTexas would act as the permanent mortgage insurer with respect to the loans, TriTexas owed Central Savings a duty of good faith and fair dealing. According to the court, however, the evi-

446. *Id.* at 746.

447. 848 S.W.2d 232 (Tex. App.—Dallas 1992, no writ).

448. *Id.* at 236.

449. *Id.* at 239.

450. *Id.*

451. *Id.* (citing *Adolph Coors Co. v. Rodriguez*, 780 S.W.2d 477, 482 (Tex. App.—Corpus Christi 1989, writ denied)).

dence revealed that TriTexas was not an insurance company but a mortgage servicing company.⁴⁵² Because TriTexas was not an insurer and did not issue mortgage guaranty insurance, the court held that TriTexas did not owe Central Savings a duty of good faith and fair dealing.⁴⁵³

In a very brief opinion, conspicuously lacking any citations of authority, the Fifth Circuit in *Bui v. St. Paul Mercury Insurance Co.*⁴⁵⁴ held that a person hired by the insurance company to investigate a loss cannot be held liable for negligently investigating the claim.⁴⁵⁵ The extent of the court's discussion of this issue was that no action could be maintained against the investigator "because [the investigator] was not a party to the [insurance] contract and, under the particular facts of this case, owed no duty to the Buis under Texas law."⁴⁵⁶ A contractual relationship, however, is not required to hold a person liable in negligence or for violations of the DTPA and Insurance Code.

2. *Breadth of the Duty: Underwriting/Claims Handling/Policy Cancellation*

When the supreme court first recognized the duty of good faith and fair dealing, it did so in the context of a case involving the insurer's claims handling procedures.⁴⁵⁷ In *Hopkins v. Highlands Insurance Co.*⁴⁵⁸ the court held that an insurer breaches its duty of good faith and fair dealing by canceling insurance coverage when: (1) there is an "absence of a reasonable basis for cancellation of coverage; and (2) [t]he insurer knew, or should have known, that there was not a reasonable basis for cancellation of [the] coverage."⁴⁵⁹ "The first element of this test require[s] an objective determination of whether a reasonable insurer under similar circumstances would have canceled insurance coverage, once coverage ha[d] commenced."⁴⁶⁰ The evi-

452. *Id.* at 242.

453. *Id.* On the issue of who is an insurer, compare *Temple Eastex, Inc. v. Old Orchard Creek Partners, Ltd.*, 848 S.W.2d 724 (Tex. App.—Dallas 1992, writ denied). While this case does not involve an action for breach of the duty of good faith and fair dealing, the court made important holdings about insurance. Old Orchard owned an apartment complex and hired Greener & Sumner as the general contractor for a construction project. One of the subcontractors hired by Greener & Sumner caused a fire that destroyed the complex. Old Orchard and Greener & Sumner executed a standard American Institute of Architects contract that required Old Orchard to maintain adequate property insurance. The contract also provided that Old Orchard would waive all its rights against Greener & Sumner and the subcontractors for damages caused by fire and that the parties would look solely to the property insurance. The contract required Old Orchard to notify Greener & Sumner if it intended not to carry adequate insurance. Old Orchard never gave such notice but did not carry enough insurance to cover the fire loss. The court held that Orchard, thus, became the insurer and was liable for damages to the extent that an insurance carrier would have been liable had adequate insurance been obtained. *Id.* at 731. Thus, it stands to reason that if TriTexas agrees to act as insurer, even though not incorporated as such, it should have the same duties as any other insurer.

454. 981 F.2d 209 (5th Cir. 1993).

455. *Id.* at 210.

456. *Id.*

457. *Arnold v. National County Mut. Fire Ins. Co.*, 725 S.W.2d 165 (Tex. 1987).

458. 838 S.W.2d 819 (Tex. App.—El Paso 1992, no writ).

459. *Id.* at 827.

460. *Id.*

dence in this case showed that, according to its own internal guidelines, Highlands would cancel coverage on a driver when the driver had more than three moving violations in the past three years. However, Hopkins had only three tickets in the preceding three years; all of which were issued prior to the effective date of the insurance policy. The court, therefore, held that Highlands did not establish, as a matter of law, that there was a reasonable, objective basis for canceling the coverage based on the application of its own internal guidelines.⁴⁶¹ The court then held that the second element was met when the insurer actually knew, or should have known, that there was no reasonable basis for cancellation of insurance coverage.⁴⁶² According to the court, Highlands should have known that excluding Hopkins from policy coverage was contrary to its own guidelines. Therefore, the summary judgment was improper and reversed as to Highlands for breach of the duty of good faith and fair dealing.

Chief Justice Osborn wrote a concurring opinion to make clear that the court was extending the rule announced in *Aranda*⁴⁶³ and *Arnold* as those cases involved delays or denials of payment of claims.⁴⁶⁴ This case, however, involved cancellation of coverage.⁴⁶⁵ Chief Justice Osborn noted that the same concern regarding the need for this duty in connection with payment of claims is present with respect to the cancellation of coverage. That is, since the insurer has exclusive control of the decision-making process and a disparity of bargaining power exists between insurer and insured, without the existence of a duty of good faith and fair dealing, an insurer can arbitrarily cancel coverage.⁴⁶⁶ According to Chief Justice Osborn, the right of an insurance company to cancel a policy is not absolute and, once coverage is provided, an insurer may not indiscriminately cancel that policy during a policy period.⁴⁶⁷ Chief Justice Osborn, however, noted that an insurance company has an absolute right to cancel for nonpayment of premiums or a violation of policy provisions that place some duty on the insured.⁴⁶⁸

The court in *Shelton v. Union Bankers Insurance Co.*⁴⁶⁹ also held that an insurer has the duty to exercise good faith and fair dealing when canceling insurance policies.⁴⁷⁰ According to the court, this duty is applicable to the entire contract, not just to the handling of claims.⁴⁷¹

In *Commonwealth Lloyds Insurance Co. v. Downs*⁴⁷² the court refused to extend the duty of good faith and fair dealing to cover the underwriting

461. *Id.*

462. *Id.*

463. *Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210 (Tex. 1988).

464. *Hopkins*, 838 S.W.2d at 828 (Osborn, C.J., concurring).

465. *Id.*

466. *Id.*

467. *Id.*

468. *Id.*

469. 853 S.W.2d 589 (Tex. App.—Texarkana 1993, writ granted).

470. *Id.* at 593.

471. *Id.*

472. 853 S.W.2d 104 (Tex. App.—Fort Worth 1993, writ denied).

phase of an insurance transaction.⁴⁷³ The court reached its conclusion because it could find no other cases recognizing the existence of the duty in such a context, although no cases were cited rejecting this notion.⁴⁷⁴

B. THE STANDARD BY WHICH BAD FAITH IS JUDGED

1. *The Bona Fide Dispute Defense*

The courts of appeals are split on how to judge whether the insurer had a reasonable basis for denying or delaying payment of a claim with some wanting to focus only on the facts known to the insurer that support its denial or delay while others view all the evidence that supports the jury's findings. The former courts tend to find no breach if the insurer shows some facts to support its conclusion that there was no coverage, even if other facts support a conclusion that there was coverage. The other courts give greater weight to the jury's findings, allow the jury to make the determination of whether the insurer acted in a reasonable manner.

The effort to recognize what has been called the "bona fide dispute" defense has been spearheaded by the San Antonio court, most notably in *State Farm Lloyds, Inc. v. Polasek*.⁴⁷⁵ There the court held that, to establish a breach of the duty of good faith and fair dealing, an "insured must prove that there were no facts before the insurer, which, if believed, would justify denial of the claim."⁴⁷⁶ Thus, according to the court, the jury should not consider evidence contradicting insurer's position, but should only determine whether evidence relied upon by insurer supported a denial of the claim.⁴⁷⁷

In 1990, a fire destroyed a video rental business owned by the Polaseks and insured by State Farm. State Farm denied the Polaseks' claim after concluding that the Polaseks started the fire. The Polaseks filed suit and, ultimately, a jury found that they did not commit arson and that State Farm breached its duty of good faith and fair dealing by denying the claim.

The court first decided that State Farm did not establish, as a matter of law, that the Polaseks had set fire to the video store.⁴⁷⁸ The court held that in order to establish the defense of arson, State Farm had to prove that the Polaseks set the fire or caused it to be set.⁴⁷⁹ While the court found some evidence that the fire did have an incendiary origin and that the Polaseks had an opportunity and motive to set the fire, the court also found evidence that the Polaseks had nothing to do with the fire.⁴⁸⁰ Because the evidence on this issue was conflicting, the court held that it was up to the jury to resolve this fact issue.⁴⁸¹ The court refused to disturb the jury's finding and affirmed

473. *Id.* at 119.

474. *Id.*

475. 847 S.W.2d 279 (Tex. App.—San Antonio 1992, writ denied).

476. *Id.* at 284.

477. *Id.* at 285.

478. *Id.* at 283.

479. *Id.*

480. *Id.*

481. *Id.*

the judgment based on the insurance contract.⁴⁸²

The court next turned to State Farm's argument that there was no evidence to support the jury's finding that State Farm had breached its duty of good faith and fair dealing. The Polaseks had to prove that State Farm had no reasonable basis for denying the claim or that it failed to determine whether there was any reasonable basis for denying the claim. This burden is not satisfied, wrote the court, by proving that the Polaseks did not commit arson, that State Farm should have paid the claim, or that State Farm acted unreasonably in denying the claim.⁴⁸³ Instead, an "insured must prove that there are no facts before the insurer which, if believed, would justify denial of the claim."⁴⁸⁴ According to the court, the trier of fact should not weigh conflicting evidence on the issue of reasonableness, but should decide whether evidence existed and whether, standing alone, it was a reasonable ground for denying the claim.⁴⁸⁵ Therefore, if an insurer possesses evidence reasonably showing that the insured's claim might not be valid, there is no breach of the duty of good faith and fair dealing as a matter of law.⁴⁸⁶ The court did concede that the basis for the denial must be reasonable, but the court felt that the trier of fact should not be allowed to second guess the insurer about reasonableness.⁴⁸⁷ Furthermore, courts should be careful to insure that an action for breach of the duty of good faith and fair dealing is reserved for those cases of flagrant denial or delay of payment when no reasonable basis exists and not for mere unreasonable denial or delay.⁴⁸⁸ The court then held that there was ample evidence that a reasonable basis existed for denying Polaseks' claim.⁴⁸⁹ There was evidence that the fire had an incendiary origin, that there was no accidental cause, and that there was no forced entry into the store. There was also evidence that Mrs. Polasek was the last person on the premises the night of the fire, and that the Polaseks lived a short drive from the store. The court also noted evidence that the store was marginally profitable and that the Polaseks had a \$6,500 note for video tapes coming due five days after the fire. The court also pointed to evidence that the Polaseks had borrowed some money to put into the business, that they had been late paying rent, and that Mr. Polasek had removed an uninsured air-compressor on the day of the fire. According to the court, when State Farm decided whether arson by the Polaseks may have caused the fire, it was entitled to assess the evidence in light of the substantive law of arson that permits an arson finding on circumstantial evidence.⁴⁹⁰ The court, therefore, held that, as a matter of law, a reasonable basis existed for denying the claim.⁴⁹¹

482. *Id.*

483. *Id.*

484. *Id.* at 284.

485. *Polasek*, 847 S.W.2d at 285.

486. *Id.* at 287.

487. *Id.*

488. *Id.*

489. *Id.*

490. *Id.*

491. *Id.*

The Polaseks argued that State Farm also breached the duty of good faith and fair dealing by failing to determine whether there was a reasonable basis for denying the claim. They argued that State Farm did not talk to persons who would have loaned them money to pay debts rather than resorting to burning their own store down. The court held that an insurer does not have to pursue every lead and that the investigation done by State Farm was sufficient.⁴⁹² The court, therefore, reversed the judgment awarding mental anguish and exemplary damages for breach of the duty of good faith and fair dealing and rendered judgment that the Polaseks take nothing.⁴⁹³

The court utilized the same reasoning in *Employers National Insurance Co. v. Dalros*⁴⁹⁴ to reverse a judgment against the insurer based on the jury's verdict that it breached its duty of good faith and fair dealing.⁴⁹⁵ After Dalros drained his pool in order to clean and whitewash the sides he noticed that the pool had risen about one foot above ground level. According to his neighbor, this occurred because heavy rains had saturated the ground and forced the empty pool up. The pool was refilled and it settled about half-way back into the ground. A couple of weeks later, the pool cracked and Dalros called Employers. Several days later, Employers told Dalros that the claim would be denied due to flooding. Employers later sent an adjuster out to inspect the pool, who suggested that the claim be denied because the loss was caused by cracking, an exclusion under the policy. Approximately one year later, an attorney hired by Dalros sent a demand letter to Employers. Within two months Employers sent Dalros a \$10,000 check, representing the policy limits. Dalros later filed suit, alleging that Employers breached its duty of good faith and fair dealing. The jury found against Employers and awarded \$12,500 as damages for mental anguish and \$250,000 in exemplary damages. The court of appeals reversed and rendered judgment that Dalros take nothing.

The court once again held that Dalros was required to show that there were no facts, which if believed, supported Employers' initial denial and resulted in delay in order to establish a breach of the duty of good faith and fair dealing.⁴⁹⁶ According to the court, when there is a bona fide controversy, the insurer has a right to deny the claim, await litigation, or even change its mind and pay the claim, as long as there exists a reasonable basis for denying the claim.⁴⁹⁷

The court noted that the exclusion relied on by Employers was an exclusion for losses caused by cracking. According to the court, no matter what the cause, if cracking existed, it was excluded. In this case, there was no dispute that the pool cracked after it rose, thereby presenting a reasonable basis for denying the claim. The fact that Employers eventually paid the claim, according to the court, did not mean that during the year of delay was

492. *Id.* at 288.

493. *Id.*

494. No. 04-92-00078-CV (Tex. App.—San Antonio, Mar. 31, 1993, n.w.h.).

495. *Id.*

496. *Id.*, slip op. at 6.

497. *Id.*

acting without a reasonable basis.⁴⁹⁸ To the contrary, it would be an indication, at least to this court, of Employers' good faith desire to resolve the conflict in spite of a clear exclusion in the policy.⁴⁹⁹

Two courts have criticized and rejected the reasoning of *Polasek* as an aberration in the law concerning the duty of good faith and fair dealing. The first is *State Farm Fire & Casualty Co. v. Simmons*⁵⁰⁰ and the other is *Nationwide Mutual Insurance Co. v. Crowe*.⁵⁰¹

In *Simmons*, State Farm refused to pay a claim for fire loss that resulted in the total destruction of their home, accusing the Simmonses of arson. The jury found, among other things, that State Farm breached its duty of good faith and fair dealing and awarded \$75,000 as contract benefits, \$200,000 for mental anguish, and \$2 million for punitive damages. The trial court entered judgment based on the jury's verdict and State Farm appealed. The court of appeals affirmed.⁵⁰²

State Farm, relying on *Polasek*, argued that there was neither factually nor legally sufficient evidence to support the jury's finding that there was no reasonable basis for State Farm's decision to deny the Simmonses' claim. The court, however, held that *Polasek* is an abrupt substantive departure from present law as it eliminates the "should have known" requirement⁵⁰³ under *Aranda v. Insurance Co. of North America*.⁵⁰⁴ In *Aranda*, the court held that to prove breach of the duty of good faith and fair dealing, an insured must show: "(1) the absence of a reasonable basis for denying or delaying payment of the benefits of the policy and (2) that the carrier knew or should have known that there was a reasonable basis for denying the claim or delaying payment of the claim."⁵⁰⁵

The first element of this test requires an objective determination of whether a reasonable insurer, under similar circumstances, would have delayed or denied the claimant's benefits. Thus, the court imposed the duty on an insurer to that degree of care and diligence, which a man of ordinary care and prudence would exercise in the management of his own business.⁵⁰⁶

The *Simmons* court felt that *Polasek* abrogated the common law cause of action for breach of the duty of good faith and fair dealing because it removed the question of good faith and fair dealing from the fact-finding process and looked only at the insurer's evidence, rather than the insured's.⁵⁰⁷ The court felt that the determination of reasonable basis for denial of a claim is a fact question and that the *Polasek* court left this matter solely to the

498. *Id.*, slip op. at 8.

499. *Id.*

500. 857 S.W.2d 126 (Tex. App.—Beaumont 1993, writ denied).

501. 857 S.W.2d 644 (Tex. App.—Houston [14th Dist.]), *judgment set aside*, 863 S.W.2d 462 (Tex. 1993).

502. *Simmons*, 857 S.W.2d at 143.

503. *Id.* at 134.

504. 748 S.W.2d 210, 213 (Tex. 1988).

505. *Id.*

506. *Id.*

507. *Simmons*, 857 S.W.2d at 134.

insurers.⁵⁰⁸ Thus, according to the court, *Polasek* is not only a dangerous, but a frightening, precedent.⁵⁰⁹ The court also wrote that the focus of *Polasek* on the mind-set of State Farm as to the issue of reasonableness, destroys the special relationship of loyalty owed by an insurer to its policyholders.⁵¹⁰ The duty of good faith and fair dealing, according to the court, is the stop-gap that bridges the disparity of bargaining power and exclusive control that an insurer has and exercises over claim processing.⁵¹¹ If *Polasek* is correct, wrote the court, "[t]he entire matter regarding claims investigation now begins and ends with the insurer."⁵¹² The court thus concluded that the far better inquiry in bad faith actions is, "Did the insurer fulfill its duty to its insured by pursuing a thorough, systematic, objective, fair, and honest investigation of the claim prior to the denying such claim?"⁵¹³

With all of this in mind, the court then reviewed the evidence presented by both the Simmonses and State Farm and concluded that the jury had sufficient evidence to find that State Farm did not use the degree of care and diligence that a man of ordinary prudence would exercise in the management of his own business in denying the Simmons' claim. The evidence showed that on June 2, 1985, at approximately 2:00 a.m. the Simmonses left their house for Louisiana. A short time later, Irene Lawrence, whose newspaper delivery route took her by the Simmons' home, spotted smoke. Lawrence borrowed a neighbor's phone and quickly alerted the fire department. Within minutes, the volunteer fire department arrived on the scene and began attacking the fire. Unfortunately, by the time the firemen arrived, much of the roof was already engulfed in flames and the firefighters were unable to save the house. The Simmonses returned to their home in the early evening of June 2, 1985 and discovered that their home and all of their possessions had been destroyed by the fire. The following day the Simmonses reported the fire to State Farm. The evidence showed that they cooperated fully with State Farm in its investigation, which included the authorization of State Farm to obtain all of the financial information it might desire.

The Simmonses contended that unknown to them, State Farm from the inception decided to investigate them, and set out within a few days of the investigation to establish that they were responsible for the fire. At the conclusion of State Farm's investigation, it decided that the Simmonses were responsible for the fire, although it had no direct evidence of their involvement. State Farm concluded that the fire was incendiary, that the Simmonses had opportunity to set the fire, and that they had motive to set the fire. From the beginning of its investigation, State Farm viewed the fire as suspicious because of a recent burglary to the Simmons' home. Thus, the Simmons' claim was referred to State Farm's special investigative unit (SIU), which operated as a special arson and fraud unit.

508. *Id.*

509. *Id.* at 135.

510. *Id.* at 135-36.

511. *Simmons*, 857 S.W.2d at 136.

512. *Id.*

513. *Id.*

State Farm, when it took the recorded statement of Mr. Simmons, learned that he was behind in his mortgage but had worked out a repayment agreement with the Veteran's Administration that involved weekly payments in lieu of a monthly obligation. Mr. Simmons further informed State Farm that he was not current on those payments. According to State Farm, this was the motive for the Simmonses to burn their house. However, the total arrearage on the mortgage payments was not as great as State Farm had originally thought since the information it received from the Veteran's Administration was erroneous. Even after State Farm learned that the information was incorrect, it did not change State Farm's position about motive.

The evidence also revealed that State Farm, about one month after the fire, learned that someone had confessed to burglarizing the Simmons' home. However, State Farm never contacted or interviewed the suspects regarding their whereabouts at the time of the fire. State Farm did not investigate the police criminal files on those individuals either. The reason given by State Farm for not following through with an investigation of the suspects was that it felt the suspects would not tell them anything. There was also evidence that Mr. Simmons had a confrontation with one of the suspects who burglarized his home, yet State Farm made no contact whatsoever with this person. The jury also heard evidence that State Farm knew that even if the policy proceeds had been paid and applied to the mortgage, there would still have been a remaining mortgage balance. There was also evidence that the fire was not incendiary in nature but may have been caused by unrepaired electrical problems in the den. State Farm, however, did not fully investigate this matter. In light of all of this evidence, the court concluded that the jury had sufficient evidence to conclude that State Farm did not have a reasonable basis for denying the Simmons' claim.⁵¹⁴

In *Nationwide Mutual Insurance Co. v. Crowe*, the other case to explicitly criticize *Polasek*, John Crowe suffered a heart attack while installing a water heater at a job site and died later that day. Mr. Crowe's wife and son made a claim for workers' compensation death benefits to Nationwide, the workers' compensation carrier. Nationwide denied the claim contending that there was no evidence that Mr. Crowe's death was in the course of his employment. The Crowes then brought suit against Nationwide alleging negligence and breach of the duty of good faith and fair dealing in failing to pay the workers' compensation death benefits. The jury found in favor of the Crowes and awarded each \$10,000 in actual damages. The jury also found that Nationwide acted with conscious indifference and awarded each of the Crowes \$500,000 in punitive damages. The court of appeals affirmed.⁵¹⁵

Nationwide first argued that there was no breach of the duty of good faith and fair dealing, as a matter of law, because the Industrial Accident Board (IAB) also determined that Mr. Crowe's death was not in the course of employment and thus, denied the claim. Nationwide, therefore, argued that its denial of the claim was reasonable. Nationwide also argued that Mr.

514. *Id.* at 137-38.

515. *Crowe*, 857 S.W.2d at 647 (judgment set aside).

Crowe's death certificate, which did not state that his death was in the course of employment, was a reasonable basis for denying the claim, as a matter of law. The court held that a dispute about whether there is any reasonable basis to support the denial of a claim is an issue for the jury, and must be judged by the facts before the insurer at the time the claim is denied.⁵¹⁶ In reaching this decision, the court disapproved of the holding in *Polasek* to the extent that it implies that anything less than an objectively reasonable basis to deny a claim would conflict with the *Aranda* standard.⁵¹⁷ The court, therefore, held that the probative value of the hearing examiner's determination was limited because it was made after Nationwide had denied the claim.⁵¹⁸ Thus, the only facts before Nationwide when it denied the claim were those contained in the death certificate, which listed the immediate cause of death as massive myocardial infarction due to severe coronary artery disease. Because there was evidence that it was not proper procedure to deny a claim based solely on information in the death certificate, the court held that there was a fact question to be submitted to the jury regarding Nationwide's alleged breach of the duty of good faith and fair dealing.⁵¹⁹

The supreme court had the opportunity to resolve the differences in *Polasek* and *Simmons* by granting an application for writ of error in either case, but in both cases the application for writ of error was denied. The court, instead, used *Lyons v. Millers Casualty Insurance Co.*⁵²⁰ to write on this issue. However, as will be seen, the court did not provide clear direction regarding the standard by which to judge bad faith. Lyons alleged that her home was damaged in a windstorm. The insurer sent an adjuster and two different experts, all of whom concluded the damage was from settling and cracking, which were excluded causes. The jury found that the insurer acted in bad faith and committed a false, misleading, or deceptive act by denying the claim. The jury found that 75% of the damage was the result of settling and cracking, but 25% was a covered loss caused by the windstorm. The jury awarded \$25,000 as cost of repairs, \$75,000 in other actual damages, and \$8,700 as additional damages under DTPA § 17.50(b)(1). The court of appeals found no evidence to support the jury finding that the insurer breached its duty of good faith and fair dealing. The supreme court affirmed.⁵²¹ The first issue addressed by the court was the method by which Texas courts should conduct legal sufficiency review of fact findings of bad faith against an insurer.⁵²² The court noted that to prove breach of the duty of good faith and fair dealing, the insured must prove that there is no reasonable basis to deny the claim and the insurance company knew, or should have known, that there was no reasonable basis.⁵²³ After stating the tradi-

516. *Id.* at 648.

517. *Id.* at 648-49 n.1.

518. *Id.* at 649.

519. *Id.*

520. 866 S.W.2d 597 (Tex. 1993).

521. *Id.* at 602.

522. *Id.* at 600.

523. *Id.*

tional standard for a no-evidence review, the court held in the bad faith context, the "focus should be on the relationship of the evidence arguably supporting the bad faith finding to the elements of bad faith."⁵²⁴ The court continued by saying:

The evidence presented, viewed in the light most favorable to the prevailing party, must be such as to permit the logical inference that the insurer had no reasonable basis to delay or deny payment of the claim, and that it knew or should have known it had no reasonable basis for its action.⁵²⁵

The court further determined that the evidence must relate to the tort issue of no reasonable basis, not just to the contract issue of coverage.⁵²⁶

The court noted that the evidence offered by Lyons to prove Millers' bad faith included an expert's opinion that the wind caused the damage, and the testimony of Lyons and her neighbors that the house was visibly damaged after the storm. The court viewed this evidence as supporting contractual liability, but did not consider it in connection with the bad faith claim.⁵²⁷ Instead, the court found that "Lyons offered no evidence that the reports of Millers' experts were not objectively prepared, or that Millers' reliance on them was unreasonable, or any other evidence that showed that Millers acted without a reasonable basis."⁵²⁸ According to the court, the insurer will not be liable for breach of the duty of good faith and fair dealing if it reasonably relied on expert reports which indicate that the loss incurred was not a covered risk, even though liability on the policy is ultimately established.⁵²⁹ Justice Doggett, joined by Justices Gammage and Hightower, dissented accusing the majority of engaging in a factual sufficiency review of the evidence, which is prohibited by the Texas Constitution.⁵³⁰ According to the dissent, under a legal sufficiency review, the court "must consider only the evidence and inferences tending to support the jury's finding, viewed most favorably in support of the finding, and disregard all contrary evidence and inferences."⁵³¹ The majority, said Justice Doggett, discounted Lyons' expert witness, thereby evaluating "the credibility, sufficiency, and weight of Millers' experts in order to find that their investigation was serious, adequate and factually constituted a reasonable basis for the denial of the claim."⁵³² As such, the court engaged in a factual sufficiency review not a legal sufficiency review. The dissent next recounted the evidence that would support the jury's verdict and questioned why the majority chose to ignore such evidence.⁵³³ Lyons and her neighbors testified about the damage to the home

524. *Id.*

525. *Lyons*, 866 S.W.2d at 600.

526. *Id.*

527. *Id.* at 601.

528. *Id.*

529. *Id.*

530. *Lyons*, 866 S.W.2d at 602 (Doggett, J., dissenting).

531. *Id.* (Doggett, J. dissenting) (quoting *Havner v. E-Z Mart Stores, Inc.*, 825 S.W.2d 456, 458 (Tex. 1992)).

532. *Id.* at 604 (Doggett, J., dissenting).

533. *Id.* (Doggett, J., dissenting).

immediately after the windstorm. There was also expert testimony that the wind had caused the damage to the home. Additionally, there was evidence that Millers initially denied Lyons claim within a month of its receipt based solely on a three sentence "report;" its claims adjuster refused to talk to Lyons, even to the point of hanging up when she called with inquiries; and its investigators consciously chose not to interview any independent eyewitnesses until Lyons, almost two years after making her claim, filed suit.⁵³⁴ Even after mentioning all this evidence, the dissent wrote that the court should not be engaged in a review of the factual sufficiency of the evidence as that is beyond the constitutional grant of jurisdiction.⁵³⁵ According to Justice Doggett, the majority substituted its preference for the jury's verdict thereby eroding the constitutional right to trial by jury.⁵³⁶

a. Other Cases Reviewing Insurer's Alleged Bad Faith

Most courts have not engaged in the *Polasek/Simmons* debate, but seem to have adopted one of these two conflicting views concerning the standard by which to determine whether an insurer acted in bad faith.

i. Courts Finding Bad Faith

Southern Life & Health Insurance Co. v. Alfaro,⁵³⁷ a case decided by a different panel of the San Antonio Court of Appeals, while not mentioning *Polasek*, rejected its approach by upholding the jury's finding of insurer's lack of good faith in light of conflicting evidence on this issue.⁵³⁸

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

SL&H argued that there was no evidence that it did not attempt a good faith settlement after liability had become reasonably clear because a bona fide controversy is sufficient reason for an insurer not to pay a claim. In deciding whether SL&H acted in good faith to affect a prompt, fair, and equitable settlement of the claim, the court looked at all of the evidence presented to the jury, which the court admitted was conflicting.⁵³⁹ The court found that there was some evidence that Tony was not attempting to

534. *Lyons*, 866 S.W.2d at 604 (Doggett, J., dissenting).

535. *Id.* at 605 (Doggett, J. dissenting).

536. *Id.* (Doggett, J., dissenting).

537. No. 04-91-00470-CV (Tex. App.—San Antonio, Feb. 26, 1993, n.w.h.).

538. *Id.*, slip op. at 8.

539. *Id.*

commit an assault or any other felony at the time Castillo shot him.⁵⁴⁰ Furthermore, there was evidence that SL&H did not conduct a thorough investigation of the claim, as it did not interview two women who were present at the murder scene and did not review Castillo's written confession until three months after the claim was denied. Additionally, the jury was presented with evidence that SL&H postponed its decision regarding the claim until the end of Castillo's trial. In light of all of this evidence, the court held that the jury's finding was not so contrary to the overwhelming weight of evidence as to be clearly wrong and unjust.⁵⁴¹

Recovery was also permitted in *State Farm Fire & Casualty Co. v. Price*,⁵⁴² even though there was some evidence supporting State Farm's position. Price made a claim under his homeowners policy issued by State Farm for damage to his house. After the initial inspection of the damages, a claims adjuster for State Farm told Price the claim would be paid because the plumber determined that the damage was caused by a plumbing break. State Farm then had an engineer inspect the house. Based on this inspection, State Farm determined that the damage was caused by the settling of the house over a period of years, and the claim was denied. The policy coverage excluded loss caused by settling, cracking, bulging, shrinkage, or expansion of foundations, walls, and floors except when caused by accidental air discharge, breakage or overflow of water or steam within a plumbing, heating, or air conditioning system.

The jury found that the damage to the house was caused by accidental discharge, breakage, or overflow of water from within a plumbing, heating, or air conditioning system, and that State Farm breached its duty of good faith and fair dealing. The jury found actual damages of \$102,500 and the trial court awarded additional damages of \$205,000.

On appeal, State Farm argued that the evidence was not sufficient to support the jury's finding of breach of the duty of good faith and fair dealing. The court held that, in determining whether the evidence was legally sufficient to support the jury's verdict, it could "consider only the evidence and reasonable inferences which, when viewed in their most favorable light, support[ed] the findings and [should] disregard all evidence and inferences to the contrary of the fact finding."⁵⁴³ State Farm argued, relying on *St. Paul Guardian Insurance Co. v. Luker*,⁵⁴⁴ that its denial of Price's claim was in good faith because the denial was based on information available at the time of the denial. Such information included an analysis done by an engineer hired by State Farm that showed that the damages were not caused by a leak in the water lines, but by the soil being improperly prepared for the construction, by the slab being too thin, and by the seasonal changes and moisture content in the soil. The court held, however, that whether there was a

540. *Id.*

541. *Id.*, slip op. at 13.

542. 845 S.W.2d 427 (Tex. App.—Amarillo 1992, writ dismissed).

543. *Id.* at 436.

544. 801 S.W.2d 614 (Tex. App.—Texarkana 1990, no writ).

reasonable basis for the denial of the claim, was a question for the jury to resolve.⁵⁴⁵ After considering all the evidence, some of which supported the position of Price and some of which supported State Farm, the court was "unable to say that the jury's responses [were] so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust."⁵⁴⁶ The court, therefore, determined that it could not set aside the jury's verdict merely because a different conclusion could have been drawn from the evidence.⁵⁴⁷

In *State Farm Lloyds v. Mower*⁵⁴⁸ Mower's home was involved in a serious fire. Mower had homeowner's insurance with State Farm that had a face value of \$175,000 for dwelling. First Federal, the mortgagee, was a loss payee on the policy. After the fire, State Farm, based on the recommendation of an independent adjuster, set the reserve for Mower's claim at \$175,000. Soon after the fire, Mower requested bids to rebuild his home from Hudnell, the original builder, and Stewart, a contractor specializing in reconstruction of fire damaged homes. Hudnell submitted a bid of \$88,000, and Stewart bid about \$86,000 to totally reconstruct the home, but Hudnell would not guarantee the slab. Both estimates stated that the slab and garage remnants would be used in the reconstruction. Based on these bids, State Farm concluded that the loss was not total and offered to pay Mower \$90,000. Mower rejected this offer and submitted a counter-offer of \$104,000, which was the pay-off of the mortgage, which had been accelerated because Mower had stopped making mortgage payments after the fire. After Mower rejected State Farm's offer, State Farm notified First Federal that it was offering \$90,000 to pay the claim. First Federal informed Mower that it intended to exercise its rights under the deed of trust to accept State Farm's offer. Mower objected.

State Farm then filed an interpleader action to request instruction from the court as to whom it should pay. Mower sued State Farm claiming that it had breached its contract by not paying total loss benefits, and that it breached its duty of good faith and fair dealing. The trial court ordered separate trials on these issues. On the contract claim, the jury determined that the house was a total loss. At the second trial, the jury determined that State Farm breached its duty of good faith and fair dealing by not paying total loss benefits. The jury thus awarded Mower \$50,000 for mental anguish and \$5 million in punitive damages. The court of appeals reversed and remanded.⁵⁴⁹

State Farm argued that there was no evidence to support the jury's finding that it breached the duty of good faith and fair dealing. The court held there was some evidence to raise an issue of whether State Farm had a reasonable basis to deny the total loss claim, however, the court determined that the trial court committed reversible error by excluding evidence that State Farm

545. *Price*, 845 S.W.2d at 437.

546. *Id.* at 438.

547. *Id.*

548. No. 01-91-00216-CV (Tex. App.—Houston [1st Dist.], Dec. 9, 1993, n.w.h.).

549. *Id.*

had in its possession, at the time it determined the home was not a total loss, the bids from two experts that showed the home could be rebuilt for less than the policy limits, and that both the slab and the garage were usable remnants and would be used for rebuilding.⁵⁵⁰ According to the court, the plaintiff in a bad faith case must prove that the insurer had no reasonable basis for denying the claim or delaying payments, or that it failed to determine whether there was any reasonable basis for denying or delaying payment.⁵⁵¹ From this, the court determined that a plaintiff must prove that there were no facts before the insurer which, if believed, would justify the denial of the claim.⁵⁵² Thus, the court held that the evidence State Farm was prevented from offering to the jury was central to the issue of whether State Farm had a reasonable basis for denying payment for total loss under the policy.⁵⁵³ The court, therefore, reversed the judgment based on a breach of the duty of good faith and fair dealing.

ii. Courts Finding No Bad Faith

In *Dixon v. State Farm Fire & Casualty Co.*⁵⁵⁴ Dixon brought suit against State Farm to recover contractual damages and damages for breach of the common law duty of good faith and fair dealing due to the manner in which her insurance claim was resolved. Dixon filed a claim with State Farm, her insurer, after her house burned down. State Farm refused to pay the claim, contending that she had paid someone to set the fire. Dixon filed suit upon State Farm's refusal to pay her claim. State Farm moved for a partial summary judgment on the allegation of breach of the duty of good faith and fair dealing. Dixon filed no opposition to this motion. The court held that State Farm had properly met the burden of showing no genuine issue of material fact, and that it was entitled to partial summary judgment as a matter of law.⁵⁵⁵

The court held that under Texas law, insurance policies are to be liberally construed in favor of the insured.⁵⁵⁶ An insurer may violate its duty of good faith and fair dealing by failing to promptly pay a claim when its liability becomes clear. The court stated that to prevail on such a cause of action, "the insured must establish (1) the absence of a reasonable basis for denying or delaying payment of the claim and (2) that the insurer knew, or should have known, that there existed no reasonable basis for the denying or delaying payment of the claim."⁵⁵⁷ The court reasoned that in defending against an action for breach of good faith and fair dealing, the insurer "need only show that it had a reasonable basis for believing the [insured] was at

550. *Id.*, slip op. at 11.

551. *Id.*, slip op. at 10.

552. *Id.*

553. *Id.*, slip op. at 11.

554. 799 F. Supp. 691 (S.D. Tex. 1992).

555. *Id.* at 694.

556. *Id.*

557. *Id.*

fault."⁵⁵⁸ An insurer need not establish fault to a legal certainty, and need only demonstrate a reasonable basis for attributing fault to the insured.⁵⁵⁹ According to the court, State Farm's uncontroverted evidence included: recorded admissions of Dixon, detection of flammable liquids at the scene, the statement of an occupant of Dixon's house, a fire scene examination concluding that the fire was the result of an incendiary act with the burn pattern denoting deliberateness, and a committee report establishing motive and opportunity. Thus, State Farm met its burden.⁵⁶⁰

The Fifth Circuit reversed a judgment in favor of the insured based on breach of the duty of good faith and fair dealing in *Thrash v. State Farm Fire & Casualty Co.*⁵⁶¹ Thrash sued State Farm for, *inter alia*, breach of the duty of good faith and fair dealing as a result of State Farm's refusal to pay for the loss to his home caused by fire. State Farm denied the claim, accusing Thrash of arson. The jury found that Thrash did not commit arson and State Farm breached its duty of good faith and fair dealing. Focusing only on the evidence State Farm offered to support its denial of the claim, the court concluded that "no reasonable juror could have concluded that State Farm lacked a reasonable basis for believing that Thrash was responsible for the fire. . . ."⁵⁶²

2. Comparative Bad Faith

Many attorneys representing insurance companies have begun to advance the argument that the insured owes a duty of good faith and fair dealing to the insurer in an effort to submit comparative fault in a bad faith case. While no reported case has accepted such a notion, a couple of the justices on the San Antonio court have indicated their willingness to adopt this principle.⁵⁶³ In *Texas Farmers Insurance Co. v. Soriano*,⁵⁶⁴ Soriano, while driving under the influence of alcohol, attempted to pass a truck and collided head-on with a vehicle driven by Medina. Soriano's friend, Lopez, was in the car with him and was fatally injured as a result of the collision. In the car with Mr. Medina were his wife and two children. The collision killed Mrs. Medina, seriously injured Mr. Medina, and injured the two children.

Soriano was insured under his parent's policy with Farmers, which provided only the minimum coverage of \$10,000 per person with the aggregate not to exceed \$20,000. Farmers initially attempted to settle the entire case directly with the Medinas by tendering the policy limits of \$20,000. The Medinas refused this offer and hired an attorney to discover whether or not Soriano possessed any personal assets. Eventually the parents of Lopez also

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

559. *Id.*

560. *Id.* at 695.

561. 992 F.2d 1354 (5th Cir. 1993).

562. *Id.* at 1358.

563. *Texas Farmers Ins. Co. v. Soriano*, 844 S.W.2d 808 (Tex. App.—San Antonio 1992, writ granted). (Decision en banc. Opinion by Justice Chapa; concurring opinions by Chief Justice Reeves and Justice Biery; dissenting opinions by Justice Peeples and Justice Butts.)

564. *Id.*

hired an attorney and filed suit. Farmers hired Fred Auforth to defend Soriano in both lawsuits, which were consolidated for trial. Before trial, Farmers settled the Lopez claim for \$5,000 and offered the remaining \$15,000 of insurance to the Medinas. The Medinas refused the offer and demanded the full original policy limits of \$20,000. The case went to trial and the Medinas recovered a judgment of \$172,187 plus interest against Soriano. Soriano then assigned whatever rights he had against Farmers in exchange for a covenant not to execute. Suit was then filed in Soriano's name against Farmers, wherein various causes of action were alleged, including negligence, gross negligence, and breach of the duty of good faith and fair dealing. Farmers sought contribution or indemnity from the law firm of Auforth, Keas & O'Reilly, which had represented Soriano in the underlying lawsuits. The jury found that Farmers was negligent and grossly negligent in handling the Medina claims, and that it had breached its duty of good faith and fair dealing to Soriano. Based on the jury verdict, the trial court rendered judgment against Farmers for \$520,577.24 in actual damages and prejudgment interest, plus \$5 million in exemplary damages. The trial court also ordered a take-nothing judgment on Farmers' third-party action against Auforth, Keas & O'Reilly. The court of appeals conditionally affirmed as reformed on a condition of remittitur of exemplary damages.⁵⁶⁵

Farmers first argued that, in this multiple-claimant case, it could not be liable in negligence or for the breach of the duty of good faith and fair dealing because Soriano did not obtain a finding that the Lopez settlement, when viewed by itself, was negligent or in bad faith. The court rejected this piecemeal approach, and held that in determining whether an insurer has breached the duty of good faith and fair dealing, the factfinder should consider the totality of the circumstances surrounding the occurrence.⁵⁶⁶ This would necessarily include the relationship between the insured and the insurer and all claims arising from the incident.⁵⁶⁷ The court held that in multiple claims cases, if the factfinder considers whether the settlement of one claim was reasonable, viewed by itself and without regard to the other unsettled claims, this would relieve the insurer of any responsibility to protect the insured as long as it could be said that the payment of one of the claims was reasonable.⁵⁶⁸ Therefore, the reasonableness of the insurer's handling of the claim must be evaluated in light of all claims arising out of the incident.⁵⁶⁹

Justice Biery agreed with the majority that a fact finder should consider all the relevant factors and relationships in deciding whether the duty of good faith and fair dealing had been breached.⁵⁷⁰ Justice Biery noted that comparative bad faith is but the logical extension of this notion.⁵⁷¹

565. *Id.* at 831.

566. *Id.* at 817.

567. *Id.*

568. *Id.* at 816.

569. *Id.*

570. *Id.* at 832 (Biery, J., concurring).

571. *Soriano*, 844 S.W.2d at 832 n.2 (Biery, J., concurring).

Justice Peeples dissented, stating that each claim should be viewed independently from any other claims arising out of the incident.⁵⁷² Thus, since it could not be said that Farmers was unreasonable in paying \$5,000 on the Lopez claim, when viewed by itself, Justice Peeples thought that Farmers did not act in bad faith when it offered the remaining \$15,000 under the policy to Medina.⁵⁷³ Thus, Justice Peeples would hold that an insurer could settle with some claimants in good faith even though the settlement may exhaust the insurance fund, or deplete it so that a subsequent judgment creditor would be unable to collect his judgment in full from the remaining insurance coverage.⁵⁷⁴

Justice Butts also dissented and suggested that the duty of good faith and fair dealing be applied to both the insurer and insured.⁵⁷⁵ According to Justice Butts, the evidence in this case of the insured's lack of good faith was that he was solely responsible for the accident causing the deaths and injuries and had only minimum insurance coverage.⁵⁷⁶

The suggestion by Justices Biery and Butts, which Justice Chapa seemed to agree with, that the duty of good faith and fair dealing is a "two-way street" and should extend to the insured as well as the insurer misapprehends the basis of the duty in Texas. Justices Biery and Butts cite with approval an article by James Walker⁵⁷⁷ that it is based almost solely on California law, which is very different from Texas law.

In *Comunale v. Traders & General Insurance Co.*,⁵⁷⁸ the court noted that under California law, there is "an implied *covenant* of good faith and fair dealing in every contract that *neither* party will do anything which will injure the rights of the other to receive the benefits of the agreement."⁵⁷⁹ The court extended this general rule to contracts of insurance and held that there is an implied obligation of good faith and fair dealing on the part of the insurer to settle claims in a reasonable manner.⁵⁸⁰

Texas law, however, does not recognize a two-way implied covenant of good faith and fair dealing in every contract. In fact, in *English v. Fischer*, the court expressly refused to adopt this "novel theory of law enunciated only by California courts."⁵⁸¹ Justice Spears' concurrence in *English v. Fischer* agreed there was no implied, two-way covenant, but noted that Texas law does recognize a duty of good faith and fair dealing in certain special relationships, including insurance.⁵⁸²

Approximately three years after deciding *English v. Fischer*, the court held

572. *Id.* at 839 (Peeples, J., dissenting).

573. *Id.* at 844 (Peeples, J., dissenting).

574. *Id.* at 843 (Peeples, J., dissenting).

575. *Id.* (Butts, J., dissenting).

576. *Id.* at 821 (Butts, J., dissenting).

577. James W. Walker, *Comparative Bad Faith—Its Time Has Come in Texas*, 55 TEX. B.J. 792 (1992).

578. 50 Cal.2d 654, 328 P.2d 198-200 (1958).

579. *Id.* at 198-200 (emphasis added).

580. *Id.* at 201.

581. 660 S.W.2d 521, 522 (Tex. 1983).

582. *Id.* at 524.

that an insurer owes a common law *duty* of good faith and fair dealing to its insured.⁵⁸³ In so doing, the court once again stated that it was refusing to impose an implied *covenant* of good faith and fair dealing.⁵⁸⁴ Instead, the court explained that because of the special relationship between the insurer and insured, the *insurer* owed the insured a *duty* of good faith and fair dealing.⁵⁸⁵ The court further explained that a special relationship exists because the parties have unequal bargaining power and the insurer has exclusive control over the evaluation, processing, and denial of claims.⁵⁸⁶ Without such a duty, the insurer would be able to "arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed."⁵⁸⁷

Thus, it is clear that under Texas law the duty is imposed only on the insurer because of the insurer's superior bargaining power and exclusive control over the handling and paying of the claim. Since the insured, by definition, has inferior bargaining power and lacks control over the decision to pay claims, he owes no duty of good faith to the insurer.

Moreover, the refusal to adopt a doctrine of comparative bad faith will not prevent an insurer from offering evidence that its denial or delay in payment was reasonable because of some conduct of the insured, such as the failure to cooperate or submit the necessary information to process the claim. But how could the fact that the insured caused an accident (for which insurance was purchased) or that not enough insurance was obtained serve as an excuse for the insurer's unreasonable denial or delay. Yet this is exactly what the dissenters find Mr. Soriano guilty of.

C. RELATIONSHIP OF COVERAGE TO BREACH OF DUTY

Because the duty of good faith and fair dealing is imposed as a result of a special relationship between the insurer and the insured and does not emanate from the terms of the insurance contract, a breach of this duty gives rise to an action in tort that is separate from a breach of contract action.⁵⁸⁸ Thus, it is possible for an insurer to breach its duty of good faith and fair dealing even though there is no coverage under the policy.⁵⁸⁹ However, in most cases, an insurer will be able to show that it had a reasonable basis for denying the claim if there is no coverage under the policy, as is seen by the following cases.

As seen above, the court in *Charter Roofing Co. v. Tri-State Insurance Co.*⁵⁹⁰ affirmed a summary judgment in favor of the insurer holding that a general liability insurer does not owe a duty of good faith and fair dealing to its policyholder.⁵⁹¹ The court also concluded that even if Tri-State did owe

583. Arnold, 725 S.W.2d at 167.

584. *Id.*

585. *Id.*

586. *Id.*

587. *Id.*

588. Viles v. Security Nat'l Ins. Co., 788 S.W.2d 566, 567 (Tex. 1990).

589. First Texas Sav. Ass'n v. Reliance Ins. Co., 950 F.2d 1171, 1179 (5th Cir. 1992).

590. 841 S.W.2d 903 (Tex. App.—Houston [14th Dist.] 1992, writ denied).

591. *Id.* at 904.

Charter a duty of good faith and fair dealing, the summary judgment evidence established, as a matter of law, that Tri-State conducted a reasonable investigation and had a reasonable basis for denying the claim.⁵⁹² The evidence showed that the claims adjuster spoke with a representative of Charter and with the subcontractor as well as investigating the scene. The adjuster found that the work was not supervised by Charter and recommended that the claim be denied because the policy excluded coverage for damage not caused by property in the care, custody, and control of Charter. Charter's controverting evidence was an affidavit by its president stating that Tri-State unfairly failed and refused to pay the claim; failed to investigate the claim; and did not attempt, in good faith, to settle the claim. The court held that these statements were opinions and conclusions and were therefore incompetent summary judgment proof.⁵⁹³ Because the court felt that Charter did not raise a fact issue as to Tri-State's lack of good faith, it held that the summary judgment was proper.⁵⁹⁴

In *Martinka v. Commonwealth Land Title Insurance Co.*⁵⁹⁵ the court found that a title insurer did not breach its duty of good faith and fair dealing.⁵⁹⁶ Martinka purchased title insurance from Commonwealth at the time he purchased a condominium from Minns. Several years later when attempting to refinance his mortgage, Martinka discovered that Piotrowski, in seeking a divorce from Minns, had filed a *lis pendens* on the property on the day Martinka purchased the property. Martinka requested that Commonwealth defend his title. Martinka then intervened in the divorce proceeding, naming Commonwealth as another defendant. The divorce action, however, had been previously abated. Two years later the abatement was lifted and within a few months Commonwealth obtained a summary judgment denying Piotrowski her claim to the property. Martinka's claims against Commonwealth were then transferred out of the divorce proceeding and a summary judgment rendered in favor of Commonwealth.

On appeal, Martinka argued that trial court erred in granting the summary judgment on his claim for breach of the duty of good faith and fair dealing. Martinka had alleged that Commonwealth unreasonably delayed in responding to his request to either defend his title or pay under the policy, preventing him from refinancing and eventually losing the property. The court of appeals held that Martinka's allegations did not support a bad faith claim.⁵⁹⁷ According to the court, Martinka had to show that Commonwealth had no reasonable basis for denying or delaying payment of a claim.⁵⁹⁸ Commonwealth, however, was never obligated to pay under the

592. *Id.* at 906. This may explain the reason for the supreme court denying Charter Roofing's application for writ of error since the court of appeals was clearly wrong in holding that a general liability insurer does not owe its policyholder a duty of good faith and fair dealing. *See infra* at 322.

593. *Id.*

594. *Id.*

595. 836 S.W.2d 773 (Tex. App.—Houston [1st Dist.] 1992, writ denied).

596. *Id.* at 776.

597. *Id.*

598. *Id.*

title policy because it had successfully defended Martinka's title.⁵⁹⁹

In *Redwine v. AAA Life Insurance Co.*⁶⁰⁰ Redwine's mother bought her a travel accident insurance policy from AAA based on the representation by an AAA employee that the policy would cover any injuries sustained in a serious travel accident. After Redwine suffered a spinal cord injury and incomplete paralysis of her lower limbs in a car accident a claim was submitted to AAA. AAA, however, denied the claim because the policy provided coverage only in the event of death, loss of limb, or loss of sight. Redwine contended that "loss of limb", a term not defined in the advertisement sent to her mother, included loss of use. AAA showed, however, that the certificate of insurance defined "loss of limb" as "severance at or above the wrist or ankle joint."

The trial court, at the close of Redwine's case, granted a directed verdict that there was no coverage under the policy and that AAA did not breach its duty of good faith and fair dealing. In its charge to the jury on the remaining causes of action, the trial court instructed the jury that AAA did not breach its duty of good faith and fair dealing and that there was no coverage. The jury resolved all remaining issues in AAA's favor.

Redwine appealed, arguing that the trial court's instructions amounted to a comment on the weight of the evidence. The court of appeals agreed finding that the jury did not need to be instructed on these matters decided as a matter of law because the instructions did not clarify any of the remaining issues.⁶⁰¹ According to the court, the instructions served only to suggest to the jurors that the trial court viewed AAA's case favorably and that they should resolve the remaining causes of action in AAA's favor as well.⁶⁰² Thus, while affirming the directed verdict, the court reversed and remanded for new trial the remaining causes of action.⁶⁰³

In *Bartlett v. American Republic Insurance Co.*⁶⁰⁴ the insurer denied a claim for benefits relating to a radical mastectomy and radiation and chemotherapy treatment received by Carolyn Bartlett. Additionally, American Republic rescinded the policy which covered the entire Bartlett family. The denial of the claim was based on the pre-existing nature of Carolyn's illness, while the policy was rescinded because of alleged misrepresentations on the policy application. The Bartletts filed suit against American Republic for breach of contract, a 12% penalty under article 3.62 of the Insurance Code, breach of the duty of good faith and fair dealing, and violations of the DTPA and article 21.21. The trial court granted American Republic's motion for summary judgment and rendered a take-nothing judgment against the Bartletts.

The Bartletts argued that the summary judgment on their breach of the duty of good faith and fair dealing claim was improper. The court, having

599. *Id.*

600. 852 S.W.2d 10 (Tex. App.—Dallas 1993, no writ).

601. *Id.* at 16.

602. *Id.*

603. *Id.* at 17.

604. 845 S.W.2d 342 (Tex. App.—Dallas 1992, no writ).

found that Carolyn's condition fell within the policy's exclusion from coverage of preexisting conditions, held that American Republic established a valid basis for denying the Bartletts' claim.⁶⁰⁵ Thus, American Republic negated an element of the Bartletts' claim for breach of the duty of good faith and fair dealing based on its denial of the claim, making the summary judgment proper in this case.⁶⁰⁶

The Bartletts next argued that since American Republic's motion addressed only their cause of action for refusal to pay a claim and did not address their claim for wrongful rescission of the policy, the trial court should not have granted a summary judgment on all of their claims. The Bartletts argued that regardless of whether American Republic had an obligation to pay the claim submitted, a question remained concerning American Republic's authority to cancel the policy and refuse coverage for any other ailment. The court of appeals agreed, and remanded to the trial court the Bartletts' claims for wrongful rescission.⁶⁰⁷

In *McCracken v. United States Fire Insurance Co.*⁶⁰⁸ the court held that an insurer does not breach its duty of good faith and fair dealing where both insured and insurer present reasonable interpretations of a policy term and the insurer seeks a declaratory judgment prior to denying coverage.⁶⁰⁹ While driving his stepfather's power boat, McCracken was involved in an accident in which he ran over and killed his friend, Doug Swafford, who had been water skiing behind the boat. Williams, the stepfather, had watercraft insurance through State Farm and an umbrella policy through United States Fire. The umbrella policy provided coverage for watercraft liability in excess of the \$100,000 limit of Williams' underlying State Farm insurance policy. The United States Fire policy in question defined "insured" as, ". . . (c) any other person under the age of 21 in the care of any insured. . . ."⁶¹⁰ In contrast, the State Farm policy defined "insured" as "any person using the power boat with Williams' permission."⁶¹¹

Following the accident, the Swafford family filed a wrongful death and survival statute lawsuit against McCracken and Williams. However, United States Fire notified McCracken that he was not covered under Williams' umbrella policy because he did not fit the policy's definition of an "insured." United States Fire then filed a declaratory judgment action concerning coverage under the policy. After a trial on the merits, the court found (1) the umbrella policy's definition of "insured" to be ambiguous; and (2) McCracken was an "insured" under the policy because such ambiguities must be resolved in favor of recovery for the insured. The Swafford's eventually agreed to a \$550,000 settlement, \$350,000 of which was paid by United States Fire.

605. *Id.* at 348.

606. *Id.* at 348-49.

607. *Id.* at 349.

608. 802 F. Supp. 30 (W.D. Tex. 1992).

609. *Id.* at 37.

610. *Id.* at 33.

611. *Id.*

McCracken then filed this lawsuit against U.S. Fire for violations of the Insurance Code and DTPA, and breach of the duty of good faith and fair dealing. McCracken sought to recover past and pending attorney's fees as well as damages for emotional distress. United States Fire moved for summary judgment on McCracken's claims of misrepresentation, failure to defend, and breach of the duty of good faith and fair dealing. The court granted this motion.⁶¹² The court, when considering McCracken's cause of action for the breach of the duty of good faith and fair dealing stated that to prevail on such a claim, the plaintiff must show: "(1) the absence of a reasonable basis for denying or delaying the payment of policy benefits and (2) that the insurer knew or should have known that there was no reasonable basis for denying the claim or delaying payment."⁶¹³

The court determined that no reasonable juror would conclude that U.S. Fire breached this duty because coverage of a stepchild had not been considered by a Texas court and that the court, in the initial lawsuit, determined that both parties presented reasonable interpretations of the definition of "insured."⁶¹⁴ Moreover, United States Fire brought a declaratory judgment action to confirm its position before denying coverage.

The court wrongly concluded that United States Fire did not breach its duty of good faith and fair dealing. The reason why coverage was determined to exist in the first declaratory judgment action was because when an insurance policy is ambiguous, that is, it is susceptible to more than one reasonable interpretation, the court *must* construe the policy in favor of the insured.⁶¹⁵ This rule of contract construction has long been utilized by Texas courts in construing insurance policies.⁶¹⁶ Thus, insurers know, or should know, of this legal principle favoring coverage. Accordingly, it is difficult to conclude that, as a matter of law, an insurer acted reasonably and in good faith by insisting on a contract interpretation denying coverage when the insured has offered a reasonable interpretation providing coverage. This fact issue should be left for a jury to resolve.⁶¹⁷

D. LIMITATIONS

In *Davis v. Aetna Casualty & Surety Co.*⁶¹⁸ Davis suffered an injury on September 18, 1984, while working for Allright Parking. He filed a claim with Aetna for benefits and medical expenses under the Worker's Compensation Act. On January 7, 1986, Aetna denied Davis' claim. On September 28, 1987, the Industrial Accident Board awarded Davis benefits under the

612. *Id.* at 39.

613. *Id.* at 36, (citing *Automobile Ins. Co. v. Davila*, 805 S.W.2d 897, 904 (Tex. App.—Corpus Christi 1991, writ denied)).

614. *Id.* at 37.

615. See *State Farm Fire & Cas. Co. v. Reed*, 36 Tex. Sup. Ct. J. 1315 (Sept. 29, 1993); *National Union Fire Ins. Co. v. Hudson Energy Co.*, 811 S.W.2d 552, 555 (Tex. 1991).

616. See *Brown v. Palatine*, 89 Tex. 590, 25 S.W. 1060, 1060 (1896).

617. See Philip K. Maxwell, *The "Bona Fide Dispute" Defense in Bad Faith Litigation: Second Guessing the Jury*, 11 Texas Consumer Law Reporter 123.

618. 843 S.W.2d 777 (Tex. App.—Texarkana 1992, no writ).

Act. Aetna appealed. In a deposition taken during preparation for the trial of the worker's compensation appeal, Dr. Criswell testified that Davis' injury had aggravated a preexisting condition and had left him totally and permanently disabled. The case subsequently went to trial, and the jury found for Davis. On March 9, 1990, Davis filed this breach of the duty of good faith and fair dealing suit against Aetna. The trial court granted a summary judgment in favor of Aetna finding that his suit was barred by the statute of limitations. The court of appeals affirmed.⁶¹⁹

The court noted that a suit for breach of the duty of good faith and fair dealing must be filed within two years after the insurer denies coverage.⁶²⁰ Aetna denied coverage on January 7, 1986, but the suit was not filed until March 9, 1990. Davis argued, however, that the discovery rule should be applied. The court disagreed holding that application of the discovery rule is limited to those cases where there has been no outright denial of a claim.⁶²¹ In such a case, the cause of action accrues when the plaintiff has sufficient facts to put a reasonable person on notice that the claim was being denied.⁶²²

Davis then argued that Aetna committed a new breach of the duty of good faith and fair dealing when it failed to honor his claim after it learned of Dr. Criswell's diagnosis as stated in his deposition. The court disagreed holding that the injury-producing event was the denial of coverage.⁶²³ While acts of bad faith committed after the denial of the claim may be evidence supporting the cause of action, the court held that they were not the cause of action itself and that this tort was not a continuing one.⁶²⁴ The court further held that limitations are not tolled by additional wrongful acts or damages occurring after the denial of the claim.⁶²⁵

E. DAMAGES

In *Davis v. Twin City Fire Insurance Co.*⁶²⁶ Davis injured her lower back in the course and scope of her employment. She filed a workers' compensation claim against Twin City, her employer's workers' compensation carrier. The parties eventually entered into a compromise settlement agreement under which Twin City agreed to pay Davis a lump-sum of \$37,500 in addition to five years future medical expenses with Dr. Key. Prior to signing the settlement agreement, Dr. Key had prescribed for Davis a hot tub or jacuzzi for a large body for life. This prescription was sent to Twin City, who then requested that Dr. Key provide a letter of medical necessity. Davis provided Dr. Key's letter and four estimates for hot tubs. Twin City forwarded Dr. Key's letter to Texas Medical Foundation (TMF), which Twin City had retained to do medical consultations. TMF completed its review and sup-

619. *Id.* at 777.

620. *Id.* at 778.

621. *Id.*

622. *Id.*

623. *Id.*

624. *Id.*

625. *Id.*

626. 865 S.W.2d 231 (Tex. App.—Texarkana 1993, writ requested).

ported the use of the hot tub for Davis' condition. Twin City, however, denied the claim for the hot tub.

Davis then filed suit against Twin City alleging fraud, breach of contract, breach of the duty of good faith and fair dealing, and violations of the Insurance Code and DTPA. The jury found that Twin City breached its duty of good faith and fair dealing, engaged in unfair or deceptive acts or practices, and acted with conscious indifference to Davis. The jury did not award any damages for mental anguish, but assessed \$100,000 in exemplary damages against Twin City. The trial court granted Twin City's motion to disregard jury findings, and did not award exemplary damages in the judgment. Instead, the court rendered judgment for Davis for \$3,500 (the cost of the hot tub) plus attorney's fees.

Twin City argued that trial court was correct in denying recovery of exemplary damages as a result of the breach of the duty of good faith and fair dealing because the \$3,500 actual damages could have been awarded under Davis' breach of contract action. The court, however, followed *Vail v. Texas Farm Bureau Mutual Insurance Co.*⁶²⁷ and held that, as a matter of law, the damages for breach of the duty of good faith and fair dealing are the amount of the benefits wrongly withheld.⁶²⁸ Therefore, Twin City's tortious conduct caused Davis actual damages, as a matter of law, and exemplary damages were available.⁶²⁹ Furthermore, the court held that when the prevailing party fails to elect between alternative measures of damages, the court should utilize the findings affording the greatest amount of recovery and render judgment accordingly.⁶³⁰ In this case, Davis could recover greater damages under the tort action than under the contract action because of the availability of exemplary damages. Therefore, according to the court of appeals, the trial court should have rendered judgment for the exemplary damages.⁶³¹

Twin City also argued that the trial court should have been deemed to have found that Twin City's tortious conduct did not proximately cause Davis to incur actual damages. However, because the damages for a breach of the duty of good faith and fair dealing are, as a matter of law, the amount of the benefits withheld, the court held that no finding of proximate cause was necessary and none should have been deemed.⁶³² Furthermore, proximate cause becomes an issue in suits alleging bad faith only when the plaintiff seeks actual damages beyond the amount of the benefits wrongly withheld.⁶³³ Twin City further contended that an award of exemplary damages would be improper because the jury did not award any damages for mental anguish. The court held that a finding of conscious indifference to the rights

627. 754 S.W.2d 129, 136 (Tex. 1988).

628. *Davis*, 865 S.W.2d at 236.

629. *Id.*

630. *Id.*

631. *Id.*

632. *Id.*

633. *Id.* at 236-37. See also 4 STATE BAR OF TEXAS, TEXAS PATTERN JURY CHARGE PJC 110.18 (1990).

of others supports an award of exemplary damages even in the absence of any damages for mental anguish.⁶³⁴

Next, Twin City asserted that the exemplary damages awarded by the jury were excessive because they were more than twenty-eight times the actual damages. After considering the nature of the wrong, the character of the of the conduct involved, the degree of culpability of the wrongdoer, the situation and sensibilities of the parties, and the extent to which such conduct offended a public sense of justice and propriety, the court concluded that there was ample evidence to support the award of exemplary damages found by the jury.⁶³⁵ In this case, Twin City wrongly denied Davis a piece of medical equipment that an orthopedist concluded would help treat her back pain. Moreover, Twin City misplaced a vital review of Davis' file and admittedly lied to Davis in denying the claim. The court also felt that the exemplary damages were necessary to deter Twin City from treating other injured workers in a similar way.

Davis next argued that she should have been awarded prejudgment interest as requested in her pleadings. The court agreed and held that the trial court should have awarded Davis prejudgment interest on her actual damages of \$3,500 calculated at 10% per annum, accruing from the day Twin City refused to pay her claim.⁶³⁶

F. SEVERANCE

Counsel for insurers are more frequently attempting to sever the breach of contract action from the so-called extra-contractual claims, such a breach of the duty of good faith and fair dealing and violations of article 21.21 of the Insurance Code and the DTPA. Both Houston courts of appeals have held that a trial court's failure to sever the underlying contract claim from a bad faith claim based on the insurer's denial of coverage amounts to an abuse of discretion.⁶³⁷ In both cases, the courts held that severance was necessary because of the prejudice to the insurers' interests that would result by trying the contract claim, wherein settlement negotiations are not admissible, with the bad faith claim in which settlement negotiations can be raised by the insurer to show that it acted in good faith.⁶³⁸ The court in *Millard* further held that severance was appropriate because the bad faith, Insurance Code, and DTPA claims were dependent on the outcome of the contract claim.⁶³⁹ Thus, according to the court, if the plaintiff does not prevail on the contract claim, there will be no need to try the other claims.⁶⁴⁰

634. *Davis*, 865 S.W.2d at 236. See also *Trenholm v. Radcliff*, 646 S.W.2d 927, 933 (Tex. 1983).

635. *Davis*, 865 S.W.2d at 237.

636. *Id.* at 239.

637. See *State Farm Mut. Auto. Ins. Co. v Wilborn*, 835 S.W.2d 260, 261 (Tex. App.—Houston [14th Dist.] 1992, original proceeding) [leave denied] and *United States Fire Ins. Co. v. Millard*, 847 S.W.2d 668, 672-73 (Tex. App.—Houston [1st Dist.] 1993, original proceeding) [leave denied].

638. See *Wilborn*, 835 S.W.2d at 261; *Millard*, 847 S.W.2d at 672-73.

639. *Millard*, 847 S.W.2d at 672.

640. *Id.*

The El Paso and Corpus Christi courts, while agreeing that severance is sometimes warranted, have disagreed with the Houston courts' view that severance of the contract and bad faith claims is mandatory.⁶⁴¹ In *Progressive County Mutual Insurance Co. v. Parks*⁶⁴² Progressive County Mutual asked the court of appeals to order Judge Parks to sever a breach of the contract action from the causes of action for breach of the duty of good faith and fair dealing, violations of the insurance code, and violations of the DTPA. Progressive, relying on *Wilborn* and *Millard*, argued that the severance was mandatory and that the trial court abused its discretion by refusing to sever the causes of action. The court held that severance of the breach of contract claim is not mandatory when joined with a bad faith claim.⁶⁴³ Instead, the court considered the specifics of the lawsuit to determine whether any prejudice could result from evidence of settlement offers. The court held that the need for severance had not been established as there was no indication of any offers of settlement being made or any attempt to discover privileged materials that might be admissible on one claim but not on the other.⁶⁴⁴

After the court denied the petition for writ of mandamus, Progressive County Mutual filed another motion for severance in the trial court. The trial court granted the motion, but ordered, to the insurer's displeasure, that the bad faith claim be tried before the contract claim. Progressive County Mutual then filed another petition for writ of mandamus. This time it asked the court of appeals to order the trial court to try the contract claim first. Again, the court refused to grant the relief requested.⁶⁴⁵ The court held that it was not within its power to set the trial court's docket and that Progressive County Mutual failed in its burden of showing that facts and law permit a trial court to make but one decision of the proper scheduling of civil cases.⁶⁴⁶ Consequently, the court held that the trial court did not abuse its discretion ordering the bad faith claim tried first.⁶⁴⁷

Justice Koehler dissented, arguing that the trial court did abuse its discretion in ordering the extra-contractual claims tried prior to the contractual claim.⁶⁴⁸ According to Justice Koehler, the extracontractual claims depend on the result reached in the contractual cause of action.⁶⁴⁹ Justice Koehler also wrote that because of this interdependency, a nonsuit of the contractual claim would also result in a nonsuit of the noncontractual claims.⁶⁵⁰ The majority, however, rejected such a view, finding no authority for the automatic nonsuit of extracontractual claims because of the nonsuit of a contrac-

641. See *infra* note 632.

642. 856 S.W.2d 776 (Tex. App.—El Paso 1993, orig. proceeding, no writ).

643. *Id.* at 779.

644. *Id.*

645. *Progressive County Mut. Ins. Co. v. Parks*, 856 S.W.2d 780, 781 (Tex. App.—El Paso 1993, orig. proceeding).

646. *Id.* at 782.

647. *Id.*

648. *Id.*

649. *Id.*

650. *Parks*, 856 S.W.2d at 782.

tual claim.⁶⁵¹

The Corpus Christi court also has determined that there is no presumption that the mere joining of contract and bad faith claims creates a conflict requiring severance. In *Allstate Insurance Co. v. Hunter*⁶⁵² Allstate argued that severance of the contract claim from the tort claims is required because of the problems inherent in a joint trial with regard to evidence of settlement negotiations and of privileged matters such as advice of counsel regarding coverage. The court of appeals held that Allstate did not show that the trial court abused its discretion by refusing to sever and thus denied the petition for writ of mandamus.⁶⁵³

The court began its discussion by noting that the trial court has broad discretion in determining whether or not to sever causes of action. The court held that a trial court has a duty to order severance when all of the facts and circumstances indicate that the legal rights of the parties will be prejudiced and an injustice will result if the severance is not ordered.⁶⁵⁴ The court then noted that the Houston courts in *Wilborn* and *Millard* held that a trial court's failure to sever the underlying contract claim from a bad faith claim amounts to an abuse of discretion.⁶⁵⁵ The court, however, disagreed with the Houston courts and held that there is no general prohibition against trying contract and bad faith claims together, nor is severance of such claims always required.⁶⁵⁶ The court also noted that it is not necessarily true that the bad faith, Insurance Code, and DTPA claims are contingent on the outcome of the underlying contract claim.⁶⁵⁷

Moreover, even if the bad faith claims were derivative or contingent on the contract claim, the court found that there was no general prohibition against trying the two claims together.⁶⁵⁸ The court held that it is not the law in Texas that a contingent or dependent claim may never be joined and tried together with the underlying claim because of the possibility that the underlying claim may fail.⁶⁵⁹ To the contrary, the court recognized that it may be judicially efficient to try both cases together because if the claimant recovers on the underlying claim, the contingent claim would become viable and there would be no need for a second trial.⁶⁶⁰

The court next turned to whether the existence of settlement offers and privileged matters concerning claims and coverage determinations would be prejudicial and inadmissible with regard to the contract claim, thus requir-

651. *Id.* at 782 n.1.

652. 865 S.W.2d 189 (Tex. App.—Corpus Christi 1993, orig. proceeding).

653. *Id.* at 194.

654. *Id.* at 192.

655. *Id.*

656. *Id.* at 193. See *Arnold v. Nat'l County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 168 n.1 (Tex. 1987) (recognizing that a contract claim and a claim for breach of the duty of good faith and fair dealing may, in some cases, be tried together).

657. *Hunter*, 865 S.W.2d at 193. See *Viles v. Security Nat'l Ins. Co.*, 788 S.W.2d 566 (Tex. 1990).

658. *Hunter*, 865 S.W.2d at 193.

659. *Id.*

660. *Id.*

ing severance. The court first noted that the problem presented by a joint trial of the contract and bad faith claims did not involve a conflict between the interest of the plaintiff to present evidence of settlement offers or privileged materials and that of the defendant to exclude them. Instead, the court found the real problem to be the internal conflict that may unfairly force the insurer to choose between insisting on its right to exclude evidence of settlement negotiations and coverage determinations, thereby losing the advantage of showing that it was attempting to be reasonable in defense of the bad faith claims, and putting on such evidence thus risking a prejudicial inference that it had admitted liability on the contract action.⁶⁶¹

The court, agreeing with *Progressive County Mutual Insurance Co. v. Parks*,⁶⁶² held that before a severance is required, the insurer must present evidence to the trial court showing that such a conflict would necessarily develop at trial.⁶⁶³ Allstate, however, failed to allege any specific settlement negotiations or offers and further failed to present what specific advice it had received from its attorney or how such advice might be both prejudicial to its defense against the contract claim and beneficial to its defense against the bad faith claims. The court could find, at the most, generalized allegations of prejudice, and thus held that Allstate failed to carry its burden of proof.⁶⁶⁴

In *F.A. Richard & Associates v. Millard*⁶⁶⁵ the court was faced with a different issue relating to severance. Holton and Gallery had a car accident. Holton sued Gallery for his alleged negligence. Holton also sued Highlands Insurance Company, Gallery's insurer, and Richard, an independent adjuster hired by Highlands, for violations of the DTPA and article 21.21. After the trial court refused to sever and abate the action against Highlands and Richard, Richard brought this mandamus proceeding asking the court of appeals to order the trial court to vacate its order denying the motion for severance and plea in abatement.

The court of appeals held that trial courts are given broad discretion to sever and their decisions will be reversed only when there is an abuse of discretion.⁶⁶⁶ The court, however, held that the trial court did not have discretion, in this case, to deny severance and abatement because a simultaneous trial of Holton's claim against Gallery, Highlands, and Richard would unduly prejudice all parties' rights to develop their claims and defenses and would force Richard to defend against Holton's suit prematurely.⁶⁶⁷

According to the court, a simultaneous trial of the negligence and bad faith claims would require evidence of insurance, thus prejudicing Gallery's defense and violating his right to have his liability decided without any men-

661. *Id.*

662. 856 S.W.2d 780 (Tex. App.—El Paso 1993, original proceeding).

663. *Hunter*, 865 S.W.2d at 194.

664. *Id.*

665. 856 S.W.2d 765 (Tex. App.—Houston [1st Dist.] 1993, orig. proceeding).

666. *Id.* at 767.

667. *Id.*

tion of insurance.⁶⁶⁸ The court also decided that Gallery would be prejudiced by the mention of settlement offers.⁶⁶⁹ The court further concluded that to exclude evidence of insurance and settlement negotiations would prejudice Holton's right to develop her bad faith claims against Richard and Highlands.⁶⁷⁰ Additionally, the court concluded that Richard would be forced to prematurely defend because, if in Holton's negligence lawsuit Gallery were found to be liable for damages in an amount equal to or less than Richard's highest offer, Holton's bad faith claims against Richard would be rendered moot.⁶⁷¹ Lastly, the court concluded that the trial court abused its discretion by refusing to abate the causes of action under the Insurance Code and the DTPA until the negligence claim was resolved because an abatement is necessary to avoid the parties unnecessarily expending effort and funds conducting discovery and preparing for trial claims that may be disposed of in a negligence case.⁶⁷²

The court's decision to sever the negligence and bad faith claims was correct and answers the outcries of the insurance industry made in connection with *Watson v. Allstate Insurance Co.*⁶⁷³ In *Watson*, the court permitted an injured person to bring suit against both the tortfeasor and his insurer. Allstate complained that this results in an impermissible joinder of a liability carrier to a tort action. The answer, of course, is to sever the action against the liability carrier.

The court, however, was not necessarily correct that the bad faith claims are rendered moot if the jury, in the negligence lawsuit, finds the damages to be equal to or less than the insurer's highest offer. An insurer has a duty under article 21.21 to settle a claim when liability becomes reasonably clear. Thus, if the offer to settle is unreasonably delayed, the insurer can be liable regardless of the amount of the offer.

Moreover, the action against the insurer would not necessarily have to be abated until the negligence action is decided. Because an insurer must pay a claim once liability becomes reasonably, not absolutely, clear, a judicial determination of the tortfeasor's negligence should not be required before the injured person can pursue an action against the liability insurer. A jury can decide when liability became reasonably clear without waiting for a final judgment against the tortfeasor.

G. WORKERS' COMPENSATION

In *Haines v. National Union Fire Insurance Co.*⁶⁷⁴ Haines sought a remand to state court after National Union removed based on diversity jurisdiction, arguing that her claim for breach of the duty of good faith and fair

668. *Id.*

669. *Id.*

670. *Millard*, 856 S.W.2d at 767.

671. *Id.*

672. *Id.*

673. 828 S.W.2d 423 (Tex. App.—Fort Worth 1992), *rev'd*, 37 Tex. Sup. Ct. J. 408 (Jan. 12, 1994).

674. 812 F. Supp. 93 (S.D. Tex. 1993).

dealing arose under the Workers' Compensation Act and thus was not removable pursuant to 28 U.S.C. § 1445(c). The court held that the bad faith claim was separate and distinct from the workers' compensation claim arising out of the work-related injury.⁶⁷⁵ For instance, the damages sought by Haines in the bad faith claim were distinct from the contract damages sought in the workers' compensation claim. Moreover, section 1445(c)'s prohibition of the removal of workers' compensation claims arises out of the concern to have state courts interpret and apply workers' compensation laws.⁶⁷⁶ No similar concern arises regarding claims for breach of the duty of good faith and fair dealing.

Haines also argued that there was no basis for diversity jurisdiction since she had sued a Texas resident, namely, Vallot, who was an employee of the firm that adjusted National Union's claims. The only cause of action alleged against Vallot was that he, along with the other defendants, breached the duty of good faith and fair dealing. The court held that Vallot had been fraudulently joined to defeat diversity jurisdiction because, while the duty of good faith and fair dealing extends to adjusting firms, it does not extend to their employees.⁶⁷⁷ The court did acknowledge that Vallot could be liable for misrepresentations made or deceptive trade practices committed.⁶⁷⁸ However, Haines had not alleged any such causes of action against him.

III. THE DUTY OF AGENTS TO INSURED PARTIES

The issue in *May v. United Services Ass'n of America*⁶⁷⁹ was the extent of an agent's duty to the insured in rendering advice about and procuring a policy for health insurance. Shortly after Daryl and Faith May were married, they decided to take out a health insurance policy. Alice May, Daryl's mother, worked next door to the Preston Insurance Agency, and as a favor to her son and daughter-in-law, visited Preston and spoke with Rex Wiley, one of the agents. She was given a brochure describing the "Double Eagle" group policy, which she later gave to Daryl and Faith.

The Double Eagle policy was underwritten by Continental Bankers and could be purchased by members of the United Services Association of America. This policy featured relatively low premiums and deductibles, but its termination provision allowed the underwriter to cancel the entire group at any time. The policy also contained a deferral provision that permitted the underwriter to defer coverage on group members or covered dependents who were hospitalized or totally disabled at the time coverage began.

675. *Id.* at 95.

676. *Id.*

677. *Id.* at 96. *See also* *Ayoub v. Baggett*, 820 F. Supp. 298, 299-300 (S.D. Tex. 1993) (holding that employee of insurance company was fraudulently joined to defeat diversity even though causes of action under article 21.21 were alleged against the employee and that article 21.21 does not extend to the employees of insurance companies). *But see* *Herman v. Millicovsky*, 834 F. Supp. 182 (S.D. Tex. 1993) (remanding case because article 21.21 provides a cause of action against insurance adjuster).

678. *Id.*

679. 844 S.W.2d 666 (Tex. 1992).

Some time after being given the brochure describing the policy, Faith May visited the Preston Agency and spoke with Wiley about the Double Eagle policy. Wiley explained the basic provisions of the policy but did not tell her that Continental had received only a "C" rating from the A.M. Best Company, or that Preston sold other coverages, including an individual health policy from Reserve Life. Faith May told Wiley that they were concerned about covering medical expenses associated with pregnancy and childbirth because she had lost an infant child in a prior marriage. Wiley added a hand-written maternity rider to the policy. The Mays then joined the United group and purchased the Double Eagle policy. The coverage began on April 1, 1983.

In mid-1984, the Mays received notice that Continental had terminated the entire United group and that Hermitage, another underwriter, had agreed to underwrite the plan with identical benefits. Faith May was pregnant at the time and telephoned Wiley to determine what effect the change would have on the Mays' coverage. Wiley told her that Hermitage would continue to cover them on the same terms as Continental. Jared May was born on August 1, 1984, with congenital heart and lung disorders that required immediate medical attention. Hermitage covered his medical expenses under the policy.

In July 1985, Hermitage also terminated the United group and Keystone assumed the group's coverage. Keystone, however, classified Jared May as a totally disabled dependent and, asserting the deferral provision of the policy, refused to cover any of his medical expenses. Hermitage covered Jared May for ninety days after termination of the group. Thereafter, however, Jared May was without insurance coverage until he died in November of 1987.

In January 1987, the Mays filed suit against Preston, United, Keystone, and Hermitage seeking actual damages for unpaid medical bills and mental anguish, punitive damages, and interest. The causes of action against Keystone and Hermitage were severed because both companies were placed in receivership, and the Mays went to trial against United and Preston under common law causes of action including misrepresentation and negligence. The jury failed to find misrepresentation, but it did find that the negligence of both United and Preston proximately caused the Mays' injuries. The jury awarded \$140,000 in damages for unpaid medical expenses and \$40,000 in exemplary damages against Preston and United each. The jury did not award any damages for mental anguish. As the jury failed to find gross negligence, the trial court rendered judgment against Preston and United jointly and severally for \$140,000 plus interest and costs.

Only Preston appealed. The court of appeals reversed the judgment as to Preston's liability holding that there was no evidence of a negligent act by Preston. The supreme court affirmed the judgment of the court of appeals.⁶⁸⁰

The Mays first claimed that Preston was negligent in procuring insurance

680. *Id.* at 666-67.

that exposed them to the possibility of having no coverage on their son because Preston knew, or should have known, of the danger of a plan where the shifting of insurance coverage could result in the loss of insurance. The court recognized that an insurance agent who undertakes to procure insurance for another owes a duty to the client to use reasonable diligence in attempting to place the requested insurance and to inform the client promptly if unable to do so.⁶⁸¹ However, according to the court, that duty is typically breached when the client is misled into believing that a policy existed or that a particular risk was covered when it was not.⁶⁸² The court determined that a breach of this duty was not at issue because the jury did not find a misrepresentation and the Mays acknowledged that Wiley told them of the termination provision allowing an underwriter to cancel coverage for the entire group.⁶⁸³

According to the court, the crux of the Mays' first negligence claim was that Wiley did not exercise reasonable, prudent, professional judgment in recommending the Double Eagle policy to the Mays.⁶⁸⁴ The court, however, could find no evidence of negligence because the Mays based their claim solely on a limitation of coverage, about which they were fully apprised, and did not identify a particular negligent failure by Wiley.⁶⁸⁵ The Mays claimed that Wiley was negligent because he should have known of the risk posed to them by the potential shifting of the underwriters, but offered no evidence as to why this risk was unjustified for them in particular, or why Wiley should have prevented them from assuming it. The court held that if a breach of due care could be proved without a more concrete showing than a subsequent failure of coverage, agents would be rendered blanket insurers.⁶⁸⁶ The court also viewed as important the fact that the Mays never requested the "best available" policy and that they never asked to see different policies.⁶⁸⁷

The Mays next theory of negligence alleged that Preston was negligent in placing the coverage because Wiley either failed to investigate, or failed to investigate adequately, the financial solvency of Hermitage and Keystone, or if he did discover the financial condition of the underwriters, he was negligent for placing the Mays' coverage with them. The court noted, however, that when coverage was initially placed, Hermitage and Keystone were not yet in the picture, and the underwriter was Continental. Therefore, the court could find no negligence by Wiley in investigating Hermitage or Keystone in connection with the Mays purchasing the Double Eagle policy. Furthermore, the court held that there was no evidence that the unstable financial condition of Hermitage and Keystone contributed to the Mays'

681. *Id.* at 669.

682. *Id.*

683. *Id.* at 670.

684. *May*, 844 S.W.2d at 670.

685. *Id.* at 672.

686. *Id.*

687. *Id.* at 673.

loss.⁶⁸⁸ The court, therefore, concluded that there was no evidence of negligence on the part of Wiley and Preston.⁶⁸⁹

Justice Doggett dissented. According to Justice Doggett, insurance agents must exercise reasonable care in advising their clients in keeping them fully informed so as to remain safely insured.⁶⁹⁰ When Faith Mays sought an affordable "good policy" that would provide coverage for any future children, she entrusted to Wiley the job of assessing the available alternatives and advising her as to the most appropriate coverage. He not only failed to make such an evaluation, but neglected to inform the Mays that there were alternatives to the policy he recommended. Justice Doggett asserted that the jury's verdict should not have been disturbed.

Justice Gammage, joined by Justice Mauzy, also dissented, arguing that the majority substituted its own verdict for that of the jury's. According to Justice Gammage, Wiley had an affirmative duty to offer advice to the Mays because they had come to him seeking advice about which insurance policy was best suited for their needs.⁶⁹¹ Justice Gammage found sufficient evidence to support the jury's finding that Preston was negligent because Wiley testified that he performed little or no investigation into alternative policies, never determined what the Mays were willing to pay, and never disclosed to the Mays other policies in a comparison of their premium costs. Wiley also testified that he could have sold them a health insurance policy that would have avoided the loss of coverage for Jared, but that he made no attempt to determine the relative cost or to show the Mays what the premium difference would have been. Justice Gammage also found evidence that Wiley was concerned that the Double Eagle went through two underwriters, both of which were the subjects of insolvency proceedings, but he never communicated that concern to the Mays. Rather, each time the Mays contacted them to express their concern, he reassured them and encouraged them to stick with the Double Eagle.⁶⁹²

Justice Gammage found that there was sufficient evidence to show that Preston had failed to provide accurate information regarding the available insurance, which Wiley, the agent, knew or should have known the customer desired. Justice Gammage, like Justice Doggett, would have upheld the jury's verdict.

In *Pickens v. Texas Farm Bureau Insurance Co.*⁶⁹³ the court held that an insurer owes no duty to advise insured of various coverage limits and premiums available and thus was not liable to the insured under theories of negligence, breach of the duty of good faith and fair dealing, or violations of the Insurance Code and Deceptive Trade Practices Act for failing to advise of other coverages available.⁶⁹⁴

688. *Id.*

689. *May*, 844 S.W.2d at 673.

690. *Id.* at 675.

691. *Id.* at 676.

692. *Id.* at 678.

693. 836 S.W.2d 803 (Tex. App.—Amarillo 1992, no writ).

694. *Id.* at 806.

The Bennetts, upon moving to Amarillo, purchased a homeowner's policy with liability limits of \$25,000. Mrs. Bennett did not seek advice about coverage and did not confer with an agent. While the homeowner's policy was in effect, Johnny Bennett was cleaning a rifle in his garage when it discharged and struck James Pickens in the right arm. James Pickens and his parents filed suit against Bennett for damages. On March 31, 1986, a consent judgment was entered in favor of Pickens in the amount of \$953,000.

Texas Farm Bureau paid the policy limits of \$25,000 on behalf of Bennett. Later, Pickens and Bennett signed a covenant not to execute wherein the Bennetts agreed to pay an additional \$15,000 on the judgment and assigned any causes of action they might have against Texas Farm Bureau to Pickens. After the assignment, Pickens sued Texas Farm Bureau alleging negligence, breach of warranty, and violations of the DTPA and Insurance Code. All of these causes of action were based on the allegations that Texas Farm Bureau failed to advise the Bennetts, when they purchased the homeowner's policy, of various liability coverage limits and premiums available. The trial court rendered a take-nothing summary judgment in favor of Texas Farm Bureau. The court of appeals affirmed.⁶⁹⁵

The court initially held that Texas Farm Bureau could not be held liable for negligence since it did not owe a duty to the Bennetts to offer benefits in excess of the statutory minimum.⁶⁹⁶ The court found evidence to show that the Bennetts did not seek advice from Texas Farm Bureau as to how much coverage they should have obtained. The Bennetts received an updated policy every six months, showing the policy coverage. They did not question the amount of coverage, nor did they inquire about the other coverages available. The court also found that the Bennetts were aware of the process utilized to raise coverage limits on the policy since they had done so with respect to obtaining additional coverage when their home increased in value and when it was discovered that their gun collection was not covered by the policy.⁶⁹⁷

The court held that Texas Farm Bureau did not breach the common law duty of good faith and fair dealing by failing to advise the Bennetts of undercoverage.⁶⁹⁸ The court noted that a cause of action for breach of the duty of good faith and fair dealing is stated when it is alleged that there is no reasonable basis for denial of a claim or delay in payment or a failure on the part of the insurer to determine whether there is reasonable basis for the denial or delay. In this case, Texas Farm Bureau paid the full amount of the Bennetts' policy limits. Since there was no contention that Texas Farm Bureau wrongfully denied or delayed payment, the court held that there was no breach of this duty, and stated that it would not extend the duty to require an insurer to disclose the range of liability coverage amounts.⁶⁹⁹ The court

695. *Id.* at 807.

696. *Id.* at 805.

697. *Id.* at 806.

698. *Pickens*, 836 S.W.2d at 806.

699. *Id.*

also rejected Pickens' argument that Texas Farm Bureau violated the DTPA and Insurance Code by failing to disclose coverage options. Again, the court held that since Texas Farm Bureau owed no duty to defendants beyond selling them the homeowner's policy, there could be no violation of the DTPA or Insurance Code in this case.⁷⁰⁰

IV. LIABILITY OF INSURERS FOR AGENT MISREPRESENTATIONS

In *Celtic Life Insurance Co. v. Coats*⁷⁰¹ the court considered when an insurance company would be liable for the misrepresentations of its agent. In September 1984, Coats met with Harrell, Celtic's agent, to discuss obtaining replacement insurance coverage for the employees of his swimming pool business. Coats specifically told Harrell that he was interested in obtaining a policy that provided psychiatric benefits equal to or greater than the \$20,000 benefits he had under his prior policy. Harrell later returned with a brochure describing the coverage and benefits of a Celtic policy. According to Harrell and the brochure, the policy had a \$1 million maximum lifetime benefit for in-hospital care. Harrell did not inform Coats that psychiatric care was subject to a \$10,000 limit rather than the \$1 million limit.

After this meeting, Coats delegated to Engelmann, his business manager, the responsibility of determining whether the Celtic policy should be purchased. After reading the brochure Engelmann met with Harrell to discuss the benefits, especially the psychiatric care benefits. Harrell told her that in-hospital psychiatric care had a \$1 million maximum lifetime benefit. Based upon this information, Engelmann recommended to Coats that the Celtic policy be purchased, and the policy became effective February 1, 1985.

In August of 1985, Coats' son was admitted to Shoal Creek Hospital for psychiatric care. Shoal Creek then called Coats and told him that Celtic was claiming that the policy covered only \$10,000 of his son's psychiatric treatment. Coats immediately called Harrell, who once again said not to worry because the policy had a \$1 million hospital limit. Celtic, however, paid only \$10,000 of the \$27,000 medical expenses.

Coats filed suit against Celtic under the DTPA and article 21.21 alleging that it was liable for the misrepresentations of its agent, Harrell. The jury found that Harrell had misrepresented the terms, benefits, provisions or conditions of the policy, and that he had authority to explain, on behalf of Celtic, the benefits of the policy. The jury failed to find that the misrepresentation was made knowingly. The trial court rendered judgment against Celtic in favor of Coats. The court of appeals affirmed.⁷⁰² The supreme court, however, reversed and rendered judgment in favor of Celtic.⁷⁰³

700. *Id.*

701. 36 Tex. Sup. Ct. J. 1259 (Sept. 10, 1993).

702. *Celtic Life Ins. Co. v. Coats*, 831 S.W.2d 592 (Tex. App.—Austin 1992), *rev'd*, 36 Tex. Sup. Ct. J. 1259 (Sept. 10, 1993).

703. *Celtic Life*, 36 Tex. Sup. Ct. J. at 1261.

The sole basis for the court's reversal was that Celtic could not be liable for Harrell's misrepresentations because he did not have authority to make representations "outside the scope of the written policy."⁷⁰⁴ The jury was asked two questions regarding Harrell's authority. In answer to Question 2, the jury found that Harrell had the authority to "explain," on behalf of Celtic, the benefits of the policy, but in answer to Question 3, the jury found that Harrell did not have authority to make representations "outside the scope of the written document."

The court held that Harrell was Celtic's agent by virtue of article 21.02 of the Insurance Code.⁷⁰⁵ Article 21.02, entitled "Who Are Agents," states that anyone soliciting for an insurance company "shall be held to be the agent of the company for which the act is done, or the risk is taken, as far as relates to all the liabilities, duties, requirements and penalties set forth in this chapter . . ." ⁷⁰⁶ However, according to the court, article 21.02 does not delineate the scope of Harrell's authority and reference must be made to common law rules of agency.⁷⁰⁷

The court concluded that the jury's finding that Harrell had authority to explain the policy was immaterial to Celtic's liability, holding that the authority to "explain" is different and less than the authority to "represent," citing the 1980 edition of Merriam Webster's Collegiate Dictionary ("explain" meaning "to make plain or understandable" and "represent" meaning "to describe as having a specified character or quality").⁷⁰⁸ The level of authority needed, according to the court, is the authority "to make representations at issue." Thus, according to the court, the jury's finding that Harrell did not have authority from Celtic to make representations outside the scope of the written document precludes Celtic's vicarious liability for the misrepresentations of its agent.⁷⁰⁹

Justice Spector, joined by Justices Doggett and Gammage, wrote a dissenting opinion criticizing the majority for abandoning long-established common law rules of principal — agency law that imposed liability on a principal for the acts of its agent done in the scope of his authority even though the principal has not authorized the specific act. According to the dissent, the majority opinion is tantamount to requiring the principal to authorize misrepresentations before liability will attach.⁷¹⁰

Justice Spector also criticized Justice Enoch, author of the majority opinion, for completely disregarding his recent opinion in *Maccabees Mutual Life Insurance Co. v. McNiel*.⁷¹¹ In *Maccabees*, Justice Enoch wrote, while still on the Dallas Court of Appeals, that the insurer was liable for the agent's misrepresentations because the agent was the agent of the company

704. *Id.*

705. *Id.* at 1260.

706. TEX. INS. CODE ANN. art. 21.02 (Vernon Supp. 1993).

707. *Celtic Life*, 36 Tex. Sup. Ct. J. at 1260.

708. *Id.* at 1261.

709. *Id.*

710. *Id.*

711. 836 S.W.2d 229 (Tex. App.—Dallas 1992, no writ).

under article 21.02.⁷¹² Thus, while the agent could not contractually bind the company, he could render it liable under the DTPA and Insurance Code because of his misrepresentations.

The court has strained to find a distinction between the authority to “explain” and the authority to “represent” in order to strip from a Texas insured a judgment against a foreign insurance company for the misrepresentations of its Texas agent. In answer to Question 2, the jury found that Ken Harrell had the authority, on behalf of Celtic, to explain the terms and benefits of Celtic’s insurance policy. The court dismissed this finding as immaterial because the authority to “explain,” the court tells us, is not equivalent to the authority to “represent.”⁷¹³ According to the court, a showing of authority greater than the authority to “explain” is required before Celtic could be liable for Harrell’s misrepresentations. However, as the definitions of these words reveal, there is no qualitative difference between “explain” and “represent.”

In the most recent edition of Merriam Webster’s Collegiate Dictionary, “explain” is defined as “to make known.”⁷¹⁴ Additionally, “explain” means “to make something clear or understandable.” Explain implies a making plain or intelligible what is not immediately obvious or entirely known.⁷¹⁵ “Represent” is defined as “to bring clearly before the mind.”⁷¹⁶ Surely, there is no difference between a word that means “to make something clear or understandable” and one that means “to bring clearly before the mind.”

Moreover, the definitions of these words make clear that “explain” does not entail something less than “represent.” Two of the synonyms for “explain” are “interpret” and “construe.”⁷¹⁷ “Interpret,” in turn, means, “[t]o explain the meaning of; to conceive the significance of; construe.”⁷¹⁸ Similarly, “construe” means, “[t]o adduce or explain the meaning of interpret.”⁷¹⁹ The jury found that Harrell had the authority to explain the terms and benefits of the Celtic policy and thus the authority to interpret and construe the meaning of these benefits. Thus, there is absolutely no basis for the court’s conclusion that Harrell did not have sufficient authority to render Celtic liable for his misrepresentations made while explaining, describing, interpreting and construing the meaning of the coverage as it applied to psychiatric benefits.

If Question 2 was immaterial, it was not because of a difference between “explaining” what the benefits of an insurance policy are and “representing” what they are. It was because Harrell’s authority was proven as a matter of law. The court held in *Royal Globe Insurance Co. v. Bar Consultants, Inc.*⁷²⁰

712. *Id.* at 235.

713. *Celtic Life*, 36 Tex. Sup. Ct. J. at 1261.

714. *Id.*

715. MERRIAM WEBSTER’S COLLEGIATE DICTIONARY 409 (1993).

716. *Id.* at 993.

717. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 645 (3d ed. 1992).

718. *Id.* at 943.

719. *Id.* at 405.

720. 577 S.W.2d 688 (Tex. 1979) (emphasis added). See also *C. V. Hill & Co. v. Fricke*,

that when an agent is given the authority to *sell policies*, the principal-insurer also gives the agent the authority “to *represent the coverage* afforded by such policies to the consumer.”⁷²¹

Even without the authority of *Royal Globe*, common sense and the plain meaning of the word “sell” lead inescapably to the conclusion that the authority to sell includes the authority to represent and explain the thing that is being sold. The meaning of “sell” includes: “to persuade or induce someone to buy (something);”⁷²² “to persuade (another) to recognize the worth or desirability of;”⁷²³ and “to influence or induce to make a purchase.”⁷²⁴ It would have been impossible for Harrell to have persuaded or induced John Coats to purchase the Celtic policy if Harrell had not told Coats what type of coverage the policy provided in the case of treatment for psychiatric problems. These were the only benefits of importance to John Coats. Thus, it defies common sense, experience, reason, and law to conclude that the authority to sell insurance does not include the authority to explain, make known, describe, define, and make understandable the coverage and benefits afforded by the insurance policy. Celtic admitted that Harrell had Celtic’s authority to sell its policies in Texas. Celtic also conceded that not many Celtic policies would be sold if the agent merely placed the brochure in front of the prospective purchaser and did not say anything about the coverage provided by the policy. Additionally, Harrell testified that Celtic authorized him to sell Celtic policies in Texas and that as part of that authority he could explain and describe the terms and benefits of the policy.

Because Harrell had the authority to sell Celtic’s policies, he necessarily had the authority to represent coverage provided by the policy. This authority was undisputed and established as a matter of law. Thus, the lower courts were correct in holding Celtic vicariously liable for the misrepresentations of its agent, Ken Harrell, and the supreme court was wrong to reverse this judgment.

Question 3 asked: “Did Ken Harrell have the authority of Celtic to make representations concerning the insurance policy’s terms, benefits, provisions, and conditions, which were outside the scope of the written document?”

The jury’s answer of “No” to Question 3, however, is immaterial because the representations upon which liability is based were within the scope of the policy and the brochure. The object or intention of the policy, and the brochure describing the policy, were to provide a description or explanation of the coverage so that the insured would know the type of coverage being purchased. Included within this description of coverage were benefits for

135 S.W.2d 582, 585 (Tex. Civ. App.—Fort Worth 1940, writ *dism’d*) (finding that an agent that had the authority to sell equipment also had authority to make representations about the characteristics and qualities of the equipment so as to render principal liable when agent misrepresented those characteristics and qualities).

721. *Royal Globe*, 577 S.W.2d at 694 (emphasis added).

722. WEBSTER’S NEW UNIVERSAL UNABRIDGED DICTIONARY 1296 (1989).

723. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 1639 (1992).

724. MERRIAM WEBSTER’S COLLEGIATE DICTIONARY 1062 (1993).

psychiatric treatment; the only benefits in which John Coats was interested, as fully explained to Harrell.

The representations made by Harrell, which the jury found to be misrepresentations, concerned these benefits for psychiatric care. Coats alleged, and the jury found, that Harrell stated that the policy provided a \$1 million life-time maximum benefit for psychiatric treatment rendered in a hospital as opposed to a \$10,000 limit for out-patient psychiatric treatment. Clearly, this representation concerned a subject within the scope of the brochure and policy — coverage for psychiatric treatment — and was within the scope of Harrell's authority to make. Thus, Question 3 had no relevance to any issue in this case and should have been disregarded.

The court correctly stated the general rule that an insurance company will be liable for the wrongful acts of its agent when the agent commits the wrongful acts within the scope of his actual or apparent authority.⁷²⁵ The court then quotes from section 257 of the Restatement (Second) of Agency, which provides: "A principal is subject to liability for loss caused to another by the other's reliance upon a tortious representation of a servant or other agent, if the representation is:

- (a) authorized;
- (b) apparently authorized; *or*
- (c) within the power of the agent to make for the principal."⁷²⁶

Although not expressly stated, the court seems to decide that a principal will be liable only if he authorizes the representation as provided in section 257(a). As applied to this case, this would require Celtic to have told Harrell to make the representation or that Harrell had "reason to believe from his principal's conduct that the principal wishes the statement made although untrue."⁷²⁷ The comment to section 257, however, makes clear that there are two other situations where a principal can be liable for the representations of its agent. The first is when the other party to the transaction (here, John Coats) "reasonably believes from the conduct for which the principal is responsible that the agent is authorized to make the representations as made."⁷²⁸ The second is when the agent makes a representation which, if true, is one the agent would have been authorized to make.⁷²⁹

In this case, the evidence showed that while Celtic did not tell Harrell to make untrue statements about the policy, the representation Harrell made about psychiatric benefits was one that, if true, he was authorized to make. In other words, Celtic gave Harrell authority to make representations about coverage in order to effectuate the sale of Celtic insurance policies. Thus, such representations were within Harrell's power to make for Celtic. Ac-

725. *Celtic Life*, 36 Tex. Sup. Ct. J. at 1260.

726. *Id.* at 1261 (emphasis added) (quoting RESTATEMENT (SECOND) OF AGENCY § 257 (1958)).

727. *Id.* at § 257 cmt. a (1958).

728. *Id.*

729. *Id.*

ording to section 257 of the Restatement (Second) of Agency, Celtic is liable for Harrell's misrepresentations.

It has long been the law in Texas that a principal will be liable for the torts of its agent if the tort was committed while the agent was acting within the scope of his actual or apparent authority even if the principal did not authorize or know about the specific act.⁷³⁰ Moreover, the law has imposed liability upon the principal even if the agent's specific act was in disobedience of and contrary to the order of the principal.⁷³¹ Not only has this been the law of agency in Texas for almost one hundred and fifty years, it is the law in every other state.⁷³² Thus, by requiring the principal to authorize the specific wrongful conduct, Texas becomes a minority of one on this issue.

730. *Royal Globe Ins. Co. v. Bar Consult., Inc.*, 577 S.W.2d 688, 694 (Tex. 1979); *International & G.N.R. Co. v. Anderson*, 82 Tex. 516, 17 S.W. 1039 (1891); *Wright v. Calhoun*, 19 Tex. 412 (1857); *Henderson v. San Antonio & M.G.R. Co.*, 17 Tex. 560 (1856); *Hedley Feedlot, Inc. v. Weatherly Trust*, 855 S.W.2d 826, 837 (Tex. App.—Amarillo 1993, writ denied).

731. *Magnolia Petroleum Co. v. Guffey*, 129 Tex. 293, 102 S.W.2d 408, 409 (1937); *King v. Loessin*, 572 S.W.2d 87, 90 (Tex. Civ. App.—Houston [1st Dist.] 1978, no writ); *Bass v. Metzger*, 569 S.W.2d 917, 924 (Tex. Civ. App.—Corpus Christi 1978, writ ref'd n.r.e.); *Arterbury v. American Bank & Trust Co.*, 553 S.W.2d 943, 949 (Tex. Civ. App.—Texarkana 1977, no writ).

732. See *Autrey v. Blue Cross & Blue Shield of Alabama*, 481 So.2d 345, 347-48 (Ala. 1985); *Alaskan Village, Inc. v. Smalley*, 720 P.2d 945, 948-49 (Alaska 1986); *Nason v. Voight*, 625 P.2d 974, 976 (Ariz. App. 1981); *Ray Dodge, Inc. v. Moore*, 479 S.W.2d 518, 523 (Ark. 1972); *In re Nelson*, 761 F.2d 1320, 1322 (9th Cir. 1985) (California law); *Life Investors Ins. Co. of Am. v. Smith*, 833 P.2d 864, 868-69 (Colo. App. 1992); *Dyer v. Johnson*, 757 P.2d 178, 180 (Colo. App. 1988); *In re Brandywine Volkswagen, Ltd.*, 306 A.2d 24, 27 (Del. 1973); *Sumpolec v. Pruco Life Ins. Co.*, 563 So.2d 778, 779 (Fla. App. 1990); *Piedmont Cotton Mills v. General Warehouse No. Two*, 149 S.E.2d 72, 76 (Ga. 1966); *Silva v. Bisbee*, 628 P.2d 214, 217 (Haw. App. 1981); *Fowler v. Uezzell*, 500 P.2d 852, 856 (Idaho 1972); *Phipps v. Cohn*, 487 N.E.2d 428, 431 (Ill. App. 1985); *Clark v. Millikin Mortg. Co.*, 495 N.E.2d 544, 547 (Ind. App. 1986); *Vernon Fire & Cas. Ins. Co. v. Thatcher*, 285 N.E.2d 660, 671 (Ind. App. 1972); *State v. Sellers*, 258 N.W.2d 292, 298 (Iowa 1977); *New York Life Ins. Co. v. McGowan*, 18 Kan. 300, 320 (1877); *Liberty Nat'l Bank & Trust Co. v. Gruenberger*, 477 S.W.2d 503, 505 (Ky. App. 1972); *Woodward v. Barringer*, 24 So.2d 200, 203 (La. App. 1945); *Crowley v. Dubuc*, 430 A.2d 549, 552 (Me. 1981); *Sanders v. Rowan*, 484 A.2d 1023, 1030 (Md. App. 1984); *New England Accept. Corp. v. American Mfrs. Mut. Ins. Co.*, 344 N.E.2d 208, 212 (Mass. App. 1976); *Renda v. International Union*, 114 N.W.2d 343, 361 (Mich. 1962); *Myzel v. Fields*, 386 F.2d 718, 738 (8th Cir. 1967), *cert. denied*, 88 S. Ct. 1043 (1968) (Minnesota law); *Napp v. Liberty Nat'l Life Ins. Co.*, 159 So.2d 164, 166 (Miss. 1963); *Maryland Cas. Co. v. Huger*, 728 S.W.2d 574, 579 (Mo. App. 1987); *McCarty v. Lincoln Green, Inc.*, 620 P.2d 1221, 1224 (Mont. 1980); *Wolfson Car Leasing Co. v. Weberg*, 264 N.W.2d 178, 182 (Neb. 1978); *Young v. Nevada Title Co.*, 744 P.2d 902, 903 (Nev. 1987); *Gardner v. Rosecliff Realty Co.*, 124 A.2d 30, 34 (N.J. Super. App. Div. 1956); *Echols v. N. C. Ribble Co.*, 511 P.2d 566, 569 (N.M. App. 1973); *Gleason v. Temple Hill Assoc.*, 553 N.Y.S.2d 430, 432 (App. Div. 1990); *Parsons v. Bailey*, 227 S.E.2d 166, 168 (N.C. App. 1976); *Dewey v. Lutz*, 462 N.W.2d 435, 443 (N.D. 1990); *Pannunzio v. Monumental Life Ins. Co.*, 151 N.E.2d 545, 552 (Ohio 1958); *Foust v. Valleybrook Realty Co.*, 446 N.E.2d 1122, 1127 (Ohio App. 1981); *Estate of Bras v. First Bank & Trust Co.*, 821 P.2d 387, 391 (Okla. App. 1991); *Seiders v. Hefner*, 747 P.2d 1003, 1005 (Or. App. 1987); *Pennsylvania Nat'l Mut. Cas. Ins. Co. v. Insurance Comm'r*, 551 A.2d 368, 373 (Pa. Commw. Ct. 1988); *Cohen v. Goldman*, 132 A.2d 414, 417 (R.I. 1957); *Fudge v. Physicians Ins. Co.*, 125 F. Supp. 653, 657 (W.D.S.C. 1954); *Leafgreen v. American Family Mut. Ins. Co.*, 393 N.W.2d 275, 277 (S.D. 1986); *Holloway v. Howerdd*, 536 F.2d 690, 696 (6th Cir. 1976) (Tennessee law); *Mecham v. Benson*, 590 P.2d 304, 308 (Utah 1979); *Dodge v. Aetna Cas. & Sur. Co.*, 250 A.2d 742, 744 (Vt. 1969); *Jefferson Standard Life Ins. Co. v. Hedrick*, 27 S.E.2d 198, 202 (Va. 1943); *Watson v. Yasunaga*, 438 P.2d 607, 610 (Wash. 1968); *Holliday v. Gilkeson*, 363 S.E.2d 133, 134 (W.Va. 1987); *Henricksen v. Henricksen*, 640 F.2d 880, 887 (7th Dist. 1981) (Wisconsin law).

The court has also abolished the rule of law that a principal is responsible for an unlawful act of its agent where the act is committed by the agent for the purpose of accomplishing the mission intrusted to him by the principal.⁷³³ Harrell, of course, was acting in the furtherance of Celtic's business of selling insurance policies in Texas when he found himself describing and answering questions about the coverage. Consequently, the court should have affirmed the judgment against Celtic, as Harrell's principal.

The court's decision also unfairly discriminates between insurers whose agents are "employees" and insurers whose agents are not "employees," holding the former strictly accountable for the acts of their agents while shielding the latter from any accountability for acts of their agents. This discrimination results from the reason given by the court for refusing to follow Justice Enoch's opinion in *Maccabees*. *Maccabees* correctly held that even if he lacked actual, apparent, or implied authority to bind coverage "[a]n Article 21.02 agent of an insurance company who misrepresents coverage may render the insurance company he represents vicariously liable for the misrepresentations under the Deceptive Trade Practices Act (DTPA) and article 21.21, § 16 of the Insurance Code."⁷³⁴ In explaining why it was not following *Maccabees* in *Celtic Life*, the court "note[d] that *Maccabees* involved misrepresentations by the insurer's *employee* and sales representative, rather than an independent agent."⁷³⁵ Thus, State Farm, Allstate, and New York Life, for the sole reason that they sell their policies through an employee sales force, are liable for the very same misrepresentations that impose no liability on Celtic Life. This result is not only inequitable, it is unsupported by Article 21.02 upon which *Maccabees* rests. Article 21.02 makes an agent of the company "[a]ny *person* who solicits insurance"⁷³⁶ — not any *employee* who solicits insurance. Indeed, Article 21.02 is expressly unconcerned with the legal relationship between the company and the person soliciting. It is the person's act of solicitation of insurance that makes him the agent of the company "*whether any such act[] shall be done at the instance or request, or by the employment of such insurance company.*"⁷³⁷ Whether the agent is an "employee" or an "independent agent" is therefore immaterial under Article 21.02 and the distinction thus provides no basis for the court's refusal to follow *Maccabees* in the instant case.

According to Appleman, statutory provisions similar to article 21.02 are common.⁷³⁸ The purpose of such statutes, "is to make it as safe for persons

733. See *Aetna Cas. & Sur. Co. v. Love*, 132 Tex. 280, 121 S.W.2d 986, 990 (1938) (holding an insurance company liable for adjuster's conduct in getting public official to order unlawful autopsy); see also *Magnolia Petroleum Co. v. Guffey*, 129 Tex. 293, 102 S.W.2d 408, 409 (1937); *Southwestern Bell Tele. Co. v. Wilson*, 768 S.W.2d 755, 759 (Tex. App.—Corpus Christi 1988, writ denied); *King v. Loessin*, 572 S.W.2d 87, 90 (Tex. Civ. App.—Houston [1st Dist.] 1978, no writ); *Bass v. Metzger*, 569 S.W.2d 917, 924 (Tex. Civ. App.—Corpus Christi 1978, writ ref'd n.r.e.).

734. *Maccabees*, 836 S.W.2d at 233.

735. *Celtic Life*, 36 Tex. Sup. Ct. J. at 1260, n. 5 (emphasis added).

736. TEX. INS. CODE ANN. art. 21.02 (Vernon Supp. 1993) (emphasis added).

737. *Id.* (emphasis added).

738. 16 APPLEMAN, INSURANCE LAW & PRACTICE § 8671, at 176 (1981).

seeking insurance to deal with the agents, with whom alone they ordinarily transact their business as if they were dealing directly with the companies themselves.”⁷³⁹ Moreover, Appleman continues:

And where the statute makes such agent the agent of the insurer “as to all duties and liabilities imposed by law”, this refers not to the duties and liabilities growing out of the contract of insurance but to duties and liabilities imposed on insurance companies and agents by law independent of the provisions of the contract of insurance. Therefore, in all matters relating to the application for the policy and issuance in consequence thereof, the agent is regarded as the agent of the company.⁷⁴⁰

In construing a statute similar to article 21.02, the Mississippi Supreme Court held that such statute governed the question of authority and the insurer’s liability for the agent’s conduct concerning the agent’s acts up to and including the consummation of insurance, while principles of common law govern other matters.⁷⁴¹ Thus, if a statute designates a person as an authorized agent of an insurance company by virtue of the activities in which that person engages on behalf of the company, those activities must be within the agent’s authority. If the agent violates article 21.21 and/or the DTPA while engaged in those activities, then the insurer, as principal, must be liable for such acts of its agent. It would be incongruent with article 21.02 to find that a person is an agent of an insurance company because he was soliciting insurance on its behalf, but to conclude that the insurer was not responsible for the agent’s misrepresentations made while soliciting the insurance, when such misrepresentations are prohibited by article 21.21.

The purpose of article 21.02 is clearly to impose liability on an insurer for the acts of its agents which violate Chapter 21 of the Insurance Code. The court’s unfortunate decision not only frustrates this legislative intent, it negates it. The court’s opinion is contrary to the plain meanings of “explain,” “sell,” and “represent.” It departs dramatically, and without explanation, from established case precedent. It proceeds on a misreading of the evidence in the record. It saps all meaning from the Insurance Code’s mandate that agents who solicit insurance are agents of the insurance company whose policy they are selling. The court’s decision is, in a word, wrong on all bases on which it purports to rest.

In *Shandee Corp. v. Kemper Group*⁷⁴² the court held that an agent had apparent authority sufficient to hold the insurer vicariously liable for the agent’s fraud.⁷⁴³ Shandee purchased a general liability insurance policy from Kemper through an agent named Johnston. Prior to the expiration of the policy, Johnston told Shandee that it and Shandee’s other policies would be renewed and merged into a single Texas Multiple Perils (TMP) policy.

739. *Hurd v. Maine Mut. Fire Ins. Co.*, 27 A.2d 918, 924 (Me. 1942). See also 16 APPLEMAN, INSURANCE LAW & PRACTICE § 8671 (1981).

740. 16 APPLEMAN, INSURANCE LAW & PRACTICE § 8671, at 177 (1981).

741. *Old Colony Ins. Co. v. Fagan Chevrolet Co.*, 150 So. 2d 172 (Miss. 1963).

742. No. C14-92-00126-CV (Tex. App.—Houston [14th Dist.], Sept. 30, 1993, n.w.h.).

743. *Id.*, slip op. at 6.

After Johnston told Shandee that it would be covered, he issued certificates of insurance reflecting the existence of a general liability policy with an effective date of July 20, 1986 through July 20, 1987. During the fall of 1986, Shandee experienced several losses and submitted claims to Kemper. Initially, Kemper paid those claims but later informed Shandee that the general liability policy had not been renewed and demanded reimbursement for payment of the claims. Shandee failed to make the reimbursement and filed suit against Johnston and Kemper alleging fraud and breach of contract.

The jury found that Kemper and Johnston were guilty of fraud and assessed approximately \$52,000 in actual damages against each. The jury also found that Kemper and Johnston had acted with conscious disregard and assessed \$750,000 in exemplary damages against Kemper and \$1 million against Johnston. The jury also found that a contract for general liability coverage existed for the period of July 1986 through July 1987 and this contract had been breached by Kemper. The jury assessed about \$52,000 in actual damages and \$68,000 as reasonable attorney's fees under the breach of contract theory.

The trial court disregarded the jury findings of fraud against Kemper, disregarded the jury findings of fraud as to the general liability policy by Johnston, reduced the award of exemplary damages assessed against Johnston, and disregarded the finding of attorney's fees for breach of contract. The trial court then vacated the judgment against Johnston, severed the cause against Johnston, and required Shandee to tender a remittitur or a new trial would be ordered.

Shandee then pursued its claims against Johnston in the severed cause, and proceeded to trial once again. The jury returned a verdict in favor of Shandee again awarding approximately \$52,000 in actual damages and \$1 million in exemplary damages. Both cases were then consolidated for the purposes of appeal.

Shandee argued that Kemper should be vicariously liable for Johnston's fraud because he had actual or apparent authority from Kemper to make particular representations, quotes, or statements about coverage to Shandee. The evidence showed that the policies were usually renewed with no correspondence from Kemper. When Shandee received a billing statement indicating that the general liability policy was nonrenewed, Shandee contacted Johnston, who said not to worry because he was securing a TMP policy that would encompass general liability coverage. Shandee had purchased insurance coverage through Johnston since 1971 and had purchased insurance coverage from Kemper since 1982. Kemper had never notified Shandee that Johnston was not authorized to secure insurance coverage. In fact, internal memos from Kemper regarding the discussion about a TMP policy indicated that Kemper acknowledged Johnston's authority to make representations to Shandee that he was securing a TMP policy and not renewing the former general liability policy.

The court therefore held that the evidence showed that Johnston had the authority to secure coverage for customers such as Shandee and to assure

them that they were covered.⁷⁴⁴ The evidence also showed that the representations of coverage were false and that Johnston knew, or should have known, that they were false. Furthermore, Shandee relied on the representations and did not secure other coverage. Instead, Shandee submitted claims, which Kemper initially paid, indicating to Shandee that Johnston's representations were true. Kemper's actions, tending to ratify Johnston's representations, also kept Shandee from securing additional coverage. The court held that there was some evidence of Johnston's apparent authority to make the representations he made to Shandee.⁷⁴⁵ Thus, the court found that there was sufficient evidence to establish Kemper's vicarious liability for Johnston's fraud.⁷⁴⁶

*Abe's Colony Club, Inc. v. C & W Underwriters, Inc.*⁷⁴⁷ was brought by Abe's against its liability insurers, C & W and Mt. Hawley, for expenses incurred in defending a lawsuit brought against Abe by Callihan for injuries he incurred in a vehicle accident caused by an intoxicated patron of a bar owned and operated by Abe's. Both insurers refused to provide a defense based upon a liquor liability exclusion in the policy. Mt. Hawley and C & W sought a summary judgment that no defense was required due to a liquor liability exclusion provision in the policy and due to the statute of limitations barring Abe's DTPA, Insurance Code, and breach of the duty of good faith and fair dealing causes of action. The trial court granted this motion and the court of appeals affirmed.⁷⁴⁸

Abe's argued that Mt. Hawley had a duty to defend notwithstanding the policy exclusion because an alleged agent of Mt. Hawley misrepresented the policy's coverage. Esquell, the agent, told Abe's that she could secure liquor liability insurance. However, there was no evidence that Esquell represented that Mt. Hawley would provide liquor liability insurance. Moreover, the public records of the State of Texas did not list Esquell as an agent for Mt. Hawley. Abe's argued that Esquell was a soliciting agent of Mt. Hawley and therefore Mt. Hawley was liable for Esquell's misrepresentation by virtue of Texas Insurance Code, article 21.02. The court held that even if Esquell was a soliciting agent of Mt. Hawley, she could not bind Mt. Hawley by her representation unless Mt. Hawley bestowed apparent authority on her.⁷⁴⁹ Because the facts showed that Mt. Hawley had absolutely no contact with Abe's when the alleged misrepresentations were made, the court held that there was no evidence that Mt. Hawley had clothed Esquell with apparent authority.⁷⁵⁰

744. *Id.*

745. *Id.*

746. *Id.*

747. 852 S.W.2d 86 (Tex. App.—Fort Worth 1993, writ denied).

748. *Id.* at 91.

749. *Id.* at 90.

750. *Id.*

V. ACTIONS BY INSURER AGAINST AGENT

In *American Indemnity Co. v. Baumgart*⁷⁵¹ American Indemnity sued its local recording agent, Baumgart, to recover damages for defending and settling a personal injury claim brought against its alleged insureds. American sued Baumgart for indemnity, violations of the Texas Insurance Code, the DTPA, negligence, breach of contract, and fraud.

American alleged that in April, 1984, Baumgart obtained auto insurance for John Ventura and his wife, Jane Ford. This insurance was written through Travelers, and the Venturas renewed the policy every six months. On October 29, 1985, the policy was renewed and would have expired in April of 1986. On November 1, 1985, Ms. Ford leased a 1986 Oldsmobile and asked Baumgart to add this vehicle to the Travelers' policy. Baumgart then sent a change order to Travelers requesting that it add the Oldsmobile as an additional insured vehicle to the policy, and also requested that Travelers increase the liability limits on the Oldsmobile.

A couple of weeks later, Baumgart received a letter from Travelers that it would not increase liability exposure for the Venturas' account and that the Venturas' file had been marked for nonrenewal due to their driving records and loss activity. Thereafter, Ms. Ford instructed Baumgart to place coverage on the Oldsmobile with another carrier. On November 20, 1985, Baumgart deleted the Oldsmobile from the Travelers' policy and sent an application for insurance to American. By mailing the insurance application, Baumgart acted within his authority as local recording agent and bound coverage on the Oldsmobile with American for thirty days following the application's effective date of November 20, 1985.

On December 6, 1985, American sent Baumgart its rejection of the Venturas' application. The rejection confirmed that binder coverage would end on December 20, 1985. On December 31, 1985, one of the Venturas' employees was driving the Oldsmobile when it was involved in a collision. Sergio Martinez was injured and sued the employee, the Venturas, and the Venturas' law firm. Baumgart submitted a loss notice to American, who reminded Baumgart that the Venturas' application had been rejected and that the Oldsmobile was not covered. Baumgart, however, did not notify the Venturas that American had rejected their application until after the collision had taken place.

American undertook a defense of the Martinez lawsuit under a reservation of rights. On March 18, 1988, American paid \$100,000 to settle the suit. Thereafter, the Venturas assigned to American all their potential claims against Baumgart. Pursuant to the assignment, American sought indemnity from Baumgart for at least \$100,000, in addition to the claims accruing to American directly against Baumgart. American alleged that Baumgart was negligent in deleting the Oldsmobile from the Travelers' policy, which otherwise would have provided coverage at the time of the collision. American

751. 840 S.W.2d 634 (Tex. App.—Corpus Christi 1992, no writ).

also asserted claims against Baumgart for violations of the Texas Insurance Code, the DTPA, fraud, and breach of contract.

The trial court granted a partial summary judgment in favor of Baumgart ordering that American take nothing on all of its claims save its indemnity claim. American appealed and the court of appeals reversed and remanded.⁷⁵²

On appeal, Baumgart argued that the assignment of the Venturas' claims to American was void because Texas law does not allow a joint tortfeasor to purchase a claim from a plaintiff to whose injury a tortfeasor contributed.⁷⁵³ However, Baumgart did not prove, as a matter of law, that he and American were joint tortfeasors. Furthermore, the court held that since there was no statute expressly prohibiting this assignment, it was not void as against public policy.⁷⁵⁴

Baumgart next argued that American could not assert the Venturas' claims because the Venturas did not sustain any damages as American provided them a defense and even paid to settle the Martinez suit. The court rejected this argument as well, holding that the fact that American funded the settlement and paid the defense costs did not negate the damage element, as a matter of law, since the Venturas could have alleged additional compensatory damages against Baumgart.⁷⁵⁵

American complained that the trial court erred in holding that it had no right to bring a cause of action against Baumgart independent of the assignment. American contended that it had causes of action of its own for negligence, breach of contract, and fraud based on Baumgart's direct breaches of his duty to American. The court of appeals agreed.⁷⁵⁶

First of all, the court noted that American's alleged tortious acts injured the Venturas. If American was liable to the Venturas, it was liable only through Baumgart because he was its local recording agent. When American settled the Martinez suit and acquired an assignment of the Venturas' potential claims against Baumgart, it gained the right to seek indemnity against Baumgart.⁷⁵⁷

Secondly, the court held that American had a breach of contract claim against Baumgart independent of the assignment.⁷⁵⁸ American and Baumgart entered into an agency contract in which Baumgart became American's agent and was granted authority to procure applications for insurance on American's behalf. American alleged that Baumgart breached this contract by breaching the duty of good faith and fair dealing implicit in such contracts. The court held that the agency contract created a fiduciary duty and a special relationship giving rise to a duty of good faith and fair dealing in

752. *Id.* at 636.

753. *Beech Aircraft Corp. v. Jinkins*, 739 S.W.2d 19 (Tex. 1987).

754. *Baumgart*, 840 S.W.2d at 638.

755. *Id.*

756. *Id.*

757. *Id.*

758. *Id.* at 639.

every transaction made on American's behalf.⁷⁵⁹ Since Baumgart did not negate American's allegations, the court held that the summary judgment on such a claim was improper.⁷⁶⁰

Lastly, the court held that American had a negligence claim against Baumgart independent of the assignment.⁷⁶¹ American's negligence claim was that, had Baumgart exercised the care of an ordinary prudent local recording agent, then it would not have been compelled to undertake the defense of a risk that it had previously rejected. The court held that when management of a principal's property includes entering into contracts on the principal's behalf, the laws of negligence may also apply to the agent's acts with regard to those contracts.⁷⁶² In the present case, Baumgart did not negate American's allegations that his negligence caused it to suffer damages in defending and settling the Martinez suit.

In *Fidelity & Deposit Co. of Maryland v. Commercial Casualty Consultants, Inc.*⁷⁶³ Fidelity, an underwriter of bonds and insurance policies, brought suit against Ward and Benson as sole shareholders of Commercial Casualty, an independent insurance agency. Fidelity alleged that Commercial's corporate veil should be disregarded in holding Ward and Benson personally liable for the agency's debt, and that Ward and Benson knowingly breached their fiduciary duty to Fidelity in connection with the misappropriation and fraudulent personal use of insurance premium funds. The trial court found Ward and Benson liable on both the tort theory and the corporate disregard theory. The Fifth Circuit reversed the judgment on the corporate disregard theory, affirmed the judgment on the breach of fiduciary duty, and reversed Fidelity's award of attorney's fees against Ward and Benson.⁷⁶⁴

The court first held that Fidelity had produced insufficient evidence to establish the reliance component of the corporate disregard theory.⁷⁶⁵ The court explained that the corporate veil may be pierced when: (1) the corporation is the alter ego of its owners and shareholders; (2) the corporation is used for an illegal purpose; or (3) the corporation is used as a sham to perpetrate a fraud.⁷⁶⁶ Fidelity sought to recover under the third theory. The focus of the "sham to perpetrate a fraud theory," under which Fidelity sought to recover, is on "injustice or unfairness to the claimant caused by the corporation and its owners."⁷⁶⁷ The court noted that Fidelity failed to establish such unfairness because it failed to prove its own reliance on the financial backing of the owners, Ward and Benson. The court reasoned that Fidelity was never aware of Ward and Benson's financial condition or the extent of their involvement with Commercial. The court found no evidence sug-

759. *Baumgart*, 840 S.W.2d at 639.

760. *Id.*

761. *Id.*

762. *Id.*

763. 976 F.2d 272 (5th Cir. 1992).

764. *Id.* at 273.

765. *Id.* at 274.

766. *Id.* at 274-75.

767. *Id.* at 275 (citing *Pan Eastern Exploration Co. v. Hufo Oils*, 855 F.2d 1106, 1133 (5th Cir. 1988)).

gesting Fidelity specifically relied on Ward and Benson to personally perform Commercial's corporate functions or guarantee Commercial's performance. Therefore, the court concluded that Fidelity failed to prove the reliance necessary to prevail on its corporate disregard theory.⁷⁶⁸

The court did hold, however, that the evidence was sufficient to support the personal judgment against Ward and Benson for knowingly breaching their fiduciary duty to Fidelity.⁷⁶⁹ The court reasoned that Commercial's agency contract with Fidelity created a fiduciary relationship between the two parties.⁷⁷⁰ Commercial's breach of the duty implicit in such a special relationship was, therefore, sufficient to sustain Fidelity's independent tort action. The court noted that Ward and Benson had personal knowledge of Commercial's failure to keep insurance premium funds "separate and distinct" from general revenues despite the recommendations of a consultant, and later, the president of Commercial, to establish a separate account for insurance premiums.⁷⁷¹

VI. FRAUD

In *Fidelity & Guaranty Insurance Underwriters v. Saenz*⁷⁷² Saenz suffered a severe head injury when she fell over backwards in a chair at work. She was diagnosed with post-concussion syndrome and her doctor determined that her condition would require indefinite medical attention. Saenz sought to recover worker's compensation benefits from Fidelity, her employer's worker's compensation carrier. Armstrong was Fidelity's adjuster in charge of Saenz's case.

While continuing to pay Saenz's weekly benefits, Fidelity requested a pre-hearing conference before the Industrial Accident Board. Prior to this pre-hearing conference, Armstrong called Saenz and offered her \$65,000 cash and an additional five years of open medical. Saenz declined because she was concerned about future medical costs. At the prehearing conference, Saenz accepted Fidelity's settlement offer of \$65,000 cash and five years open medical care. Fidelity was represented by an attorney but Saenz was not. Saenz claimed that the only reason she accepted the offer was that Armstrong had told her that the maximum worker's compensation benefit she could receive was five years of medical care.

Saenz brought suit against Fidelity and Armstrong alleging various causes of action including fraud. The jury found that Fidelity ratified Armstrong's malicious, knowing, and fraudulent misrepresentation of the worker's compensation policy benefits to Saenz. Based on the jury's verdict, the court rendered judgment in favor of Saenz for \$50,000 for past mental anguish, \$200,000 for future mental anguish, \$500,000 for future medical care, and \$250,000 in punitive damages against Armstrong, and \$4 million in punitive

768. *Fidelity*, 976 F.2d at 275.

769. *Id.* at 275-76.

770. *Id.* at 276.

771. *Id.*

772. 865 S.W.2d 103 (Tex. App.—Corpus Christi 1993, writ requested).

damages against Fidelity. The court of appeals, en banc, reversed in part and rendered in part, and reversed and remanded in part.⁷⁷³

Fidelity first argued that the only remedy available to Saenz was a suit to rescind the settlement agreement. Because Saenz did not seek rescission, Fidelity argued, she had no remedy for any alleged fraud. The court, however, held that Saenz's action was not for additional worker's compensation benefits, but for recovery of damages resulting from Fidelity's misrepresentation of recoverable medical benefits and therefore concluded that Saenz was not required to seek rescission of the settlement agreement.⁷⁷⁴

Fidelity next asserted that the alleged statements made by Armstrong were only opinions about the law and thus were not actionable fraudulent misrepresentations of fact. The court noted that, generally, misrepresentations involving a point of law will not support an action of fraud. However, when a party having superior knowledge takes advantage of another's ignorance of the law to deceive that person, the misrepresentation can amount to fraud. Additionally, misrepresentations involving a point of law will be considered misrepresentations of fact if they were intended and understood as such.

The evidence in this case was that Saenz told Armstrong that she wanted workers' compensation to pay her lifetime medical benefits resulting from her head injury. Armstrong, however, told Saenz that the most workers' compensation would pay her as future medical benefits was five years. Moreover, Saenz testified that she mentioned to Armstrong that perhaps she should get an attorney. Armstrong responded that an attorney was not needed because the settlement would be the same, and Saenz would have to pay a lawyer twenty-five percent (25%) out of the settlement. Additionally, there was a letter from Fidelity's attorney to Armstrong suggesting that Saenz's case was potentially dangerous, and that efforts should be made to avoid scaring Saenz off to an attorney. From this evidence, the court held that the jury could infer that Armstrong intended the statement that workers' compensation would allow only five years of medical benefits was a fraudulent misrepresentation of a point of law.⁷⁷⁵ The court also concluded that this statement was a misrepresentation of fact and thus actionable as fraud.⁷⁷⁶

Fidelity next contended that there was no, or insufficient, evidence that any misrepresentation made by Armstrong was the proximate or producing cause of damages to Saenz. The court disagreed, pointing to the evidence that Saenz relied on Armstrong's statements and would not have signed the settlement agreement except for the representations made to her that the law did not allow her any additional medical benefits other than the five years offered by Fidelity.⁷⁷⁷

773. *Id.* at 108.

774. *Id.* at 110.

775. *Id.* at 111.

776. *Id.*

777. *Saenz*, 865 S.W.2d at 112.

Fidelity next complained about the damages awarded for Saenz's past and future mental anguish. Fidelity contended that the only evidence of mental anguish was that Saenz worried about who would pay the medical bills and that she might lose her home. The court held that to establish mental anguish, a plaintiff must show more than mere worry, anxiety, vexation, embarrassment, or anger.⁷⁷⁸ Here, the evidence showed that Saenz was very worried about who would pay the medical bills and was afraid that if she were responsible for the bills that she might lose her home. The court held that this evidence was sufficient to support the jury's finding of past mental anguish.⁷⁷⁹

The court further concluded that once the existence of mental anguish is established, much discretion must be given to the jury in setting the amount of the damages since claims for mental anguish are necessarily speculative.⁷⁸⁰ Because the court could not substitute its judgment for that of the jury, it upheld the award of \$50,000 for past mental anguish.⁷⁸¹ Likewise, the court affirmed the judgment of \$200,000 for future mental anguish damages.⁷⁸²

Fidelity next argued that there was no evidence, or insufficient evidence, to support the award of \$500,000 as future medical damages. The court agreed, because the only evidence presented was of future medical expenses related to Saenz's head injury, which was the subject of the workers' compensation claim.⁷⁸³ As such, said the court, article 8307 § 5 precludes recovery of these expenses without first rescinding the settlement agreement. The court, therefore, remanded the case to the trial court to consider rescission of the compromise settlement agreement with regard to future medical expenses.⁷⁸⁴

Fidelity next argued that there was no evidence, or insufficient evidence, to support the jury's finding that Fidelity ratified Armstrong's acts and representations relating to the settlement of Saenz's claim. The court noted that before Fidelity could be liable for exemplary damages based on Armstrong's conduct, Saenz had to prove that Fidelity ratified Armstrong's misrepresentations through a managerial agent.⁷⁸⁵ Saenz attempted to prove ratification by showing that Lawson, Armstrong's supervisor, was such a managerial agent. A managerial agent is one who has the authority to hire, fire, and direct employees of the corporation, or who has the authority to manage the entire corporation or a department or division of its business.⁷⁸⁶ The court concluded that Saenz failed to establish that Lawson was a managerial agent.⁷⁸⁷ The evidence presented at trial was that Lawson was a supervisor

778. *Id.* at 113.

779. *Id.*

780. *Id.* at 113-14.

781. *Id.* at 114.

782. *Saenz*, 865 S.W.2d at 114.

783. *Id.*

784. *Id.*

785. *Id.*

786. *Id.* at 115.

787. *Saenz*, 865 S.W.2d at 115.

for two or three claim adjusters and had worked for Fidelity for about twenty-five years. Additionally, there was evidence that Lawson approved of everything that Armstrong did in handling Saenz's claim. The court held that this evidence did not show that Lawson had the ability to hire, fire, and direct employees of the corporation, or had the authority to manage any part of Fidelity's business.⁷⁸⁸ The court further concluded that the evidence that Lawson approved of everything that Armstrong did could not be construed to mean that he approved of the misrepresentation to Saenz.⁷⁸⁹ The court, finding no evidence of ratification, thus reversed the award of \$4 million in punitive damages against Fidelity.⁷⁹⁰ The court, however, upheld the \$250,000 punitive damages assessed against Armstrong based on the finding of conscious indifference.⁷⁹¹

In *Shandee Corp. v. Kemper Group*⁷⁹² Shandee sued Kemper and its agent, Johnston, for fraud. Johnston told Shandee that its insurance policies with Kemper would be renewed and merged into a single Texas Multiple Perils (TMP) policy. Johnston then issued certificates of insurance reflecting the existence of a general liability policy with an effective date of July 20, 1986 through July 20, 1987. During the fall of 1986, Shandee experienced several losses and submitted claims to Kemper. Initially, Kemper paid those claims but later informed Shandee that the general liability policy had not been renewed and demanded reimbursement for payment of the claims. Shandee failed to make the reimbursement.

The jury found that Kemper and Johnston were guilty of fraud and assessed approximately \$52,000 in actual damages against each. The jury also found that a contract for general liability coverage existed for the period of July 1986 through July 1987 and this contract had been breached by Kemper. The trial court disregarded the jury findings of fraud against Kemper and of fraud as to the general liability policy by Johnston.

Shandee first argued that the judgment n.o.v., which disregarded the findings that Kemper had engaged in fraud, was improper because there was evidence that Kemper directly participated in the fraud. Shandee argued that Kemper's payment of claims in the fall of 1986, and its subsequent refusal to pay additional claims because of lack of coverage constituted fraud. The court held that this could constitute a material misrepresentation that coverage existed, but that Shandee was not damaged by this misrepresentation.⁷⁹³ Kemper paid the claims and later requested reimbursement of the amounts paid, but Shandee never reimbursed Kemper for those sums. Additionally, Kemper's notice that the general liability policy had not been renewed and Kemper's refusal to pay additional claims could not constitute material misrepresentations because they were true. The court, therefore,

788. *Id.* at 115-16.

789. *Id.* at 117.

790. *Id.*

791. *Id.* at 118.

792. No. C14-92-00126-CV (Tex. App.—Houston [14th Dist.], Sept. 30, 1993, n.w.h.).

793. *Id.*, slip op. at 4.

found no evidence of any fraudulent acts committed directly by Kemper.⁷⁹⁴

After the jury returned its second verdict against Johnston finding fraud in connection with the TMP policy and awarding \$1 million in exemplary damages, the trial court disregarded the finding of fraud as to the TMP policy and reduced the exemplary damages to \$80,000. On appeal, Shandee argued that the evidence supported the jury's finding of fraud by Johnston in the handling of the TMP policy and that the court erred by reducing the exemplary damages. According to the court of appeals, the evidence showed that Johnston represented that the general liability policy would be renewed as a TMP policy. Furthermore, Johnston advised Kemper not to renew the general liability policy because Shandee would be applying for a TMP. Kemper did not issue a TMP policy because it claimed it never received a completed application from Johnston, who was responsible for making the application on behalf of Shandee. The court held that this was sufficient evidence that Johnston made a false material misrepresentation and that Johnston intended for Shandee to rely on it.⁷⁹⁵ The court, therefore, held that the trial court erred in disregarding the jury's findings regarding fraud in connection with the TMP policy.⁷⁹⁶

The court also held that the jury's award of \$1 million as exemplary damages was not excessive or unreasonable.⁷⁹⁷ The court held that there is no set ratio between the amount of actual damages and the amount of exemplary damages, and whether exemplary damages are reasonable depends upon the facts of each case.⁷⁹⁸ Five factors to consider include: (1) the nature of the wrong; (2) the character of the conduct involved; (3) the degree of culpability of the wrongdoer; (4) the situation and sensibilities of the parties concerned; and (5) the extent to which such conduct offends a public sense of justice and propriety.⁷⁹⁹ The court held that insurance consumers depend on the representations of agents regarding coverage, and when insurance agents fail to live up to their promises, the consumers can suffer catastrophic losses.⁸⁰⁰ Johnston's representations that he was obtaining coverage and his subsequent failure to submit an application and obtain coverage for Shandee constituted outrageous conduct that could have caused far more damage to Shandee. The court, therefore, held that the trial court should not have reduced the exemplary damages assessed Johnston.⁸⁰¹

VII. DUTY TO DEFEND

In deciding whether an insurer has a duty to defend, the court must look only to the pleadings in the case brought against the insured and the insurance policy. The court cannot consider the truth or falsity of the allegations

794. *Id.*

795. *Id.*, slip op. at 7-8.

796. *Id.*, slip op. at 8.

797. *Shandee*, slip op. at 5.

798. *Id.*

799. *Id.*

800. *Id.*

801. *Id.*

in the underlying pleadings, and cannot consider facts ascertained before, during, or after the suit. If the factual allegations against the insured, when fairly and reasonably construed, state a cause of action potentially covered by the policy, the insurer has a duty to defend. In determining the applicability of provisions of the policy, the court must focus on the facts that show the origin of the damages, not the legal theories asserted for recovery. Furthermore, the court must indulge a liberal interpretation of the meaning of the allegations and resolve any doubt regarding coverage in favor of the insured.⁸⁰²

A. LIABILITY INSURANCE

1. What Is an "Occurrence"?

In *Old Republic Insurance Co. v. Comprehensive Health Care Associates, Inc.*⁸⁰³ the court held that there is no duty to defend a sexual harassment claim because such a claim is excluded from the definition of "occurrence" as an intentional act.⁸⁰⁴ Hankins, Robertson, and Brasier were employed as nurses at a nursing home owned and operated by CHCA. Claiming that Tarris, the administrator of CHCA, subjected them to sexual harassment that ultimately resulted in their resignations, the nurses filed suit against Tarris and CHCA alleging sexual harassment, discrimination, gross negligence, and negligent hiring. CHCA was insured by Old Republic and Unigard and both companies refused to defend CHCA in the nurses' lawsuit. Tarris and CHCA ultimately hired their own attorney and received a verdict in their favor. The insurers brought this action seeking a declaratory judgment that they had no duty to defend.

According to the court, the basis of the nurses' suit against Tarris and CHCA was that Tarris engaged in intentional acts constituting sexual harassment. The question for the court, therefore, was whether an "occurrence" under the policy included intentional or willful acts. The Old Republic policy defined "occurrence" as those damages neither expected nor intended from the standpoint of the insured, while the Unigard policy defined "occurrence" as an accident, including continuous or repeated exposure to conditions, which result in personal injury, property damage, or advertising liability neither expected nor intended from the standpoint of the insured. The court found that similar definitions of "occurrence" have consistently been interpreted as excluding coverage for intentional acts.⁸⁰⁵ In

802. All or some of these principles are set forth in *Adamo v. State Farm Lloyds Co.*, 853 S.W.2d 673 (Tex. App.—Houston [14th Dist.] 1993, writ denied); *Cullen/Frost Bank of Dallas v. Commonwealth Lloyd's Ins. Co.*, 852 S.W.2d 252 (Tex. App.—Dallas 1993, writ granted); and *Old Republic Ins. Co. v. Comprehensive Health Care Assoc.*, 786 F. Supp. 629 (N.D. Tex. 1992), *aff'd*, 2 F.3d 105 (5th Cir. 1993).

803. 786 F. Supp. 629 (N.D. Tex. 1992), *aff'd*, 2 F.3d 105 (5th Cir. 1993).

804. *Id.* at 633. On appeal, the Fifth Circuit held that the exclusions under the policies were dispositive and therefore declined to revisit the meaning of "occurrences." *Old Republic*, 2 F.3d at 107.

805. *Old Republic*, 786 F. Supp. at 632.

fact, in *Aberdeen Insurance Co. v. Bovee*⁸⁰⁶ the court found that the insurer did not have a duty to defend sexual harassment claims because the policy did not provide for such a duty. The court, thus concluded that the insurers did not have a duty to defend Tarris and CHCA in the nurses' lawsuit that arose out of claims of sexual harassment because the claims alleged intentional acts that were not "occurrences" for purposes of policy coverage.⁸⁰⁷

In *Cullen/Frost Bank of Dallas v. Commonwealth Lloyd's Insurance Co.*⁸⁰⁸ the bank foreclosed on a condominium project and began selling individual units. In 1987, some of the condominium owners sued the bank for negligence, misrepresentations under the DTPA, breach of express and implied warranties, and for rescission due to defects in the property. (This will be referred to as the Tompkins suit.) The bank had comprehensive general liability policies with Commonwealth and United States Fire Insurance Company, both of whom were notified of the Tompkins suit. The bank demanded from the insurers a defense and indemnity. The insurers refused to defend, claiming that the allegations in the Tompkins suit were not within coverage or were, alternatively, excluded from coverage. The insurers then filed this action for a declaratory judgment that they had no duty to defend the bank in the Tompkins suit. The bank counterclaimed for a defense and indemnity. The trial court granted the insurers' motion for summary judgment finding that, as a matter of law, the insurers had no duty to defend the bank. The court of appeals reversed and remanded the cause to the trial court.⁸⁰⁹

The insurers asserted that they did not have a duty to defend because the allegations in the Tompkins suit failed to allege an "occurrence" as defined in the policies. The bank contended that the Tompkins plaintiffs alleged continuous or multiple occurrences that fell within coverage periods of all five insurance policies, while the insurers argued that there was only one occurrence in the Spring of 1986, when the Tompkins plaintiffs discovered the property damage. The policies defined "occurrence" as, "an accident, including continuous, or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured."

The court held that the time of the occurrence was when the complaining party was actually damaged, not the time when the wrongful act was committed.⁸¹⁰ In cases involving continuous or repeated exposure to a condition, there can be more than one manifestation of damage, and hence, an "occurrence" under more than one policy.⁸¹¹ The court held that under the definition of "occurrence" in this case, there could be a new "occurrence" each time the complaining parties suffered damage.⁸¹²

806. 777 S.W.2d 442, 444 (Tex. App.—El Paso 1989, no writ).

807. *Old Republic*, 786 F. Supp. at 633.

808. 852 S.W.2d 252 (Tex. App.—Dallas 1993, writ granted).

809. *Id.* at 254.

810. *Id.* at 257.

811. *Id.*

812. *Id.*

The allegations in the Tompkins case were that the defects were discovered in the Spring of 1986. However, the allegations did not make it clear that all the property damage had manifested itself by the Spring of 1986. In fact, the petition asserted that the bank's failure to remedy the defects had caused repeated and continued exposure, causing loss of use of the property. The court, therefore, concluded that there were allegations that at least some property damage manifested itself after the Spring of 1986 and that the suit involved more than one "occurrence."⁸¹³

The insurers also argued that there could be no coverage because the bank intended or expected the accident constituting the "occurrence" because it knew about the damage in the Spring of 1986. The court noted that there were inconsistent allegations as to who inspected the property in the Spring of 1986 and discovered the defects. At one point the Tompkins plaintiffs alleged that they inspected the building, while at another point they alleged that the bank conducted the inspection. The court decided that it must accept the allegation that the Tompkins plaintiffs inspected the property in resolving this doubt.⁸¹⁴ The court also noted that there was no allegation that the Tompkins plaintiffs informed the bank of the damage.

Another reason the insurers asserted for failing to provide a defense was that the Tompkins suit failed to allege property damage, which was defined in the insurance policies as:

- (1) physical injury to or destruction of tangible property which occurs during the policy period, including the loss of use thereof at any time resulting therefrom, or (2) loss of the use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an occurrence during the policy period.

The court found that the Tompkins plaintiffs alleged property damage in accordance with this definition as they complained of drainage problems in the garage floor, excessive floor displacement, warped and swollen door and window frames, rotten woodwork on patio doors and window sills, warped and uneven floors, and repeated breakdown of elevators.⁸¹⁵

The insurers also claimed that they did not have a duty to defend because the policies excluded from coverage property that had been alienated by the bank. The court noted that while the bank had sold nine of the condominium units, it had retained ownership of one unit and a corresponding percentage of the common areas. The court held that the alienated-property exclusion precluded coverage of the underlying claims only to the extent that the Tompkins suit alleged damages to the plaintiffs' individual condominium units.⁸¹⁶ However, this exclusion did not apply to the allegations based on property damage to a common area that was not alienated by the bank.

Similarly, the court held that the completed-operations exclusion did not apply because not all of the alleged property damage occurred on the prem-

813. *Cullen/Frost*, 852 S.W.2d at 258.

814. *Id.*

815. *Id.* at 256.

816. *Id.* at 259.

ises no longer owned by the bank.⁸¹⁷ As previously noted, the bank had not relinquished all the possession and control to the common areas and part of the complaint in the Tompkins suit involved the common areas. Moreover, the policy providing coverage from April 9 to November 6, 1987, did not contain a completed-operations exclusion and, therefore, there was a possibility of coverage giving rise to the duty to defend under this policy.

2. Policy Exclusions

*Abe's Colony Club, Inc. v. C & W Underwriters, Inc.*⁸¹⁸ is a duty to defend case involving a liquor liability exclusion. Abe's Colony Club was sued by Callihan for injuries he incurred in a vehicle accident caused by an intoxicated patron of a bar owned and operated by Abe's. Abe's requested that C & W and Mt. Hawley Insurance defend the suit based on Abe's liability insurance policy. Both insurers refused to provide a defense. Abe's later brought suit against C & W and Mt. Hawley for expenses incurred in defending against Callihan's claim. Mt. Hawley and C & W sought a summary judgment that no defense was required due to a liquor liability exclusion provision in the policy and due to the statute of limitations barring Abe's DTPA, Insurance Code, and breach of the duty of good faith and fair dealing causes of action. The trial court granted this motion and the court of appeals affirmed.

The policy issued by Mt. Hawley to Abe's provided that there was no coverage for loss resulting from a violation of any statute, ordinance, or regulation pertaining to the sale, gift, distribution, or use of any alcoholic beverage, or by reason of the selling, serving, or giving of any alcoholic beverage to a minor or a person under the influence of alcohol, or which causes or contributes to the intoxication of any person. The court held that this exclusion negated coverage for liability arising out of the business of selling or serving alcohol.⁸¹⁹ Abe's argued that some of the allegations made by Callihan fell outside of the liquor liability exclusion, namely that Abe's was negligent in its failure to determine, discover, or notice that its customer was intoxicated, in its failure to offer its patron alternative transportation, and in its failure to properly train and supervise its employees. The court found that all of these allegations arose from the business of selling or serving alcohol to a person under the influence of alcohol or that causes or contributes to the intoxication of any person. Therefore, Callihan's complaint fell within the liquor liability exclusion and Mt. Hawley had no duty to defend under the policy.⁸²⁰

The court also affirmed the summary judgment based on limitations, holding that limitations began to run at the time Mt. Hawley denied coverage under the policy, rather than the date the underlying lawsuit became final.⁸²¹

817. *Id.* at 260.

818. 852 S.W.2d 86 (Tex. App.—Fort Worth 1993, writ denied).

819. *Id.* at 89.

820. *Id.*

821. *Id.* at 91.

Because Mt. Hawley denied Abe's coverage under the policy more than three years before Mt. Hawley was sued, the court held that Abe's DTPA, Insurance Code, and duty of good faith and fair dealing claims were barred by limitations.⁸²²

The liquor liability exclusion was also the subject of *Western Heritage Insurance Co. v. River Entertainment*.⁸²³ Western Heritage sought a declaration that it had no duty to defend or indemnify its insured, River Entertainment, in connection with a lawsuit Rodriguez brought against Hill and River Entertainment. Rodriguez originally alleged that Hill became intoxicated at an establishment owned by River Entertainment, and on his way home ran into Rodriguez's vehicle, killing his daughter. River Entertainment requested that Western Heritage defend and indemnify it pursuant to the terms of Western Heritage's comprehensive general liability policy. Western Heritage declined because of a liquor liability exclusion in the policy.

In the declaratory judgment action, the federal district court concluded that Western Heritage had no duty to defend River Entertainment. The district court dismissed the action as to the indemnity issue because any decision regarding indemnity would amount to an advisory ruling. The Fifth Circuit affirmed in part and modified and rendered in part.⁸²⁴

River Entertainment argued that the district court erred in finding no duty to defend because it did not follow the "complaint allegation rule" under Texas law. This rule, as mentioned above, asserts that an insurer's duty to defend is determined only by reference to the petition and the policy's provisions. In this case, the pleading under consideration by the court had no references to Hill being intoxicated or under the influence of alcohol. These allegations were removed from Rodriguez's petition after Western Heritage asserted the liquor liability exclusion. Yet, the district court considered facts extraneous to this petition and determined that because Hill's impaired state was a result of having consumed numerous alcoholic beverages, the liquor liability exclusion applied and Western Heritage had no duty to defend. The Fifth Circuit held that the district court's consideration of extraneous facts was proper because the petition did not contain sufficient facts to enable the court to determine if coverage existed.⁸²⁵ Relying on *State Farm Fire & Casualty Co. v. Wade*,⁸²⁶ the court concluded that Texas law would sanction the district court's methodology in reaching its conclusion.⁸²⁷

In *Wade* the court was faced with the issue of whether a private boat owner's policy would provide a defense to an underlying action brought by the representatives of a deceased passenger. The insurer alleged that the decedent was using the boat in a commercial activity and this was excluded

822. *Id.*

823. 998 F.2d 311 (5th Cir. 1993).

824. *Id.* at 315.

825. *Id.* at 314.

826. 827 S.W.2d 448 (Tex. App.—Corpus Christi 1992, writ denied).

827. *Western Heritage*, 998 F.2d at 314.

from coverage. Because the petition did not state how the boat was being used, the court looked to extraneous facts to make this determination, which was critical to resolving the issue of coverage. The Fifth Circuit held that it was impossible to discern from the Rodriguez complaint why Hill was impaired to the point where River Entertainment's employees should have restrained him.⁸²⁸ According to the court, such an explanation is critical to the question of coverage, and thus consideration of extraneous facts was proper.⁸²⁹ The court further held that because there was no duty to defend under the policy in light of the liquor liability exclusion, there could be no duty to indemnify.⁸³⁰ Therefore, the Fifth Circuit modified the judgment of the district court and rendered judgment that Western Heritage had no duty to defend or indemnify River Entertainment.⁸³¹

Departing even further from the complaint allegation rule is the case of *Ohio Casualty Insurance Co. v. Cooper Machinery Corp.*⁸³² In this case, Ohio Casualty sought a declaration that it had no obligation to defend or indemnify its insured, Cooper, in an action brought by James. James alleged that he sustained damages in an accident caused by a defective steamroller sold to his employer by Cooper and manufactured by Mauldin. Ohio Casualty refused to defend and indemnify Cooper based on the policy exclusion for completed operations. James then amended his pleadings to allege that Mauldin and Cooper failed to properly complete and finish the manufacturing of the steamroller. Cooper, thus, argued that the complete operations hazard exclusion did not apply.

The court, ignoring the principle that the truth or falsity of the allegations in the underlying pleadings cannot be considered, held that Ohio Casualty could avoid its defense obligation by showing extrinsic facts that the allegations indicating coverage are in fact false and that under the true facts there is no coverage.⁸³³ The court felt that James's petition, on its face, did not state a cause of action within coverage. But, said the court, "even if there were allegations of facts that would indicate the existence of coverage, the insurance company would be entitled in the declaratory judgment action to establish that the facts are false and that, therefore, there is no obligation under the policy, either to defend or to pay."⁸³⁴

In *Fidelity & Deposit Co. of Maryland v. Conner*⁸³⁵ Fidelity & Deposit brought a declaratory judgment action after several former directors of an insolvent bank requested a defense in an action brought against them by the FDIC and in which the directors asserted claims against each other. Fidelity & Deposit refused to provide a defense under the directors and officers liability insurance policy it had issued to the failed bank, claiming coverage

828. *Id.* at 315.

829. *Id.*

830. *Id.*

831. *Id.*

832. 817 F. Supp. 45 (N.D. Tex. 1993).

833. *Id.* at 48.

834. *Id.*

835. 973 F.2d 1236 (5th Cir. 1992).

was precluded by the "regulatory"⁸³⁶ and "insured vs. insured"⁸³⁷ exclusions. The district court granted summary judgment for Fidelity & Deposit, and the Fifth Circuit affirmed.⁸³⁸

The FDIC argued that the exclusions did not apply because its action was a shareholder/depositor derivative action. The court rejected this argument since the FDIC made no attempt to show an independent breach of duty toward the bank's depositors or shareholders—a requirement for independent shareholder liability.⁸³⁹ Moreover, the FDIC made no effort to comply with Rule 23.1 of the Federal Rules of Civil Procedure, which is the rule that sets forth the pleading requirements of a shareholders' derivative action. Rather than being a shareholders' derivative action, the court found that the FDIC's claims were asserted as subrogee of the bank.⁸⁴⁰

The FDIC next argued that enforcement of these exclusions would violate public policy by depriving it of its rights under the Financial Institutions Reform, Recovery and Enforcement Act (FIRREA).⁸⁴¹ The court held that generally people have the utmost liberty of contract and these agreements will be invalidated on grounds of public policy only in very limited situations.⁸⁴² The court concluded that public policy did not preclude the enforcement of the exclusions because public policy cannot be used to create coverage that does not otherwise exist.⁸⁴³ Moreover, Congress rejected a proposal by the FDIC to include in FIRREA a provision that would have rendered unenforceable the regulatory and insured vs. insured exclusions.⁸⁴⁴ Thus, the court rejected the notion that FIRREA's policy would be impaired by enforcing the exclusions since Congress had revealed its desire to remain neutral on this issue.⁸⁴⁵

The FDIC was also unsuccessful in its attempt to convince the court that the exclusions were ambiguous and thus should be construed in favor of coverage. The court held that the exclusions are clear, plain and unequivocal and thus would not read ambiguity into the policy language.⁸⁴⁶

In *United States Fire Insurance Co. v. FDIC*⁸⁴⁷ United States Fire sought a declaration that a fidelity bond it had issued to protect Empire Savings and Loan from employee fraud and dishonesty automatically terminated when

836. This exclusion provided that Fidelity & Deposit would not be liable for any loss in connection with claims made against the directors and officers by "any State or Federal Official or Agency, including but not limited to the Federal Deposit Insurance Corporation or Federal Savings and Loan Insurance Corporation." *Id.* at 1238.

837. This exclusion provided that Fidelity & Deposit would not be liable for any loss in connection with claims made against the directors and officers by "any other Director or Officer of the Bank/Association or by the Bank/Association, except for a shareholders' derivative action . . ." *Id.*

838. *Id.*

839. *Id.* at 1240.

840. *Conner*, 973 F.2d at 1241.

841. 12 U.S.C. §§ 1811-1833(e) (1989).

842. *Conner*, 973 F.2d at 1241.

843. *Id.* at 1243.

844. *Id.* at 1242.

845. *Id.* at 1242-43.

846. *Id.* at 1245.

847. 981 F.2d 850 (5th Cir. 1993).

Empire was placed in supervision. The district court granted summary judgment in favor of United States Fire and the Fifth Circuit affirmed.⁸⁴⁸ The bond provided that it would automatically terminate "immediately upon the taking over of the Insured by a receiver or other liquidator or by State or Federal officials." The FDIC argued that this provision was contrary to public policy, was ambiguous, and that a takeover did not occur. The Fifth Circuit dismissed these arguments as each had been previously rejected by the court in *Sharp v. FSLIC*.⁸⁴⁹ The court further held that a takeover did indeed occur even though Empire placed itself under voluntary supervisory control by the Texas Savings and Loan Commission.⁸⁵⁰ The court found that Empire, in doing so, was prohibited from engaging in activities that are core functions of a savings and loan. Since another entity assumed control or management of Empire, the court held that a takeover did occur.⁸⁵¹

3. *Excess Liability Carriers*

*Columbia Mutual Insurance Co. v. Fiesta Mart, Inc.*⁸⁵² was a declaratory judgment action brought by Columbia, Fiesta's excess liability insurer, after the demand that it indemnify Fiesta for a \$7 million judgment. Fiesta had leased space in its stores to Monytron in order to provide financial services to its customers. However, Monytron proceeded to defraud Fiesta's customers by siphoning deposits and investments involving an illegal conversion of pesos to dollars. After Fiesta notified Columbia of the pending class action suit, Columbia issued a reservation of rights letter and refused to defend Fiesta in the resulting legal action. Fiesta ultimately settled the claims against it for \$7 million and demanded indemnification from Columbia. The district court granted summary judgment for Fiesta, holding that Columbia was obligated to indemnify it for the judgment. The Fifth Circuit reversed.⁸⁵³

The court first noted that when an insurer breaches a duty to defend it is bound in subsequent proceedings by a settlement or judgment rendered against the insured. However, said the court, the issue of the insured's liability and coverage under the policy are separate and distinct. Thus, a prior judgment establishing liability of the insured to a third-party is not binding in a subsequent proceeding to determine whether the insurance policy provides coverage requiring the insurer to defend and/or indemnify the insured.⁸⁵⁴ Moreover, the insurer will not be bound by liability findings against the insured unless the finding was essential to the judgment and privity existed between insurer and insured.⁸⁵⁵

The judgment against Fiesta stated that Fiesta's negligence and DTPA

848. *Id.* at 852.

849. 858 F.2d 1042 (5th Cir. 1988).

850. *U. S. Fire Ins.*, 981 F.2d at 851.

851. *Id.* at 851.

852. 987 F.2d 1124 (5th Cir. 1993).

853. *Id.* at 1125.

854. *Id.*

855. *Id.*

violations were an "occurrence" resulting in property damage and bodily injury. The court held that this finding of "occurrence" was not essential to a judgment based on negligence or DTPA violations.⁸⁵⁶ The court also concluded that there was no privity between Columbia and Fiesta because their positions regarding coverage were in conflict.⁸⁵⁷ Therefore, the court concluded that the establishment of Fiesta's liability did not prevent the litigation of Columbia's insurance coverage in the present case.⁸⁵⁸

The court next held that Fiesta's exposure to Monytron's fraudulent activity did not constitute an "occurrence" under Columbia's insurance policy.⁸⁵⁹ The court reasoned that the "occurrence" in question was not due to Fiesta's direct negligent and unknowing acts.⁸⁶⁰ Instead, Fiesta's liability was "related [to] and interdependent" on Monytron's fraud.⁸⁶¹ The court, therefore, construed the "ultimate issue" to be whether Columbia's insurance policy covered Monytron's fraudulent activity.

Noting the lack of Texas Supreme Court authority, the court agreed with *Houston Petroleum Co. v. Highlands Insurance Co.*⁸⁶² which held that an insured's exposure to the fraud of a third party does not comport with its insurance policy's definition of an "occurrence."⁸⁶³ The court concluded that Fiesta's mere exposure to Monytron's fraud did not constitute an "occurrence" under Columbia's policy, and thus there was no coverage.⁸⁶⁴

In *Harbor Insurance Co. v. Urban Construction Co.*⁸⁶⁵ Harbor brought a declaratory judgment suit, as Urban's excess liability insurer, after the demand that it indemnify Urban for its share of a \$1.26 million judgment. During the policy period, Urban was sued for property damage caused by defects in the construction of a condominium project. As general contractor, Urban had subcontracted most of the work on the project. Urban notified Harbor of the pending suit, and Harbor reserved its rights under the policy pending an investigation of the claim. Urban's previous insurance policy with Harbor had contained a special endorsement that covered property damage performed on behalf of Urban. However, the endorsement was mistakenly omitted from the renewal policy.

As a result of arbitration, Urban was found liable for the construction defects in the amount of \$1.26 million. Urban's primary insurers tendered the limits of their policies. However, Harbor refused to pay under the claim and filed this declaratory judgment action. Urban counterclaimed for breach of contract, negligence, and violations of the Texas Insurance Code and DTPA. The district court granted summary judgment for Harbor on all

856. *Id.* at 1128.

857. *Columbia Mut.*, 987 F.2d at 1128.

858. *Id.*

859. *Id.*

860. *Id.*

861. *Id.* (citing *Old Republic Ins. Co. v. Comprehensive Health Care Assoc., Inc.*, 786 F. Supp. 629, 632 (N.D. Tex. 1992)).

862. 830 S.W.2d 153 (Tex. App.—Houston [1st Dist.] 1990, writ denied).

863. *Id.* at 155-56.

864. *Columbia Mut.*, 987 F.2d at 1128.

865. 990 F.2d 195 (5th Cir. 1993).

claims. The district court reasoned that it was precluded from considering any extrinsic evidence of the coverage issue, even if offered to prove the parties were mutually mistaken that coverage existed under the policy. The district court further reasoned that Urban's statutory counterclaims were barred by the statute of limitations because Urban should have discovered that the renewal policy lacked the desired endorsement when it was delivered, or at the latest when Urban was sued for defective construction. The Fifth Circuit affirmed.⁸⁶⁶

The court first repudiated the district court's conclusions that (1) the parol evidence rule prevented reformation of an integrated policy containing a mutual mistake; and (2) as a matter of law, Urban was bound by the terms of the policy when it accepted the policy.⁸⁶⁷ Instead, the Fifth Circuit held that Texas law allows reformation even when a written contract purports to be completely integrated.⁸⁶⁸ Moreover, the court noted that "the parol evidence rule does not preclude such a showing of mistake."⁸⁶⁹ The court also held that under Texas law, an insured's failure to read an insurance policy does not bar correction of the mistake.⁸⁷⁰ The insured, said the court, is not required to examine the delivered policy, and may rely on the assumption that the agreement was expressed in writing.

The court held, however, that the statute of limitations barred Urban's assertion of mutual mistake under the policy.⁸⁷¹ The court viewed Urban's action as one for reformation of a contract rather than breach of an intended agreement. Even though intended agreements can be enforced without a prior action for reformation, the court held that because a party asserting mutual mistake is in essence seeking reformation, the statute of limitations applicable to reformation actions also applies to the defense of mutual mistake.⁸⁷² Thus, the court held that limitations began to run when Urban knew, or should have known, that the policy did not contain the desired endorsement.⁸⁷³ The evidence showed that Urban knew of the omission in 1981 and should have known of this omission, at the latest, in February 1985 when it was sued. Urban, however, did not assert mutual mistake until September 1989, after Harbor denied the claim. Accordingly, the court concluded that Urban's failure to assert reformation in a timely fashion due to mutual mistake precluded its contractual claim against Harbor.⁸⁷⁴

Because Urban could not insist on the policy with the desired endorsements — the only basis for coverage — the court held that Harbor had a

866. *Id.* at 202.

867. *Id.* at 199.

868. *Id.*

869. *Id.* See *Cherokee Water Co. v. Forderhause*, 741 S.W.2d 377, 379 (Tex. 1987) (quoting RESTATEMENT (SECOND) OF CONTRACTS § 155, cmt. a (1981)).

870. *Harbor Ins.*, 990 F.2d at 199-200 (citing *Aetna Ins. Co. v. Paddock*, 301 F.2d 807, 811 (5th Cir. 1962)).

871. *Id.* at 200-01.

872. *Id.* at 200.

873. *Id.* at 201.

874. *Id.*

reasonable basis for denying Urban's claim.⁸⁷⁵ Thus, the court concluded that Harbor did not breach its duty of good faith and fair dealing.⁸⁷⁶

The court affirmed the remainder of the district court's rulings.⁸⁷⁷ The court held that Urban's negligence claim failed because Harbor had a reasonable basis for denying coverage; Harbor was, therefore, not negligent for refusing to settle the underlying suit.⁸⁷⁸ The court also held that limitations barred Urban's misrepresentation claims under the Texas Insurance Code and the DTPA due to its knowledge of the omission of the endorsement in 1981.⁸⁷⁹

The court, by forcing Urban to bring suit for reformation within four years of its discovery of the absence of the endorsement, but before Harbor's denial of the claim, requires Urban to accurately predict that Harbor would not abide by the agreement, even though both parties admitted they knew the true nature of the agreement. The limitations should have begun to run from the time Urban knew, or should have known, that Harbor would not comply with the agreement. This did not happen until April 1989, when Harbor reserved its rights under the policy pending an investigation of the claims asserted against Urban. Within days after Harbor's denial of the claim in September 1989, the suit was filed and Urban was asserting mutual mistake to prove the true agreement.

The inequities of the court's decision are shown by the evidence that the custom in the insurance industry is to provide coverage on the basis of intended agreements as shown by underwriting files regardless of actual policy language.⁸⁸⁰ Thus, Urban justifiably expected Harbor to provide coverage as provided in the endorsement and had no reason to institute a suit for reformation until it became clear that Harbor would act differently. The court has allowed the insurer to take advantage of an industry custom and practice to the detriment of the insured.

B. HOMEOWNERS' INSURANCE

In *Chiles v. Chubb Lloyds Insurance Co.*⁸⁸¹ Lloyds issued a homeowner's policy that provided Chiles personal liability coverage for bodily injury damages he might become obligated to pay. The policy excluded coverage for damages resulting from bodily injury caused intentionally by, or at the direction of, the insured. Patti Chiles sued Chiles for divorce, and sought damages resulting from his alleged intentional and negligent conduct, which caused her physical pain and mental anguish. Patti's negligence claims were not submitted to the jury, and the trial court entered judgment awarding Patti monetary damages for Chiles intentional infliction of emotional distress. On appeal, the Fourteenth Court of Appeals modified the trial court's

875. *Harbor Ins.*, 990 F.2d at 201.

876. *Id.* at 202.

877. *Id.*

878. *Id.*

879. *Id.*

880. *Harbor Ins.*, 990 F.2d at 201 n. 7.

881. 858 S.W.2d 633 (Tex. App.—Houston [1st Dist.] 1993, writ denied).

judgment, and denied Patti all relief except the granting of the divorce.⁸⁸²

Chiles first notified Lloyds of the suit and Patti's claims after the trial and requested that Lloyds pay the cost of defense in this divorce action. In this declaratory judgment action, the trial court determined that Lloyds did not owe a duty to Chiles to defend or pay the cost of a defense because Chiles breached the policy's conditions. The court of appeals affirmed.⁸⁸³

Chiles argued to the court of appeals that he did not breach the policy's condition precedent concerning notice because Texas law does not consider a timely notice provision in a general liability policy to be a condition precedent to coverage. The court noted that by an amendatory endorsement effective May 1, 1973,⁸⁸⁴ and applicable to all general liability policies in Texas, the State Board of Insurance now requires that the insurer be prejudiced by the insured's failure to forward suit papers before such a failure will bar liability under the policy.⁸⁸⁵ However, there was no showing to the trial court that this endorsement applied to homeowner's policies, or that a homeowner's policy is a general liability policy. Moreover, Lloyds presented an affidavit from an employee of the Department of Insurance who stated that he had searched all the policy forms and endorsements for homeowner's insurance and could find no endorsement for homeowner's policies requiring the insurer to show prejudice before denying coverage for the lack of timely notice. Therefore, because the homeowner's policy in this case stated that notice was a condition precedent, the court of appeals held that Lloyds had no duty to defend or pay defense costs because Chiles failed to give timely notice of his claims.⁸⁸⁶

In *Adamo v. State Farm Lloyds Co.*⁸⁸⁷ the court was presented with the issue of whether State Farm had a duty to defend Adamo in a legal malpractice claim pursuant to the terms of his homeowner's policy. When Marino was subpoenaed to appear before a grand jury, he turned to Adamo, his friend and attorney, for advice. Marino alleged that Adamo advised him to leave the country until the criminal investigation was resolved. Marino and Adamo then made arrangements for the transfer of Marino's personal property and management of his business to Rebescher, a friend of Adamo. When Marino returned to the United States, he found that his business had been reincorporated under a different name and Rebescher refused to relinquish control. Marino then sued Adamo and his wife, Tana, Adamo's law partner and Rebescher for legal malpractice, breach of contract, breach of fiduciary duty, fraud and conspiracy to defraud, and conversion.

Adamo requested a defense from State Farm under his homeowner's policy. State Farm determined that it had no duty to defend because of policy exclusions for business pursuits and the rendering of professional services. State Farm then filed this declaratory judgment action. The trial court

882. *Id.* at 635.

883. *Id.*

884. Board Order 23080.

885. *Chiles*, 858 S.W.2d at 635.

886. *Id.* at 635-36.

887. 853 S.W.2d 673 (Tex. App.—Houston [14th Dist.] 1993, writ denied).

granted a summary judgment in favor of State Farm. The court of appeals affirmed.⁸⁸⁸

Adamo argued that if a case is potentially within policy coverage, the insurer has a duty to defend, even if some of the causes of action are clearly outside coverage. Adamo claimed that Marino's lawsuit potentially fell within coverage because he alleged that a fiduciary relationship existed between the parties as the result of a long-time personal friendship. Thus, according to Adamo, there existed the potential that Marino's causes of action arose out of a personal, rather than a professional, relationship.

The court rejected this argument, holding that it is not the cause of action alleged which determines coverage, but the facts giving rise to the alleged actionable conduct.⁸⁸⁹ The court concluded that Marino's damages stemmed from the professional relationship between him and Adamo, acting as his attorney.⁸⁹⁰ According to the court, but for the fact that Adamo was an attorney, Marino would not have turned to him for advice. Because Marino's causes of action arose only because of the attorney-client relationship, the court held that State Farm had no duty to defend Adamo.⁸⁹¹

VIII. AUTOMOBILE INSURANCE

A. UNINSURED/UNDERINSURED MOTORIST COVERAGE

1. *Stacking of Coverage*

In 1989, the Texas Supreme Court decided in *Stracener v. United Services Automobile Association*⁸⁹² that an insurer cannot deduct from its underinsured coverage limits the amount paid to its insured under a separate policy.⁸⁹³ In *Bowen v. Aetna Casualty & Surety Co.*⁸⁹⁴ the court was faced with whether to give *Stracener* a prospective or retrospective application.

Bowen was covered by an automobile insurance policy issued by Aetna, which provided a limit of \$100,000 under the underinsured motorist provision. Bowen was rear-ended by another driver, which caused her over \$125,000 in damages and personal injuries. With Aetna's consent, Bowen settled with the tortfeasor's insurance carrier for \$25,000, the maximum benefits under the policy. Bowen then looked to Aetna for the balance of the damages.

Aetna deducted the \$25,000 paid by the other carrier and agreed to pay a total of \$75,000. Bowen signed a release, gave it to her attorney, and cashed the check from Aetna. Bowen's attorney did not deliver the release to Aetna. A few days later, *Stracener* was decided. Bowen then filed suit to recover the additional \$25,000 Aetna had deducted from her coverage. Aetna answered, contending that it owed nothing further because its debt

888. *Id.* at 674.

889. *Id.* at 676.

890. *Id.*

891. *Id.*

892. 777 S.W.2d 378 (Tex. 1989).

893. *Id.* at 379-80.

894. 837 S.W.2d 99 (Tex. 1992).

had been extinguished under the doctrines of payment, release, accord and satisfaction, and compromise and settlement. Both parties sought a summary judgment, and the trial court granted Aetna's and denied Bowen's.

On appeal, Bowen argued that the *Stracener* holding should apply and that Aetna should have paid the full \$100,000. The San Antonio Court of Appeals held that the *Stracener* decision should be applied prospectively, since there was no foreshadowing of the *Stracener* decision, and because it would be inequitable to apply it to litigants who had relied on lower court rulings to the contrary. The supreme court reversed and remanded.⁸⁹⁵ The court held that its decisions operate retroactively unless the court exercises its discretion to modify that application.⁸⁹⁶ The court held that *Stracener* should be applied retroactively since it corrected a misinterpretation of article 5.06-1 of the Texas Insurance Code by some courts of appeal, which had added words not found in the statute and had failed to construe the insurance law in accordance with its policy statements.⁸⁹⁷

The court in *Upshaw v. The Trinity Co.*⁸⁹⁸ refused to apply *Stracener* to a situation where the insured was attempting to stack underinsured motorist coverage for multiple vehicles insured under a single policy. George Upshaw was killed when his car collided with a vehicle owned by Brett Field and driven by John Pleasant. At the time of the accident, Upshaw had a single multi-vehicle insurance policy issued by Trinity covering three automobiles. Upshaw paid three separate premiums for uninsured/underinsured motorist (UM/UIM) coverage; one for each car. Coverage under the policy for UM/UIM protection was \$20,000 per person and \$40,000 per accident.

Upshaw's surviving son and daughter filed suit against Field and Pleasant for negligence and against Trinity under its policy. In the suit against Trinity, which was severed from the negligence action, the Upshaws sought a declaration that the UM/UIM provisions of the policy could be stacked to allow a maximum recovery of \$40,000, arguing that the separate premiums paid on each vehicle entitled them to such coverage. The trial court held that the UIM coverage for the multiple vehicles insured under the policy could not be stacked, and the court of appeals affirmed. The supreme court affirmed the judgment of the court of appeals in favor of Trinity.⁸⁹⁹

Initially, the Upshaws argued to the supreme court that the policy was ambiguous and should be construed to maximize coverage. The UM/UIM coverage provided that:

If separate limits of liability for bodily injury and property damage liability are shown in the Declarations for this coverage *the limit of liability for "each person" for bodily injury liability is our maximum limit of*

895. *Id.* at 100.

896. *Id.*

897. *Id.*

898. 842 S.W.2d 631 (Tex. 1992). See also *Monroe v. Government Employees Ins. Co.*, 845 S.W.2d 394 (Tex. App.—Houston [1st Dist.] 1992, writ denied), which follows *Upshaw* in not permitting intrapolicy stacking of policy limits.

899. *Upshaw*, 842 S.W.2d at 632.

liability for all damages for bodily injury sustained by any one person in any one accident. Subject to this limit for "each person," the limit of liability shown in the Declarations for "each accident" for bodily injury liability is our maximum limit of liability for all damages for bodily injury resulting from any one auto accident.⁹⁰⁰

The court held that this language was certain and not reasonably susceptible to more than one interpretation.⁹⁰¹ According to the court, the contract provided that for any one person, the limits of coverage are \$20,000 per accident. It also limited to \$40,000 the total recovery when more than one person suffers a loss in a single accident. Therefore, the court held that the policy unambiguously limited coverage to prohibit intrapolicy stacking.⁹⁰²

The Upshaws also argued that public policy mandates the intrapolicy stacking of limits because additional premiums were charged and paid in exchange for UIM coverage for each vehicle listed on the policy. In responding to this argument, the court first looked to article 5.06-1 of the Insurance Code, which mandates the minimum coverages of UM/UIM insurance and provides that such coverage:

shall include provisions that, regardless of the number of persons insured, policies or bonds applicable, vehicles involved, or claims made, the 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 . . .⁹⁰³

According to the court, this statute shows the legislature's intent to permit insurance companies to limit a single multi-vehicle policy's required UIM coverage to the stated limit of liability contained in the policy without allowing for intrapolicy stacking.⁹⁰⁴

The court next distinguished *Stracener* and held that when there are multiple insurers, a primary concern is that no single insurer be allowed to avoid liability entirely by pointing to coverage in another insurance policy. However, when there is just one insurance policy covering several automobiles, there is no danger, according to the court, that the single insurer will avoid liability entirely. The court, therefore, held that there was no overriding public policy to allow intrapolicy stacking.⁹⁰⁵

Without citing or relying upon *Upshaw*, the courts in *Texas Farm Bureau Mutual Insurance Co. v. Tatum*⁹⁰⁶ and *Bergensen v. Hartford Insurance Co.*⁹⁰⁷ both held that it is not permissible to stack uninsured/underinsured motorist coverage where there is single multi-car coverage.

In the *Tatum* case, a car owned by Cecil and Ida Tatum was involved in a one-car accident. The car was driven by Moody, with the permission of

900. *Id.* at 633 (emphasis by the court).

901. *Id.*

902. *Id.*

903. TEX. INS. CODE ANN. art. 5.06-1(2)(d) (Vernon Supp. 1993).

904. *Upshaw*, 842 S.W.2d at 635.

905. *Id.*

906. 841 S.W.2d 89, 94 (Tex. App.—Tyler 1992, writ denied).

907. 845 S.W.2d 374, 377 (Tex. App.—Houston [1st Dist.] 1992, writ requested).

Melanie Tatum, the Tatums' daughter. As a result of the accident, Melanie was killed and two friends, Robert Powell and Cherie Stanley, were injured. It was uncontested that the negligence of Moody was one of the proximate causes of the accident and damages.

At the time of the accident, Moody was insured by Allstate, which provided liability coverage in the amount of \$40,000 per accident. The Tatums' policy with Texas Farm Bureau provided an aggregate liability coverage of \$50,000 per accident and uninsured/underinsured coverage of \$20,000 per person and \$40,000 per accident. Both carriers tendered into the registry of the court their maximum liability coverage.

The trial court found that the Tatums suffered \$350,000 in actual damages as a result of Melanie's death, Robert Powell suffered \$350,000 actual damages, and Cherie Stanley suffered \$77,000 actual damages. The court then prorated the \$90,000, which was deposited into the registry of the court, among the Tatums, Powell, and Stanley. The court then determined that the Tatums, Powell, and Stanley were underinsured within the provisions of Texas Farm Bureau's policy and ordered that they recover under the underinsured coverage. Because the Tatums had four cars listed and insured on their policy, the trial court stacked the underinsured coverage and awarded the Tatums \$86,154.

Texas Farm Bureau appealed, arguing first that the Tatums, Powell, and Stanley were not entitled to benefits under the underinsured provision of the policy because the Tatum vehicle was specifically excluded from the definition of an "underinsured" vehicle. The Tatums conceded that their vehicle was excluded from coverage by the definition of "uninsured/underinsured" in the policy, but argued that such exclusion frustrates the intention of the legislature in enacting article 5.06-1 of the Texas Insurance Code. The Tatums relied on *Stracener* and *Briones v. State Farm Mutual Automobile Insurance Co.*⁹⁰⁸

The court found both *Stracener* and *Briones* distinguishable from the present case.⁹⁰⁹ The question in *Stracener* was whether the amount of multi-policy insurance coverage available or whether the amount of the injured parties' actual damages determined if the injured party qualified to recover underinsured benefits. The court allowed the stacking of the limits of underinsured coverage under four separate policies to determine whether a tortfeasor was underinsured. *Briones*, according to the court, was different because it did not involve a situation where both the operator and owner of the car were insured. Instead, *Briones* involved a situation where a passenger in a vehicle owned by his uninsured employer and driven by an uninsured co-worker was allowed to recover under the uninsured provisions of his personal automobile policy.

The court instead found *Scarborough v. Employers Casualty Co.*⁹¹⁰ to be more similar to the facts of this case. In *Scarborough* Mrs. Scarborough

908. 790 S.W.2d 70 (Tex. App.—San Antonio 1990, writ denied).

909. *Tatum*, 841 S.W.2d at 92.

910. 820 S.W.2d 32 (Tex. App.—Fort Worth 1991, writ denied).

sued her husband for injuries she sustained as a result of his negligence while driving their car and also sued the insurer for uninsured/underinsured benefits. The court of appeals in *Scarborough* affirmed a summary judgment in favor of the insurer, relying on a statement in *Stracener* that:

By purchasing this coverage along with basic liability coverage, the insured has expressed an intent not only to protect others from his or her own negligence but also to protect that person's *own family* and guests from the negligence of *others*.⁹¹¹

The *Scarborough* court reasoned that the word "others" meant strangers to the policyholders, not Mrs. Scarborough's husband.⁹¹²

The *Tatum* court, therefore, concluded that the exclusionary language in the Tatums' policy did not frustrate the intent and purpose of the legislature in enacting article 5.06-1 of the Texas Insurance Code.⁹¹³

Texas Farm Bureau next argued that the trial court was wrong to stack the Tatums' underinsured coverage in its award to the Tatums. Again, the Tatums relied on *Stracener* for their argument that stacking is permissible when there is single-policy coverage. The court disagreed, finding that *Stracener* was limited to those cases where two or more policies were involved.⁹¹⁴ The court, instead, relied on *Westchester Fire Insurance Co. v. Tucker*,⁹¹⁵ where the court held that Tucker was not entitled to stack his uninsured motorist coverage because he had paid for that coverage on several vehicles named in the policy. The court, therefore, concluded that stacking of uninsured/underinsured motor vehicle coverage is not permissible when there is single multi-car coverage.⁹¹⁶

In *Bergensen v. Hartford Insurance Co.*⁹¹⁷ Hartford issued an automobile policy to the Bergensens that included UM/UIM coverage. After being injured while riding in their car driven by Mr. Bergensen, Mrs. Bergensen sued her husband, alleging that his negligence was the proximate cause of her damages. Hartford paid \$100,000 to settle the lawsuit, which was the maximum amount covered under the liability portion of the Bergensens' policy. Later, Mrs. Bergensen filed a second suit contending that her husband was underinsured and that Hartford was liable under the UM/UIM provision of the Bergensens' policy. The trial court granted Hartford's motion for summary judgment and entered a take-nothing judgment against Mrs. Bergensen. The court of appeals affirmed.

On appeal, Mrs. Bergensen, relying on *Stracener*, argued that she was entitled to stack the uninsured motorist and liability provisions of the insurance policy. The court found *Stracener* distinguishable because there the court allowed the stacking of the limits of underinsured motorist coverage

911. *Id.* at 34 (quoting *Stracener*, 777 S.W.2d at 384) (emphasis added by the court of appeals).

912. *Scarborough*, 820 S.W.2d at 34.

913. *Tatum*, 841 S.W.2d at 93.

914. *Id.* at 94.

915. 512 S.W.2d 679, 684 (Tex. 1974).

916. *Tatum*, 841 S.W.2d at 94.

917. 845 S.W.2d 374 (Tex. App.—Houston [1st Dist.] 1992, writ requested).

under four separate insurance policies to determine whether a tortfeasor was uninsured. Mrs. Bergensen, by contrast, sought payment under two coverage provisions contained in a single insurance policy. Furthermore, the court found the uninsured motorist provision of the contract explicitly stated that it did not apply to vehicles owned by the insured.⁹¹⁸

Mrs. Bergensen next argued that excluding their car from the definition of "uninsured" vehicle would be contrary to public policy. The court, relying on *Stracener* and *Scarborough*, held that underinsured motorist coverage was intended to protect the insured from the negligence of persons who are not members of the policyholder's family.⁹¹⁹

Mrs. Bergensen next compared this case to *National County Mutual Fire Insurance Co. v. Johnson*⁹²⁰ where the court held that the family-member exclusion in a liability insurance contract was void and contrary to the Safety Responsibility Act that requires drivers to carry liability insurance covering all damages arising out of the operation of a motor vehicle. The court did not find *National County Mutual* persuasive because article 5.06-1 of the Texas Insurance Code permits the adoption of policy forms that limit the definition of "uninsured" motor vehicle. The court, therefore, determined that the exclusion of the Bergensens' vehicle from the definition of "uninsured" motor vehicle did not contravene the policy underlying article 5.06-1.⁹²¹

In *Fontanez v. Texas Farm Bureau Insurance Cos.*⁹²² the court held that the exclusion of the insured's vehicle from the definition of "uninsured" motor vehicle did contravene the policy underlying article 5.06-1. In this case, Chipman, the insured, was killed when struck by the door of her car as Street was attempting to steal it. Texas Farm Bureau refused to pay under the uninsured motorist coverage claiming that Chipman's vehicle was not an uninsured motor vehicle as defined by the policy. In reversing a summary judgment in favor of the insurer, the court relied on *Briones*, where Briones was permitted to recover under the uninsured motorist provision of his personal insurance for injuries sustained in a vehicle owned by his employer, which was not insured, and being driven by another employee, who also was uninsured. State Farm argued that there was no coverage because the vehicle was excluded from the definition of "uninsured motor vehicle" because it was furnished for Briones' regular use. The court held that denying Briones recovery would frustrate the intent of the legislature to provide protection for conscientious motorists from financial loss caused by negligent, financially irresponsible motorists.

Following this rationale, the court held that it was unlikely that Chipman realized that her uninsured coverage would not apply when an uninsured

918. *Bergensen*, 845 S.W.2d at 376.

919. *Id.* at 377.

920. 829 S.W.2d 322 (Tex. App.—Austin 1992), *aff'd*, 37 Tex. Sup. Ct. J. 75 (Oct. 27, 1993).

921. *Bergensen*, 845 S.W.2d at 377.

922. 840 S.W.2d 647, 650 (Tex. App.—Tyler 1992, no writ).

thief operating her car without permission struck and killed her.⁹²³ The court thus concluded that to deny recovery under the uninsured motorist coverage under these facts would frustrate and defeat the purpose and intent of the Uninsured Motorist Act.⁹²⁴

In *Rosales v. State Farm Mutual Automobile Insurance Co.*⁹²⁵ the court held that injured passengers are not allowed to recover both liability and uninsured/underinsured motorist benefits under a single insurance policy. Rosales and Rivera were passengers in Barrett's car when it collided with another vehicle. It was undisputed that Barrett caused the accident and that Rosales and Rivera were seriously injured. Barrett carried a State Farm automobile insurance policy that provided liability and uninsured/underinsured motorist (UM/UIM) coverage. State Farm paid Rosales and Rivera \$25,000 each, the maximum amount of bodily injury liability insurance available per person under Barrett's policy. In addition, Rosales and Rivera received underinsured motorist insurance benefits from their own insurance policies. Rosales and Rivera also made claims for UIM benefits under Barrett's policy, but State Farm denied these claims.

After Rosales and Rivera filed suit, State Farm moved for summary judgment on the ground that it had no obligation to pay UIM benefits to Rosales and Rivera because Barrett's vehicle was not an underinsured vehicle according to the policy's terms. The trial court granted summary judgment for State Farm, and the court of appeals affirmed.

The policy issued by State Farm specified that uninsured/underinsured vehicles do not include vehicles owned by, furnished, or available for the regular use of a named insured. It was undisputed that the vehicle in which Rosales and Rivera were riding was owned by or available for the regular use of Barrett at the time of the accident. The court concluded that the policy's unambiguous language prevented Rosales and Rivera from recovering UM/UIM benefits because Barrett's vehicle was not an underinsured vehicle.⁹²⁶

Rosales and Rivera next argued that this definitional exclusion contravenes the purpose and intent of Texas Insurance Code art. 5.06-1, the uninsured/underinsured motorist statute. According to the court, the purpose of this statute is to protect conscientious motorists from financial loss caused by financially irresponsible motorists. The court could find no authority for Rosales' attempt to combine or stack the liability and UIM benefits under a single insurance policy. The court refused to invalidate the definitional exclusion because nothing indicated that Barrett was a financially irresponsible motorist.⁹²⁷

The court also agreed with State Farm that Barrett did not purchase UIM coverage for the purpose of increasing her own policy limits or protecting

923. *Fontanez*, 840 S.W.2d at 649.

924. *Id.* at 650.

925. 835 S.W.2d 804 (Tex. App.—Austin 1992, writ denied); see also *State Farm Mut. Ins. Co. v. Conn*, 842 S.W.2d 350 (Tex. App.—Tyler 1992, writ denied).

926. *Rosales*, 835 S.W.2d at 805.

927. *Id.* at 806.

her passengers from her own negligence, but as a protection from the negligence of other uninsured and underinsured drivers. To allow recovery of both liability and UIM benefits under one policy would effectively convert UIM coverage into a second layer of liability coverage, a result not contemplated by the parties to the policy and not calculated in the cost of the policy premiums. Accordingly, the court held that UIM coverage is not available for damages sustained by a passenger who has already recovered the full amount of liability limits under that same policy.⁹²⁸

In *Leal v. Northwestern National County Mutual Insurance Co.*⁹²⁹ the court held that an injured person is not required to exhaust the limits of a tortfeasor's insurance coverage before he or she is entitled to recover under the underinsured motorist provision of his or her own policy. However, if the injured person settles with the tortfeasor for less than the tortfeasor's liability coverage, recovery under the injured person's underinsured motorist coverage would be only for those damages in excess of the total amount of the tortfeasor's liability coverage.⁹³⁰

Leal sued Appling alleging that she negligently caused an automobile collision injuring Leal. Leal also filed suit against Northwestern to recover under her own automobile insurance policy's underinsured motorist coverage, which had a limit of \$20,010. Leal negotiated a settlement of all claims with Appling for \$20,000 after Appling stated that this was the amount of her liability coverage. Before the settlement was completed, Leal was advised that Appling's liability coverage was actually \$25,000 per person. Following the settlement, Northwestern filed a motion for summary judgment asserting that because Leal had settled with Appling for less than the limits of Appling's liability coverage, Appling was not an underinsured motorist and Leal could not recover from Northwestern under her underinsured motorist coverage. The trial court agreed and granted Northwestern's motion, rendering judgment that Leal take nothing. The court of appeals reversed and remanded.

In order to determine whether Appling was an underinsured motorist, the court looked to article 5.06-1(2)(b) of the Texas Insurance Code, which defines an underinsured motor vehicle as:

an insured motor vehicle on which there is valid and collectible liability insurance coverage with limits of liability for the owner or operator which were originally lower than, *or have been reduced by the payment of claims arising from the same accident* to, an amount less than the limit of liability stated in the underinsured coverage of the insured's policy.⁹³¹

In *Stracener*, the court held that "payment of claims" includes any payments made by the liability carrier to the beneficiary of an underinsured

928. *Id.*

929. 846 S.W.2d 576, 579 (Tex. App.—Austin 1993, no writ); *see also* *Olivas v. State Farm Mut. Auto. Ins. Co.*, 850 S.W.2d 564 (Tex. App.—El Paso 1993, writ denied).

930. *Leal*, 846 S.W.2d at 579; *Olivas*, 850 S.W.2d at 565.

931. *Leal*, 846 S.W.2d at 578 (emphasis by the court).

motorist policy.⁹³² Therefore, as applied to this case, the court held that payment made by Appling's insurance carrier to Leal effectively reduced the limits of Appling's liability coverage for purposes of determining her status as an underinsured motorist.⁹³³ Thus, Appling's liability limits of \$25,000 were reduced by the \$20,000 paid in settlement to Leal, leaving Appling with \$5,000 remaining liability coverage. Because this \$5,000 in remaining coverage was less than the \$20,010 limit of underinsured motorist coverage as stated in Leal's policy, Appling was an underinsured motorist.

Northwestern argued that, even if Leal were underinsured, she had to exhaust the limits of Appling's insurance coverage before Leal could recover under her own policy. The court, however, could find no such requirement in the statute or in Leal's policy. Instead, the statute, article 5.06-1(5), simply requires that the insured's recovery of actual damages be reduced by the amount "recovered or recoverable" from the tortfeasor's insurance carrier. Thus, the court held that once Leal's actual damages were determined, the full amount recoverable from Appling's insurance carrier (policy limits) should be deducted, whereafter Leal would be entitled to recover from Northwestern the remainder of her actual damages up to the \$20,010 liability limit of her underinsured motorist coverage.⁹³⁴ Therefore, the court calculated the set-off as if the insured had exhausted the limits of the tortfeasor's coverage.

2. "Settlement Without Consent" Clause

In *Guaranty County Mutual Insurance Co. v. Kline*⁹³⁵ Kline was precluded from recovering under his underinsured motorist coverage because he did not obtain the consent of Guaranty County Mutual to settle with Fletcher. Kline had sued Fletcher for damages resulting from an automobile collision. At the time of the accident, Kline carried uninsured/underinsured motorist coverage with Guaranty County Mutual in the limits of \$20,000 per person and \$40,000 per accident. Kline eventually settled the suit with Fletcher for Fletcher's automobile liability policy limits of \$20,000. As part of the settlement, Kline released Fletcher from any further liability. Guaranty County Mutual did not consent to the settlement.

Later Kline sued Guaranty for underinsured motorist benefits under his policy. In response, Guaranty asserted that Kline breached the policy's "settlement without consent" clause and, therefore, Kline's settlement with Fletcher discharged Guaranty of all liability under the terms of the policy. After a jury trial, the trial court rendered judgment for Kline in the amount of \$10,000, plus attorney's fees. The court of appeals affirmed holding that the "settlement without consent" exclusion in the insurance contract was invalid. The supreme court reversed the judgment of the court of appeals and rendered judgment that Kline take nothing.

932. *Stracener*, 777 S.W.2d at 383.

933. *Leal*, 846 S.W.2d at 578.

934. *Id.* at 579.

935. 845 S.W.2d 810 (Tex. 1992).

The supreme court noted that the insurance contract between Kline and Guaranty stated that “[w]e do not provide Uninsured/Underinsured Motorist coverage for any person . . . if that person or legal representative settles the claim without our consent.”⁹³⁶ Kline argued that this exclusion violated his right to pursue benefits under his underinsured motorist policy, relying on *Stracener*. The court held, however, that *Stracener* did not affect the validity of the settlement clause because it is consistent with, and advances the purpose of, article 5.06-1(6) of the Insurance Code.⁹³⁷ The court held that to “deny the validity of this exclusion would be to repudiate the insurer’s contractual subrogation rights against the negligent motorist responsible for the insured’s damages.”⁹³⁸

3. Miscellaneous

In *Williams v. Allstate Insurance Co.*⁹³⁹ the court held that before a person can recover under his or her underinsured motorist coverage, that person must show that his or her injury resulted from actual, direct physical contact with an underinsured vehicle. Mr. Williams alleged that he sustained injuries when a piece of steel fell from an unidentified truck onto his car. Allstate, Mr. Williams’ insurer, refused to pay under his underinsured motorist coverage because his car did not come into direct contact with the truck.

The court of appeals affirmed a summary judgment in favor of Allstate based upon the language in article 5.06-1(2)(d) of the Texas Insurance Code which requires actual physical contact between the underinsured vehicle and the insured’s vehicle.⁹⁴⁰ Williams, relying upon *State Farm Mutual Automobile Ins. Co. v. Matlock*,⁹⁴¹ argued that physical contact is not necessary when there is an “uninterrupted chain of physical events” set in motion by

936. *Kline*, 845 S.W.2d at 811.

937. *Id.* at 811; see also *Traylor v. Cascade Ins. Co.*, 836 S.W.2d 292 (Tex. App.—Dallas 1992, no writ).

938. *Kline*, 845 S.W.2d at 811. On September 10, 1993, the supreme court granted writ in *Hernandez v. Gulf Group Lloyds*, on the issue of whether insured must obtain insurer’s consent to settle in order to qualify for uninsured motorist coverage. See 36 Tex. Sup. Ct. J. 1257 (Sept. 10, 1993). Elizabeth Hernandez died in a car accident. She had underinsured motorist insurance coverage under her parents’ policy from Gulf Group Lloyds in the amount of \$100,000. Hernandez’s parents settled all of her claims against the driver of the car for the \$25,000 policy limit of his insurance. Gulf Group then refused to pay any amount of underinsured motorist coverage, because the Hernandezes had not obtained Gulf Group’s consent to settle. The Hernandezes then sued Gulf Group.

The jury found in favor of the Hernandezes and the trial court rendered judgment for \$100,000, plus costs, interest, and attorney’s fees. The court of appeals, relying on *Kline*, held that the settlement without the insurer’s consent barred the Hernandezes from recovering under their own policy. Thus, the judgment was reversed and rendered. (The opinion was not published.)

The points of error upon which the supreme court granted Hernandez’s application for writ of error asserted that reliance upon *Kline* was inappropriate because the facts of this case showed that the violation of the consent-to-settle exclusion did not prejudice the insurance company’s ability to recover subrogation.

939. 849 S.W.2d 859, 861 (Tex. App.—Beaumont 1993, no writ).

940. *Id.* at 860.

941. 446 S.W.2d 81 (Tex. Civ. App.—Texarkana 1969), modified, 462 S.W.2d 277 (Tex. 1970).

the underinsured vehicle that causes the injuries. The court held that *Matlock* was effectively overruled when the Legislature amended article 5.06-1 to include the physical contact requirement.⁹⁴²

Williams next argued that there should be coverage because the truck had indirect contact with his vehicle, citing *Latham v. Mountain States Mutual Casualty Co.*⁹⁴³ In *Latham*, the court held that the actual physical contact requirement was satisfied between car A and car C when car A struck car B thereby propelling car B into car C. The court found *Latham* dissimilar to the facts of this case because there was never any contact with the truck. Thus, the court held either that there must be direct physical contact with the other vehicle or that the uninsured vehicle must create an uninterrupted chain of physical events between itself and another vehicle which ultimately results in injury to the insured.⁹⁴⁴

In *Christian v. Charter Oak Fire Insurance Co.*⁹⁴⁵ the wife and child of a motorist who was killed in an automobile accident brought an action against the motorist's underinsured motorist coverage carrier for the mental anguish they suffered as bystanders to the accident. The limits on the underinsured motorist coverage were \$100,000/\$300,000 and Charter Oak paid the Christians \$100,000 for the wrongful death of Mr. Christian. The wife and child claimed that they had separate injuries, requiring Charter Oak to pay them each \$100,000. The court of appeals affirmed a summary judgment in favor of the insurer, holding that an action for wrongful death is one action, no matter how many claimants are separately injured by the death.⁹⁴⁶ Since mental anguish is an element of damages for wrongful death and the Christians settled this claim, the court held that they had no additional claim against the insurer.⁹⁴⁷

B. FAMILY-MEMBER EXCLUSION

The court, in deciding *Sanford v. Liberty Mutual Fire Insurance Co.*,⁹⁴⁸ became the third court of appeals to conclude that the family-member exclusion (endorsement 575) violates the statutory public policy of Texas requiring every driver to have liability insurance. Prior to *Sanford*, the Texas Supreme Court granted writ in *National County Mutual Fire Insurance Co. v. Johnson*,⁹⁴⁹ and on October 27, 1993, issued its opinion affirming the judgment of the court of appeals that the family-member exclusion is invalid.⁹⁵⁰

942. *Williams*, 849 S.W.2d at 860.

943. 482 S.W.2d 655 (Tex. Civ. App.—Houston [1st Dist.] 1972, writ ref'd n.r.e.).

944. *Williams*, 849 S.W.2d at 861.

945. 847 S.W.2d 458 (Tex. App.—Tyler 1993, writ denied).

946. *Id.* at 460.

947. *Id.* at 461.

948. 845 S.W.2d 354 (Tex. App.—Houston [1st Dist.] 1992, writ denied); see also *National County Mut. Fire Ins. Co. v. Johnson*, 829 S.W.2d 322 (Tex. App.—Austin 1992), *aff'd*, 37 Tex. Sup. Ct. J. 75 (Oct. 27, 1993); *Segal v. Southern County Mut. Ins. Co.*, 832 S.W.2d 617 (Tex. App.—Dallas 1992, no writ).

949. 829 S.W.2d 322 (Tex. App.—Austin 1992), *aff'd*, 37 Tex. Sup. Ct. J. 75 (Oct. 27, 1993).

950. *National County Mut. Fire Ins. Co. v. Johnson*, 37 Tex. Sup. Ct. J. 75 (Oct. 27, 1993).

Randall Johnson, while driving his truck, rear-ended another automobile, which resulted in injuries to his wife who was riding with him. Mrs. Johnson later filed suit against her husband alleging that his negligence caused her injuries. Mr. Johnson forwarded the petition and citation to National County and demanded a full and unconditional defense to the suit. National County refused to provide an unconditional defense, but would provide a defense subject to a reservation of rights to deny coverage and payment of any judgment rendered against him. National County argued that a family-member exclusion in its policy precluded coverage for this claim. Johnson advised National County that he would not accept any reservation of rights and then filed a declaratory judgment action requesting the court to declare the rights and legal relations arising between the parties as a result of the insurance policy. National County filed its counterclaim for declaratory relief asking the court to determine whether the family-member exclusion is valid under Texas law. The trial court found the family-member exclusion invalid. It declared that the exclusion conflicts with the Safety Responsibility Act, enjoys no rational justification supporting its adoption by the State Board of Insurance, contravenes the public policy of the State of Texas, and does not in any way serve the interests of the people of Texas. Accordingly, the trial court rendered judgment for Johnson and decreed that National County was liable for his coverage and defense under the policy. The court of appeals affirmed as did the supreme court.

The court determined that the policy behind the Texas Safety Responsibility Act is to protect all potential claimants from damages resulting from automobile accidents.⁹⁵¹ This purpose is embodied in the Act's mandatory requirement of liability insurance in at least the minimum amounts to cover all sums which the insured may become legally obligated to pay. The court held that the family-member exclusion is inconsistent with the purposes of the Act in that it creates a situation in which an innocent victim is not allowed to recover damages if the person at fault happens to be a family member.⁹⁵² The court further noted that the majority of jurisdictions with mandatory insurance laws have held family member exclusions to be invalid because they are contrary to public policy.⁹⁵³

Justice Cornyn concurred with the four-member plurality in the decision that the family-member exclusion is invalid but only up to the statutorily imposed minimum limit of automobile liability insurance.⁹⁵⁴ Thus, Justice Cornyn held that the insurer's liability should be fixed at the minimum limits mandated by statute.⁹⁵⁵

951. *Id.* at 76.

952. *Id.* at 77.

953. *Id.*

954. *Id.* at 79.

955. *Id.*

C. NOTICE OF SUIT

In *Cruz v. Liberty Mutual Insurance Co.*⁹⁵⁶ Liberty Mutual issued an automobile policy to Metropolitan, which operated a taxicab company. Cruz sued Metropolitan after one of its cabs struck the Cruzes' children. Before Cruz filed suit, Liberty Mutual was sent a notice of this claim, but Liberty Mutual did not respond. Cruz obtained a default judgment against Metropolitan, which was forwarded to Liberty Mutual. Again, Liberty Mutual did not respond. Metropolitan then assigned to Cruz its claims against Liberty Mutual and this lawsuit was filed. The trial court granted a summary judgment to Liberty Mutual on the grounds that Liberty Mutual was prejudiced because it did not receive notice of the suit against Metropolitan and that the policy had been canceled. The court of appeals reversed and remanded for trial.

Liberty Mutual argued that it was prejudiced by the lack of notice because it was unable to defend the lawsuit against Metropolitan. According to the court of appeals, a fact question existed as to whether Liberty Mutual was prejudiced by the lack of notice because there was evidence that Liberty Mutual had always maintained that the policy had been canceled, thus indicating that even if it had received notice of the lawsuit, it would not have provided a defense.⁹⁵⁷

The supreme court reversed and rendered judgment that Cruz take nothing. According to the court, the Liberty Mutual policy required the insured to notify the insurer if a lawsuit was brought against the insured. Liberty Mutual, in order to avoid liability under the policy for lack of notice, must show that it was prejudiced by the lack of notice. The court held that an insurer that is not notified of suit against its insured until a default judgment has become final, absent actual knowledge of the suit, is prejudiced as a matter of law.⁹⁵⁸

IX. HEALTH, LIFE & ACCIDENT INSURANCE

A. POLICY CONSTRUCTION/INTERPRETATION

1. *Benefits After Policy Is Terminated*

In *Forbau v. Aetna Life Insurance Co.*⁹⁵⁹ the court was faced with the question of whether an insurer was required to pay benefits for an injury sustained while the policy was in force but after the policy had terminated. Amy Miller was severely injured in a car wreck, leaving her a permanently disabled, spastic, quadriplegic in need of constant care. She was covered under a health policy through her father's employer. Aetna provided the coverage, but the employer terminated the contract with Aetna and named

956. 853 S.W.2d 714 (Tex. App.—Texarkana), *rev'd*, 37 Tex. Sup. Ct. J. 276 (Dec. 8, 1993).

957. *Id.* at 716.

958. *Liberty Mut. Ins. Co. v. Cruz*, 37 Tex. Sup. Ct. J. 276, 278 (Dec. 8, 1993).

959. 37 Tex. Sup. Ct. J. 345 (Jan. 5, 1994).

Safeco as the successor. Aetna paid all of Amy's claims until the date its coverage ended. Claims after that date were sent to Safeco. When Safeco stopped paying, suit was brought on Amy's behalf against Aetna. Although other causes of action were alleged, the only one that reached the jury was breach of contract. The plaintiffs took the position that Aetna's policy covered all expenses for an injury sustained during the policy period. Aetna asserted that its coverage only applied to charges incurred when the policy was in effect. The jury found Aetna breached its contract, and the trial court rendered judgment for Amy in the amount of \$283,000 for past medical expenses, \$2.5 million future medical expenses, and \$500,000 in attorney's fees.

The court of appeals reversed and rendered a take-nothing judgment holding that the policy unambiguously supported Aetna's position that coverage only extended to charges incurred while the policy was in effect.⁹⁶⁰ The supreme court affirmed the judgment of the court of appeals.

The court held that the interpretation of insurance contracts in Texas is governed by the same rules as interpretation of other contracts.⁹⁶¹ The contract must be considered as a whole to ascertain the agreement of the parties and each part of the contract should be given effect.⁹⁶² As an example, the court said that when a contract provision makes a general statement of coverage, and another provision specifically states the time limit for such coverage, the more specific provision will control.⁹⁶³

The operative language, in the opinion of the majority, was that Aetna would pay for "covered medical expenses incurred during a calendar year for treatment of a covered family member." There was also language in the policy stating that it did not provide insurance for charges incurred while the person was not a covered family member. According to the court, the unambiguous language of the contract provided that Aetna's obligation to pay benefits under the contract terminated upon the discontinuance of the group policy, unless some other provision in the policy extended coverage.⁹⁶⁴ There was an extension of benefits for an additional year, but Forbau sought coverage for treatment provided beyond this additional year. According to the court, the policy did not provide for coverage for medical expenses incurred after the group policy was canceled.⁹⁶⁵

The dissent argued however, that the policy was susceptible to more than one reasonable interpretation and, thus, was ambiguous.⁹⁶⁶ Accordingly, the dissent noted that the policy should be construed in favor of coverage. According to the dissent, the policy provided coverage for all medical expenses resulting from an accident that occurred while coverage was in effect, even though the expenses were incurred after the policy terminated.⁹⁶⁷

960. 808 S.W.2d 664 (Tex. App.—Amarillo 1991).

961. *Forbau*, 37 Tex. Sup. Ct. J. at 346.

962. *Id.*

963. *Id.*

964. *Id.*

965. *Id.*

966. 36 Tex. Sup. Ct. J. at 870-71.

967. *Id.* at 871.

A case presenting the same issue of contract interpretation is *Reynolds v. Mid-South Insurance Co.*⁹⁶⁸ Mid-South issued a major medical health insurance policy to Reynolds. Reynolds paid his first monthly premium on February 1, 1987, but failed to pay the premium due on March 1, 1987. The policy provided a grace period of thirty-one days for payment of premiums and extended coverage until the end of the grace period. However, Reynolds did not pay the March premium within the grace period and Mid-South terminated coverage as of April 1, 1987. On April 7, 1987, Reynolds began seeing a doctor because of a problem he was having with a kidney stone. Around the middle of April of 1987, Reynolds attempted to pay the past due premiums, but Mid-South refused to accept payment, and denied Reynolds' claim for benefits.

Reynolds then filed suit to recover medical expenses he had incurred in the treatment of the kidney stone. He alleged that, even though the expenses were incurred after the grace period ended, there should be coverage since the illness originated before the policy terminated. The trial court granted summary judgment in favor of Mid-South and Reynolds appealed.

The court of appeals affirmed, holding that the policy did not cover expenses for illnesses manifested before the end of the grace period but not incurred during such time.⁹⁶⁹ The court reached its conclusion based on the language of the policy, which stated that it would pay for incurred covered expenses. The policy stated that a covered expense is considered incurred on the date that the item of care, services, or supplies for which the claim is made is furnished. Since the medical charges were not incurred until after the grace period had expired, the court held that Reynolds could not recover under the policy.⁹⁷⁰

2. *Death Dividends*

In *Beaston v. State Farm Life Insurance Co.*⁹⁷¹ Heaton, an agent with State Farm, sold Terri and David Beaston graduated-premium whole life policies. The monthly payment on David Beaston's policy, due on December 28, 1983, was not paid. The thirty-one-day grace period ran from December 28, 1983, to January 28, 1984. On January 31, 1984, David Beaston was killed in a one-car accident. When Terri Beaston called on State Farm to pay the life insurance policy benefits, State Farm refused, contending that David Beaston's policy had lapsed on January 28, three days before his death.

Terri Beaston filed suit against State Farm and Heaton asserting claims for breach of contract, violations of article 21.21, and the DTPA. The trial court granted Beaston an instructed verdict that there was coverage at the time of death and awarded the policy benefits of \$250,000. The court of appeals affirmed this portion of the judgment.

968. 836 S.W.2d 349 (Tex. App.—Tyler 1992, no writ).

969. *Id.* at 351.

970. *Id.*

971. 861 S.W.2d 268 (Tex. App.—Austin 1993, writ requested).

State Farm argued that the trial court erred in its directed verdict establishing life insurance coverage at the time of David Beaston's death. State Farm argued that when David Beaston died on January 31, 1984, there was no coverage because the policy had lapsed due to nonpayment of the premium on January 28, 1984. Beaston's position at trial was that the policy was ambiguous regarding dividends paid by the policy and could be read to allow a prorated dividend at death to be applied to premiums in order to extend coverage past the date of David Beaston's death. The trial court ruled that the policy provisions regarding dividends were ambiguous and construed the policy in favor of coverage. The court of appeals held that if a policy provision is susceptible to two or more reasonable interpretations, it is ambiguous and the court must adopt the construction that favors coverage.⁹⁷² Thus, the issue for the court of appeals was whether the policy could be reasonably read to allow a prorated dividend at death that would have been sufficient to pay the overdue premium. The key provisions were:

Dividend at Death. A dividend for the period from the start of the policy year to the Insured's death will be part of the proceeds.

Accumulations to Avoid Lapse. If a premium has not been paid by the end of its grace period, any available dividend accumulations will be used to pay all or part of that premium.

The evidence showed that State Farm declared dividends on this class of policies. In fact, State Farm admitted that if the insurer had credited David Beaston's policy with a dividend at death, the prorated amount would have been more than enough to pay the overdue premium. Based on this evidence and the policy language, the court held that the policy could reasonably require State Farm to apply a prorated dividend to David Beaston's policy, which would have cured the lapse.⁹⁷³

The court noted that State Farm's interpretation of the policy was reasonable. But, once it is determined that a policy is ambiguous, the court must adopt the insured's interpretation, even if the insurer's interpretation is reasonable, or even more reasonable than the one put forth by the insured.⁹⁷⁴ The court, therefore, agreed with the trial court that the policy provisions were ambiguous and construed the policy in favor of the insured.

3. *Suicide Clause*

The court in *Payne v. Prudential Insurance Co.*⁹⁷⁵ was called upon to determine the correct interpretation of a suicide clause in a life insurance policy. On October 1, 1984, Payne became covered under a group life insurance policy issued by Prudential with death benefits in the amount of \$150,000. On April 1, 1985, Payne increased the amount of the death benefit to \$300,000, and then on October 1, 1989, he increased the amount payable to

972. *Id.* at 276

973. *Id.* at 277.

974. *Id.*

975. No. 2-92-140-CV, 1993 Tex. App. LEXIS 307 (Tex. App.—Fort Worth, Jan. 26, 1993, n.w.h.).

\$500,000. Payne committed suicide on January 23, 1990. After a claim was made under the life insurance policy, Prudential paid \$300,000 in death benefits but refused to pay the additional \$200,000 that became effective on October 1, 1989. Prudential claimed that this increase was not payable because Payne had committed suicide within one year from the effective date of the increase. Prudential's refusal to pay the increase was based on the following policy provision:

Suicide: The insurance does not cover loss of life of the Participant which results from or is caused by suicide within one year from the date he became a covered individual. The amount of any increase in insurance with respect to a Participant will not be payable with respect to any loss of life of the Participant which results from or is caused by suicide within one year from the effective date of such insurance.

The trial court found this provision unambiguous and held that Prudential was not obligated to pay the \$200,000 increase in the amount of death benefits to Payne's estate. The court of appeals reversed and rendered judgment for Payne's estate.

Payne's estate argued that the suicide clause excused the insurer from paying any increase in the amount of death benefits only if the insured committed suicide within one year of the date he initially became a covered individual because the phrase "such insurance" in the suicide clause referred to the total coverage under the insurance policy, not the increase in death benefits. Because Payne's suicide happened more than a year after he initially became covered under the policy, Payne's estate claimed that Prudential was obligated to pay the \$200,000 increase in death benefits.

Prudential, on the other hand, argued that the clear language of the policy excused it from paying any increase in the amount of death benefits if the insured committed suicide within one year of the date the increase became effective.

The majority of the court held that the only reasonable interpretation of the suicide clause was that advanced by Payne's estate.⁹⁷⁶ According to the court, the interpretation suggested by Prudential would require the insertion of a qualifying phrase and, therefore, violate the plain meaning rule of contract construction.⁹⁷⁷ The court further held that if the parties had intended to excuse Prudential from paying any increase in the amount of death benefits that became effective after the first year of coverage, it could have written the suicide clause to read "such increase in insurance" or "such increase," rather than "such insurance."⁹⁷⁸ The court, therefore, held that Prudential was obligated, as a matter of law, to pay the \$200,000 increase in death benefits to Payne's estate.

976. *Id.*, slip op. at 5.

977. *Id.*

978. *Id.*, slip op. at 5-6.

4. Preexisting Conditions

In *Bartlett v. American Republic Insurance Co.*⁹⁷⁹ the insurer denied a claim for benefits relating to a radical mastectomy and radiation and chemotherapy treatment received by Carolyn Bartlett, claiming that her illness was a preexisting condition. The Bartletts filed suit against American Republic for breach of contract, a 12% penalty under article 3.62 of the Texas Insurance Code, breach of the duty of good faith and fair dealing, and violations of the DTPA and article 21.21. The trial court granted American Republic's motion for summary judgment and rendered a take-nothing judgment against the Bartletts.

On February 1, 1988, the Bartletts applied for health insurance from American Republic and a policy was issued effective April 1, 1988. On February 24, 1988, Carolyn visited Dr. North, a plastic surgeon, about having "scoop-out" procedure and breast augmentation to prevent the possibility of breast cancer. Dr. North told Carolyn that she had a mass in her left breast and recommended that she discuss the situation with another doctor. Carolyn contacted Dr. Payne, her gynecologist, who recommended that she wait until June 1988 to have further tests or treatment because her December 1987 mammogram had disclosed no irregularity. On June 2, 1988, Carolyn underwent a mammogram, and Dr. Payne detected a malignant cyst. Carolyn subsequently underwent a radical mastectomy and radiation and chemotherapy treatment.

The court first faced the issue of whether the mass in Carolyn's left breast was a preexisting condition. The policy defined "preexisting condition" as:

(A) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 5 year period before the date coverage begins for a covered person; or

(B) a health condition for which medical advice was given or treatment was recommended by or received from a doctor within a 5 year period before the effective date of the coverage of a covered person.

The Bartletts argued that a material fact question existed as to Carolyn's awareness of the nature of her condition prior to the effective date of the policy. The court held, however, that her actual knowledge of the true nature of her condition was immaterial since the definition of "preexisting condition" did not require diagnosis of an illness as a prerequisite to the duty to disclose a health condition.⁹⁸⁰ Because it was undisputed that, before the effective date of the policy, Dr. North discovered and informed Carolyn of the mass in her left breast, the court concluded that Carolyn did have a health condition prior to the effective date of the policy.⁹⁸¹

The court next concluded that Carolyn was given medical advice concerning this health condition prior to the effective date of the policy because Dr. North suggested that she consult another doctor, have a repeat mammogram to determine whether a biopsy should be performed, and to have a biopsy if

979. 845 S.W.2d 342 (Tex. App.—Dallas 1992, no writ).

980. *Id.* at 346.

981. *Id.*

necessary.⁹⁸² Even though Carolyn may not have been able to disclose that she had breast cancer until after she had a mammogram in June 1988, the court held that she knew before the effective date of the policy that she had a health condition, a mass in her left breast, and that Dr. North had given medical advice to consult another doctor for a mammogram to determine whether a biopsy of the mass should be performed. The court concluded that American Republic established, as a matter of law, that Carolyn had a preexisting condition that was excluded from coverage.⁹⁸³ Therefore, the summary judgment on the Bartletts' breach of contract claims was proper.

B. ONE WHO MURDERS INSURED FORFEITS RIGHT TO INSURANCE PROCEEDS

In *Francis v. Marshall*⁹⁸⁴ Francis appealed a summary judgment awarding insurance proceeds under his wife's life insurance policy to her mother. Karen Francis was murdered by her husband, Douglas Francis. After his conviction was final, the trial court awarded the life insurance proceeds to Karen's mother, who was named the contingent beneficiary. Mr. Francis argued that the summary judgment was improper because there was a fact question as to whether he willfully caused his wife's death. The court held that the element of willfulness was essential to his conviction for murder and thus had been litigated.⁹⁸⁵ As such, Francis was barred by collateral estoppel from relitigating this issue. Because Francis murdered his wife, the court held that he was prevented from financially benefiting from his wrong under section 41 of the Texas Probate Code and article 21.23 of the Texas Insurance Code.⁹⁸⁶

Francis next argued that the summary judgment was improper because there was no evidence that he brought about his wife's death with the intent of accelerating the due date of the insurance policy and collecting the insurance proceeds. The court held that this did not have to be proven. The only requirement under the Insurance and Probate Codes to nullify Francis's right to the insurance proceeds is that he willfully caused the death of his wife.⁹⁸⁷

Similarly, the Fifth Circuit in *Metropolitan Life Insurance Co. v. White*⁹⁸⁸ held that, under Texas law, a husband's interest in his wife's life insurance policy is forfeited because of his conviction for murdering her.⁹⁸⁹ The husband, however, argued that since the policy had been issued by Metropolitan under the Federal Employees Group Life Insurance Act (FEGLIA), Texas law could not be used to disqualify him from a federal statutory right. The

982. *Id.* at 347.

983. *Id.*

984. 841 S.W.2d 51 (Tex. App.—Houston [14th Dist.] 1992, no writ).

985. *Id.* at 54.

986. *Id.*

987. *Id.*

988. 972 F.2d 122, 124 (5th Cir. 1992), *cert. denied*, 113 S. Ct. 1426 (1993).

989. TEX. INS. CODE ANN. art. 21.23 (Vernon Supp. 1993). *See also* TEX. PROB. CODE ANN. § 41(D) (Vernon Supp. 1993).

husband argued that under the FEGLIA, insurance proceeds are payable to an insured's widow or widower in the absence of a designated beneficiary. Since the wife had not designated a beneficiary, the husband claimed entitlement to the proceeds.

The court held that the FEGLIA should be interpreted consistent with state terms defining domestic relations because they are primarily a matter of state concern.⁹⁹⁰ The court also held that even if state law did not govern the outcome of this case, the result would be the same because federal common law provides the same bar to recovery of life insurance proceeds by the murderer of the insured.⁹⁹¹ Thus, the court affirmed the district court's judgment awarding the insurance proceeds to the father of the deceased.

C. CONVERSION COVERAGE

In *Schnabel v. Philadelphia American Life Insurance Co.*⁹⁹² the court determined that Texas law requires group insurers to provide employees the option of either continuing their group coverage or converting it to individual coverage if their eligibility from group coverage terminates. Schnabel was covered under a group insurance policy provided by his employer, which had a maximum lifetime benefit of \$1 million for each covered person. After Schnabel lost his job because of terminal illness, he elected to convert his group coverage to individual coverage in accordance with article 3.51-6 of the Texas Insurance Code.⁹⁹³ Schnabel completed a conversion application and hand-delivered it to Philadelphia American along with the requisite premium within thirty-one days of his last day of employment. In response, Philadelphia American told Schnabel the application he used was an old one and that he would have to complete a new application form. Because Schnabel did not return the new application, Philadelphia American denied his application for conversion coverage. Schnabel filed suit seeking a declaratory judgment that he was entitled to an individual insurance policy providing insurance benefits in accordance with the application form he submitted to Philadelphia American. Both parties filed motions for summary judgment. The court granted Schnabel's and denied Philadelphia American's.

The court determined that Schnabel satisfied all of the requirements for exercising his conversion privilege, rejecting Philadelphia American's argument that it did not have to provide conversion coverage because Schnabel used the wrong application form.⁹⁹⁴ According to the Texas Insurance Code, conversion coverage must be provided without evidence of insurability if an application and payment of the first premium is made within thirty-one days after termination.⁹⁹⁵ The court found that Schnabel complied with these requirements.

990. *White*, 972 F.2d at 124.

991. *Id.*

992. 795 F. Supp. 816, 820 (S.D. Tex. 1992).

993. TEX. INS. CODE ANN. art. 3.51-6, § 1(d)(3) (Vernon Supp. 1993).

994. *Schnabel*, 795 F. Supp. at 820.

995. TEX. INS. CODE ANN. art. 3.51-6, § 1(d)(3)(A)(i) (Vernon Supp. 1993).

Philadelphia American then argued that even if Schnabel was entitled to some conversion coverage, he was limited to \$7,500 in maximum lifetime benefits available under the conversion policy made available at the time he submitted his application. Philadelphia American also argued that it had no statutory or contractual duty to provide a minimum level of coverage under the conversion policy. The court disagreed on both counts.

The court held that the Texas Insurance Code prescribed minimum standards for conversion policies by providing that the insurer's standards must bear some reasonable relationship to the actual health care costs in the area in which the insured lived at the time of conversion, and that the insurer's standards must be filed with the commissioner of insurance prior to their use in denying coverage.⁹⁹⁶ The court denied Philadelphia American's motion for summary judgment because it failed to offer any summary judgment evidence that its conversion policy, which provided maximum lifetime benefits of \$7,500, met either of these standards.

Philadelphia American next argued that the group policy obligated it only to offer Schnabel the conversion contract that it customarily issued when he attempted to convert in February of 1990. This conversion contract provided maximum lifetime benefits of \$7,500. The group policy obligated Philadelphia American to "issue an individual contract, in a form customarily issued by it, with benefits not greater than the . . . [Group] Contract." The court held that this language was ambiguous because neither the terms and conditions of the conversion policy were identified or described in a manner to limit this promise to convert.⁹⁹⁷ The court further held that because language of an insurance contract is normally chosen by the insurer, when that language is ambiguous, the court must adopt the construction urged by the insured.⁹⁹⁸ The court next held that the right of conversion is a right to continue the basic coverage in another type of policy. Relying on *Baker v. Washington National Insurance Co.*,⁹⁹⁹ the court thus held that Philadelphia American's unrestricted promise to issue a conversion policy created a contractual duty to provide coverage no less advantageous than that provided in the group policy.¹⁰⁰⁰

After the court issued its order, Philadelphia American filed a motion to amend the judgment, arguing that Texas law does not set minimum standards for conversion coverage.¹⁰⁰¹ The court noted, however, that such minimum standards are prescribed in 28 Texas Administrative Code § 3.3828, which provides that an insurer issuing group long-term care shall provide a basis for continuation or conversion of coverage.¹⁰⁰² This regulation also provides that a "converted policy" means an individual policy of

996. *Schnabel*, 795 F. Supp. at 821. See TEX. INS. CODE ANN. art. 3.51-6, § 1(d)(3)(A)(ii) (Vernon Supp. 1993).

997. *Schnabel*, 795 F. Supp. at 823.

998. *Id.*

999. 823 F.2d 156 (5th Cir. 1987).

1000. *Schnabel*, 795 F. Supp. at 823.

1001. *Schnabel v. Philadelphia Am. Life Ins. Co.*, 807 F. Supp. 1268 (S.D. Tex. 1992).

1002. *Id.* at 1269-70.

long-term care, insurance providing benefits identical to, or determined by the board to be substantially equivalent to, or greater than, those provided under the group policy from which conversion is made.¹⁰⁰³

Philadelphia American also argued that *Baker*, the case on which this court based its original decision, contravenes the Texas Insurance Code. In *Baker*, the Fifth Circuit held that:

[I]f a company includes an undertaking to offer a conversion policy and its promise is no more definite than that it will issue an undisclosed, undefined form of conversion policy, it is bound to furnish at least one that is no less advantageous to the insured than the coverage it agrees to convert.¹⁰⁰⁴

The court held that nothing in *Baker* contravenes the Texas Insurance Code because article 3.51-6 of the Insurance Code requires the issuance of conversion policies and the Administrative Code mandates that conversion policies issued in Texas provide benefits that are no less advantageous than those provided under the group policy from which conversion is made.¹⁰⁰⁵

D. MISREPRESENTATION DEFENSE

In *Garcia v. John Hancock Variable Life Insurance Co.*¹⁰⁰⁶ the court found that the "intent to deceive" component of a misrepresentation defense is a question of fact and cannot be resolved by summary judgment. Carmen Garcia, the beneficiary of her husband's life insurance policy, brought suit against John Hancock to collect the proceeds under the policy. John Hancock did not pay the claim, contending that Alfredo Garcia misrepresented his health when applying for the policy. John Hancock moved for summary judgment on its affirmative defense of misrepresentation. John Hancock argued that Mr. Garcia intentionally misrepresented the state of his health in obtaining the life insurance policy one year prior to his death. The trial court granted summary judgment for John Hancock. The court of appeals reversed.

The summary judgment evidence showed that Mr. Garcia represented on two applications that he had never been treated for, and did not have, diabetes. He also represented that: (1) he had not seen a doctor in five years; (2) he was not taking any prescription drugs; (3) he had never experienced dizziness; and (4) he did not smoke. However, Mr. Garcia had been diagnosed with diabetes sixteen years before his application. He had visited a doctor, was taking prescription medication for diabetes at the time the application was made, had experienced dizziness, and did smoke.

According to the court, the insurer must plead and prove five elements in order to establish the affirmative defense of misrepresentation:

- (1) the making of a representation;
- (2) the falsity of the representation;

1003. 28 TEX. ADMIN. CODE § 3.3828 (West 1988).

1004. *Baker*, 823 F.2d at 159.

1005. *Schnabel*, 807 F. Supp. at 1270.

1006. 859 S.W.2d 427, 431 (Tex. App.—San Antonio 1993, writ requested).

- (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.¹⁰⁰⁷

The court assumed that elements one, two, three, and five were established. The court was thus faced with the issue of whether John Hancock established, as a matter of law, that Mr. Garcia intended to deceive John Hancock.

John Hancock argued that Mr. Garcia's "intent to deceive" was established by the fact that he misrepresented his health on two applications made within two weeks of each other. Both were completed near the time he was being treated by a doctor and taking prescription medicine for diabetes. However, the court likened the "intent to deceive" component of misrepresentation to the "intent" component in an allegation of fraud.¹⁰⁰⁸ The court stated that it knew of no reported Texas case in which the element of fraudulent intent had been proven, as a matter of law, in a summary judgment proceeding.¹⁰⁰⁹ Similarly, the court observed that it would be rare to establish subjective intent as a matter of law.

In reaching its decision, the court relied on *Flowers v. United Insurance Co. of America*¹⁰¹⁰ and *Estate of Diggs v. Enterprise Life Insurance Co.*¹⁰¹¹ Both courts refused to find the existence of an insured's "intent to deceive" as a matter of law, even though the insureds knew of their poor health and made misrepresentations on applications.¹⁰¹² The court thus concluded that the fact that a person knows about his health problems and misrepresents his health does not establish, as a matter of law, his "intent to deceive."¹⁰¹³ This is a fact question to be resolved by a jury.

In *Shelton v. Union Bankers Insurance Co.*¹⁰¹⁴ several months after purchasing a health insurance policy from Union Bankers, Shelton underwent hip replacement surgery. Union Bankers denied the claim, contending that his hip necrosis was an undisclosed pre-existing condition not covered by the policy. Union Bankers then attempted to reform the policy to eliminate coverage for Shelton's hip condition. When Shelton refused to agree to the reformation, Union Bankers canceled the policy, contending that Shelton made a material misrepresentation when applying for insurance by failing to disclose his condition on the application.

Because of Union Bankers' failure to pay the claim and cancellation of the policy, Shelton sued for breach of contract, violations of the DTPA and Insurance Code, and breach of the duty of good faith and fair dealing. The

1007. *Id.* (quoting *Mayes v. Massachusetts Mut. Life Ins. Co.*, 608 S.W.2d 612, 616 (Tex. 1980)).

1008. *Garcia*, 859 S.W.2d at 431.

1009. *Id.*

1010. 807 S.W.2d 783 (Tex. App.—Houston [14th Dist.] 1991, no writ).

1011. 646 S.W.2d 573 (Tex. App.—Houston [1st Dist.] 1982, writ ref'd n.r.e.).

1012. *Flowers*, 807 S.W.2d at 786; *Diggs*, 646 S.W.2d at 575-76.

1013. *Garcia*, 859 S.W.2d at 433.

1014. 853 S.W.2d 589 (Tex. App.—Texarkana 1993, writ granted).

jury resolved all issues against Shelton except for finding that he did not intend to deceive Union Bankers regarding his condition at the time he applied for the insurance. The court of appeals affirmed in part and reversed and remanded in part.

Shelton first argued that because the jury found that he did not intend to deceive Union Bankers by misrepresenting his condition, the trial court should have found, as a matter of law, that Union Bankers breached the insurance contract by canceling the policy. Shelton contended that a misrepresentation must be made with intent to deceive before it may be grounds for voiding an insurance policy. Union Bankers argued that the requirement of intent to deceive applied only to life insurance policies. Health insurance policies, argued Union Bankers, are governed by article 3.70-3 of the Insurance Code, which allows a health insurance policy to be voided on the basis of an unintentional misrepresentation within two years of the policy's inception.

The court concluded that intent to deceive must be proven to void a health insurance policy on the basis of a misrepresentation, rejecting Union Bankers' argument.¹⁰¹⁵ The court first looked to article 3.70-3(a)(2) of the Texas Insurance Code, which provides that article 3.70-3 shall not be construed as to affect any legal requirement for avoidance of a policy or denial of the claim during the initial two-year period. The court interpreted this language to incorporate the common law rule that fraud be proven to void a health insurance policy.¹⁰¹⁶

The court then looked to *General American Life Insurance Co. v. Martinez*,¹⁰¹⁷ where the court held that a material misrepresentation did not defeat recovery if made without intent to deceive. The policy involved in *Martinez* was a disability policy, which this court held was a health insurance policy.¹⁰¹⁸ The court then noted that the *Martinez* case was cited by the Texas Supreme Court, in a life insurance case, when it held that an insurer must plead and prove intentional misrepresentation before it can void a policy.¹⁰¹⁹ The court therefore concluded that because the jury found that Shelton did not intend to deceive Union Bankers, Union Bankers breached the insurance contract when it canceled the policy.¹⁰²⁰

E. EVIDENCE

In *McCraw v. Maris*¹⁰²¹ the court held that evidence of a duplicate beneficiary form was admissible in an action to determine whether the surviving spouse or the surviving children were entitled to life insurance proceeds. Donna Maris was an employee of the Department of Labor and insured under a Federal Employee's Group Life Insurance policy. Under federal

1015. *Id.* at 591.

1016. *Id.*

1017. 149 S.W.2d 637 (Tex. Civ. App.—El Paso 1941, writ dism'd judgm't cor.).

1018. *Shelton*, 853 S.W.2d at 592.

1019. *See Clark v. National Life & Acc. Ins. Co.*, 200 S.W.2d 820 (Tex. 1947).

1020. *Shelton*, 853 S.W.2d at 592.

1021. 828 S.W.2d 756 (Tex. 1992).

statute, the surviving spouse is entitled to the life insurance proceeds unless the insured signs a written beneficiary designation form. Ms. Maris' children filed this declaratory judgment action contending that she signed such a form, although it was later lost. Jimmie Maris, Donna's estranged husband, asserted he was entitled to the life insurance proceeds.

During the trial, there was evidence that Donna's habit was to complete handwritten duplicate forms prior to typing the original form. The trial court, however, excluded from evidence a duplicate beneficiary designation form in Donna's handwriting that designated her children as beneficiaries. The trial court ruled that Mr. Maris was entitled to the life insurance proceeds and the court of appeals affirmed.¹⁰²² The supreme court reversed, finding that the duplicate beneficiary designation form in Donna's handwriting was admissible. The court concluded that this form was not hearsay because it was not offered to prove the truth of any matter asserted within it, but only that it existed.¹⁰²³ This form was offered to prove that Donna followed her usual habit of typing and filing a form from the draft.

X. HOMEOWNERS' INSURANCE

A. POLICY INTERPRETATION

In *State Farm Fire & Casualty Co. v. Reed*¹⁰²⁴ the court held that the business pursuit exclusion and exception thereto based on activities incidental to non-business pursuits in a homeowner's policy are ambiguous and must be construed in favor of coverage. While at a daycare center operated by the Reeds out of their home, Michael Ford crawled through an opening in a fence that separated the play area from a pool and drowned. The Reeds had a homeowner's policy issued by State Farm.

The Fords sued the Reeds in a wrongful death action and obtained a judgment in the amount of \$480,000. The Fords agreed not to execute on the judgment against the Reeds in exchange for the Reeds' assignment of any causes of action they might have against State Farm. The Reeds and Fords then brought this action against State Farm alleging breach of contract, breach of the duty of good faith and fair dealing, and violations of the Insurance Code and DTPA. State Farm answered and counterclaimed for declaratory relief and moved for summary judgment on its claim for declaratory relief. The Fords and Reeds counterclaimed for declaratory relief and filed their own motion for summary judgment. The trial court concluded that there was coverage under the policy, entered a judgment accordingly, and ordered the coverage controversy severed so it could be appealed.

The policy issued to the Reeds by State Farm provided that State Farm would pay all sums that the Reeds became legally obligated to pay as damages because of bodily injury. The policy also provided that there was no

1022. 837 S.W.2d 646 (Tex. App.—Dallas 1990).

1023. *McCraw*, 828 S.W.2d at 757.

1024. 36 Tex. Sup. Ct. J. 1315, 1318 (Sept. 29, 1993).

coverage for "any business pursuits of an Insured except activities therein which are ordinarily incidental to non-business pursuits."

The court of appeals determined that the child's death occurred as a result of a business pursuit because it happened while the Reeds were operating a daycare service.¹⁰²⁵ However, the court of appeals concluded that there was coverage under the "ordinarily incidental" exception because one of the causes of the child's death was the negligent failure to maintain the fence, an activity ordinarily incidental to a non-business pursuit.¹⁰²⁶ The supreme court affirmed.

The supreme court began its analysis by noting that a contract of insurance is subject to the same rules of construction as other contracts. If the policy is worded so that it can be given only one reasonable construction, it will be enforced as written. However, if a contract of insurance is susceptible to more than one reasonable interpretation, the court must resolve the uncertainty by adopting the construction most favorable to the insured. An intent to exclude coverage, according to the court, must be expressed in clear and unambiguous language.¹⁰²⁷

The court noted that other jurisdictions have taken three different approaches to the question of whether child care in the home is excluded under a homeowner's policy as a business pursuit or is an exception to this exclusion because it is incidental to non-business pursuits. Some jurisdictions focus on the ongoing nature and profit aspect of the enterprise and hold that child care for compensation is a business pursuit and is not ordinarily incidental to non-business pursuits. According to the court, this approach has been criticized because it focuses too much on the business nature of child care and always renders the exception to the exclusion inapplicable.

Another approach is that child care is always ordinarily incidental to a non-commercial pursuit. This approach has been criticized as too broad because the ordinary incident to non-business pursuit exception swallows the business pursuits exclusion in the context of child care. The third approach focuses on the type of activity that caused the injury and gives effect to the exclusion when that activity is not ordinarily associated with the function of child care.

After reviewing the different approaches, the court concluded that the exclusion and exception are susceptible to more than one reasonable interpretation, and thus are ambiguous.¹⁰²⁸ Because the exclusion and the exception do not clearly and unambiguously exclude coverage, the court held that it must adopt the construction most favorable to the insured.¹⁰²⁹ Accordingly, the court held that coverage existed under the policy for damages resulting from the death Michael Ford.¹⁰³⁰

1025. 826 S.W.2d 659, 663 (Tex. App.—Houston [14th Dist.] 1992), *aff'd*, 36 Tex. Sup. Ct. J. 1315 (Sept. 29, 1993).

1026. *Id.*

1027. *Reed*, 36 Tex. Sup. Ct. J. at 1318.

1028. *Id.*

1029. *Id.*

1030. *Id.*

At issue in *State Farm Fire & Casualty Co. v. S.S. & G.W.*¹⁰³¹ was the "intentional injury" exclusion. G.W. & S.S. had sex at G.W.'s house. G.W. did not tell S.S. that he had genital herpes, and she contracted the disease. S.S. demanded that G.W. compensate her for her damages. G.W., in turn, notified State Farm, his homeowner insurer, of the claim and requested a defense. State Farm agreed to investigate the claim and provide G.W. with defense counsel but required that G.W. sign a non-waiver agreement. G.W. rejected State Farm's offer of counsel and employed his own attorney. S.S. filed suit against G.W. alleging that he negligently transmitted genital herpes to her. G.W. agreed to a \$1 million judgment in favor of S.S. She agreed not to execute in return for an assignment of some of G.W.'s rights under the insurance policy.

When State Farm learned of the judgment, it sought declaratory relief to establish that the policy did not provide any coverage. G.W. and S.S. counterclaimed, alleging that the policy covered the injury, and that State Farm had adjusted the claim in bad faith. State Farm filed a motion for summary judgment contending that S.S.'s claims fell within the intentional injury exclusion in the policy and G.W. breached his duty to cooperate under the policy by failing to notify State Farm of S.S.'s lawsuit and entering into an agreed judgment without State Farm's knowledge. The trial court rendered summary judgment in favor of State Farm on the specific ground that the homeowner's policy did not, as a matter of law, provide coverage for any of the claims asserted by S.S. in the underlying lawsuit. The trial court's summary judgment order did not address State Farm's claims that G.W. breached his duty to cooperate. The court of appeals reversed and remanded, finding that State Farm failed to carry its burden to prove conclusively that G.W. intended to cause injury to S.S.¹⁰³² The supreme court affirmed the judgment of the court of appeals.

State Farm argued that, as a matter of law, the transmission of genital herpes came within the "intentional injury exclusion" of G.W.'s homeowner's policy. The court disagreed, holding that ordinarily whether an insured intended harm or injury to result from an intentional act is a question of fact.¹⁰³³ The court held that an insured intends to injure or harm another if he intends the consequences of his act, or believes that they are substantially certain to follow.¹⁰³⁴ In this case, while it was undisputed that G.W. intentionally engaged in sexual intercourse without informing S.S. of his condition, the summary judgment evidence did not indicate that G.W. acted with intent to cause S.S. bodily injury. The summary judgment evidence indicated that G.W. did not believe it was possible to transmit the disease without an active lesion and failed to demonstrate that G.W. knew that engaging in sexual intercourse with S.S. was substantially certain to result in transmission of the disease to S.S. Consequently, the court concluded that

1031. 858 S.W.2d 374 (Tex. 1993).

1032. 808 S.W.2d 668 (Tex. App.—Austin 1991), *aff'd*, 858 S.W.2d 374 (Tex. 1993).

1033. *State Farm*, 858 S.W.2d at 378.

1034. *Id.*

an issue of material fact existed whether G.W. knew at the time with substantial certainty that he would transmit herpes to S.S.¹⁰³⁵

State Farm also argued that even if G.W. did not intend to injure S.S. by his conduct, his intent to injure was inferred, as a matter of law, because this case involved sexual misconduct. The court held, however, that the cases relied on by State Farm usually involved situations of sexual misconduct with minors or forcible sex acts between adults. These cases were distinguishable because G.W. and S.S. were consenting adults. Thus, the court refused to infer intent to injure, as a matter of law.¹⁰³⁶

State Farm next argued that the summary judgment should be affirmed on the ground that G.W. breached his duty to cooperate. The court held, however, that because this ground was not specified in the trial court's summary judgment order, it could not be considered on appeal.¹⁰³⁷

The issue before the court in *Jerry v. Kentucky Central Insurance Co.*¹⁰³⁸ was the meaning of the word "vacant," because the insurer denied coverage for a loss claiming the home had been vacant for more than ninety days. In November 1985, Mr. and Ms. Jerry moved to Utah but retained ownership of their house in Harris County. In April 1986, Ms. Jerry returned to the property and discovered that it had been broken into and vandalized. The Jerrys submitted a theft claim to their insurer and received replacement value for the furnishings. About six months later, Ms. Jerry's parents visited the property and discovered it destroyed by fire. Kentucky Central denied this claim and canceled the policy because the property had been vacated. By the terms of the policy, the company was not liable if the house was vacant for more than ninety days. The policy also provided, however, that a "building in the course of construction shall not be deemed to be vacant."

The Jerrys then brought suit against Kentucky Central for breach of contract, negligence, breach of the duty of good faith and fair dealing, and violations of article 21.21 and the DTPA. After a trial before the court, a take-nothing judgment was entered in favor of Kentucky Central. The court of appeals affirmed.

On appeal the Jerrys challenged the trial court's finding that the house had been vacant and not under construction at the time of the fire. Initially, the court held that the term "vacant" means "entire abandonment, deprived of contents, empty, that is, without contents of substantial utility."¹⁰³⁹ The evidence showed that when the Jerrys moved to Utah, they had cut off the utilities and that the house was not occupied by anyone after that time. Furthermore, there was evidence that everything of value left in the house was taken by burglars even before the fire occurred. The court did note, however, that there was conflicting evidence on whether the items were replaced in the house. There was some evidence that just prior to the fire, the house

1035. *Id.* at 379.

1036. *Id.* at 379-80.

1037. *Id.* at 380.

1038. 836 S.W.2d 812 (Tex. App.—Houston [1st Dist.] 1992, writ denied).

1039. *Id.* at 815.

contained living room furniture, a sofa, wicker furniture, a bedroom suite, and other items. There was other evidence, however, by the adjuster hired by Kentucky Central that he found the home contained no refrigerator, stove, pots and pans, or light meter. Also, he saw no evidence of furniture in the master bedroom or living room, but saw an unburned mattress in the yard, indicating to him that the house had been abandoned before the fire. Additionally, Lamb testified that a neighbor had told him that the doors to the house had been left open for months before the fire. The court of appeals held that in light of this record, there was sufficient evidence to support the trial court's finding that the house was vacant.¹⁰⁴⁰

The Jerrys argued that the vacancy clause was suspended by the fact that repairs were being made to the house. As previously mentioned, the policy provided that a building in the course of construction shall not be deemed to be vacant. The court held that construction, as used in the policy, meant creation of a new structure rather than restoring something already in existence.¹⁰⁴¹ The court, therefore, held that the house was not under construction merely because it was being repaired.¹⁰⁴² Accordingly, the court held that there was no breach of contract by Kentucky Central and no liability under the policy.¹⁰⁴³

In *Bonner v. United Services Automobile Ass'n*¹⁰⁴⁴ the insurer claimed there was no coverage under a homeowner's policy because of the exclusion for "any act or omission in connection with premises, other than as defined, which are owned, rented or controlled by an Insured." USAA issued a homeowner's policy to Gloria Padgett, the mother of Roger Padgett, which covered a dwelling in Canyon Lake. Roger shot and killed his girlfriend, Linda Tarrant, at an apartment the two shared in Houston. Bonner, as the next friend of Tarrant's minor son, brought a wrongful death action against Roger. A judgment was rendered against Roger in excess of USAA's policy limits. USAA then filed a declaratory judgment action against Roger, asserting non-coverage because of two policy exclusions: the "in connection with" exclusion and the "intentional injury" exclusion.

The jury found that Roger was a resident of his mother's household and that Tarrant's death was "in connection with" premises owned, rented or controlled by Roger in Houston. The jury, however, was unable to answer whether Roger intentionally caused Tarrant's death. Based on this partial verdict, the trial court entered judgment for USAA and Roger appealed.

The court, finding no Texas cases construing the "in connection with" exclusion, held that it is susceptible of two reasonable constructions and thus is ambiguous.¹⁰⁴⁵ As such, the exclusion must be construed in favor of the insured and against the insurer.¹⁰⁴⁶ Thus, the court concluded that for the

1040. *Id.*

1041. *Id.* at 816.

1042. *Id.*

1043. *Id.*

1044. 841 S.W.2d 504 (Tex. App.—Houston [14th Dist.] 1992, writ denied).

1045. *Id.* at 507.

1046. *Id.*

exclusion to apply there must be some causal relationship between the act or omission and the other premises owned, rented, or controlled by the insured.¹⁰⁴⁷ The court held that if the insurer had intended to exclude coverage for any act or omission occurring on other premises, the exclusion could have been stated exactly in those words rather than "in connection with" the other premises.¹⁰⁴⁸

The court next concluded that because there was some evidence that Roger had intentionally caused the death of Tarrant, the case should be remanded for a new trial since the jury was deadlocked on this question.¹⁰⁴⁹

B. INSURABLE INTEREST

The issue of when a person has an insurable interest in property was the subject of *Jones v. Texas Pacific Indemnity Co.*¹⁰⁵⁰ The Joneses owned a home insured by Texas Pacific. The policy listed the Joneses as the named insured and Martin as the mortgagee. Martin foreclosed on the home after the Joneses defaulted on their mortgage payments. Eleven days after the foreclosure, while the Joneses remained in the house as tenants at sufferance, the house burned. Texas Pacific paid the Joneses the policy limits for content loss and additional living expenses and paid Martin the dwelling's total value.

The Joneses sued on the policy to collect for structural damage to the house. Texas Pacific claimed that the Joneses were not the owners and, therefore, not entitled to recover for structural damage under the policy. Texas Pacific moved for summary judgment on this basis, which the trial court granted. The court of appeals affirmed.

The Joneses argued on appeal that, although they no longer owned the property, they still had an insurable interest and were entitled to the insurance proceeds for damage to the structure. The court, while agreeing that it is not necessary for a party to own property to have an insurable interest, held that to have an insurable interest the Joneses had to prove that they would sustain pecuniary loss from the destruction of the house or that they would derive pecuniary benefit or advantage by the preservation and continued existence of the house.¹⁰⁵¹ The court further held that whether a person has an insurable interest in property is a question of law, not fact.¹⁰⁵²

The court noted that because the Joneses were tenants at sufferance after the foreclosure and subject to immediate eviction, they had no future legal interest in the dwelling, and diminished motive and opportunity to protect the property.¹⁰⁵³ The court held that the Joneses did not suffer any pecuniary loss from the fire or receive any benefit from the dwelling.¹⁰⁵⁴ Therefore,

1047. *Id.*

1048. *Id.*

1049. *Id.* at 508.

1050. 853 S.W.2d 791 (Tex. App.—Dallas 1993, no writ).

1051. *Id.* at 794.

1052. *Id.*

1053. *Id.* at 795.

1054. *Id.*

they had no insurable interest in the dwelling, and the trial court's summary judgment was correct.

The Joneses next argued that Texas Pacific was estopped from refusing to pay for structural damage because it paid their additional living expenses under the dwelling coverages extended benefits. The court held, however, that the Joneses waived any estoppel argument for failure to raise it at the trial level.¹⁰⁵⁵

C. TOTAL LOSS

The issue in *State Farm Lloyds v. Mower*,¹⁰⁵⁶ involved the total loss of a structure. In March 1986, Mower's home was involved in a serious fire. Mower had homeowner's insurance with State Farm. The policy had dwelling coverage of \$175,000. First Federal, the mortgagee, was a loss payee on the policy. After the fire, State Farm assigned Barnhill, an independent adjuster, to investigate the loss. Barnhill concluded that remnants could be used in reconstructing the house — namely, the garage and the slab. Although there were usable remnants, Barnhill believed that the cost of reconstructing the house would exceed the \$175,000 policy limit. Based on this belief, Barnhill recommended that State Farm's reserves be set at \$175,000. State Farm in accordance with Barnhill's recommendation, set the reserve for Mower's claim at \$175,000.

Soon after the fire, Mower requested bids to rebuild his home from Hudnell, the original builder, and Stewart, a contractor specializing in reconstruction of homes damaged by fire. Hudnell submitted a bid of \$88,000, and Stewart bid about \$86,000 to reconstruct the home, but Hudnell would not guarantee the slab. Both estimates stated that the slab and garage remnants would be used in the reconstruction. Based on these bids, State Farm concluded that the loss was not total and offered to pay Mower \$90,000. Mower rejected this offer and submitted a counter-offer of \$104,000, the pay-off amount of the mortgage, which had been accelerated because Mower had stopped making mortgage payments after the fire.

After Mower rejected State Farm's offer, State Farm notified First Federal that it was offering \$90,000 to pay the claim. First Federal informed Mower that it intended to exercise its rights under the deed of trust to accept State Farm's offer. Mower objected.

State Farm then filed an interpleader action to request instruction from the court as to whom it should pay. Mower sued State Farm claiming that it had breached its contract by not paying total loss benefits, and that it breached its duty of good faith and fair dealing. The trial court ordered separate trials on these issues. On the contract claim, the jury determined that the house was a total loss. At the second trial, the jury determined that State Farm breached its duty of good faith and fair dealing by not paying total loss benefits. The jury thus awarded Mower \$50,000 for mental

1055. *Id.*

1056. No. 01-91-00216-CV, 1993 Tex. App. LEXIS 3253 (Tex. App.—Houston [1st Dist.], Dec. 9, 1993, n.w.h.).

anguish and \$5 million in punitive damages. The court of appeals reversed and remanded.

State Farm first argued that there was no evidence, or insufficient evidence, to support the jury's finding that Mower's house was a total loss. According to the court, the test for determining whether a building is a total loss by fire depends on whether a reasonably prudent owner, desiring to rebuild, would have used the remnants for restoring the building.¹⁰⁵⁷ The evidence supporting the jury's verdict included Barnhill's determination that the structure was a total loss when he initially inspected the house. Furthermore, a State Farm employee testified that if it had been his house, he would have thought his house had burned down. The court also noted that although Hudnell stated that he would use the original slab in his estimate to rebuild, he would not guarantee the slab after the fire. The court found that this was sufficient evidence to support the jury's finding of total loss.¹⁰⁵⁸

State Farm next argued that the trial court erred by refusing to instruct the jury that the garage and the slab were part of the structure covered by the policy. The court held that such an instruction would not have helped the jury to understand the meaning and effect of the law since no witness testified that the policy did not cover the slab and the garage.¹⁰⁵⁹

XI. LIABILITY INSURANCE

A. COVERAGE ISSUES

In *CIGNA Insurance Co. of Texas v. Jones*¹⁰⁶⁰ the court was presented with the issue of whether liability coverage should be extended to a liquefied petroleum gas (LPG) provider after the policy had been canceled but without notice to the Texas Railroad Commission. Caravan, in order to obtain and renew an LPG license, had to obtain liability insurance and file a certificate of insurance with the Commission. Once the certificate is filed, it need not be renewed each time the license is renewed. The certificate can be canceled by the insurer giving written notice to the Commission of its intent to cancel the policy.

Caravan initially had insurance with Aetna, which filed a certificate of insurance with the Commission. INA (which later became CIGNA) eventually replaced the Aetna coverage, but it did not file a certificate with the Commission. About a year after issuing its policy, INA canceled Caravan's insurance for non-payment of premium. Neither INA nor Aetna, however, had notified the Commission of the cancellation of Caravan's policy until May 1988, about two years after cancellation. After the policy had been canceled, however, Caravan's license was not renewed for failure to apply timely for renewal. When Caravan finally applied for renewal, the Commission rejected this application because Caravan did not submit proof of insur-

1057. *Id.*, slip op. at 4.

1058. *Id.*, slip op. at 5.

1059. *Id.*, slip op. at 8.

1060. 850 S.W.2d 687 (Tex. App.—Corpus Christi 1993, no writ).

ance. Thus, Caravan was instructed to cease operations that required an LPG license.

After the insurance was canceled, Jones was injured because of Caravan's negligence in furnishing LPG services to Jones. Jones sued Caravan and obtained a judgment for \$500,000 against Caravan. Jones then sought a declaratory judgment that CIGNA was liable on the policy under the certificate on file with the Commission at the time of his injuries. The trial court determined that, because Aetna had not notified the Commission of the cancellation, the certificate of insurance on file with the Commission bound CIGNA to cover Jones's loss. The court of appeals reversed and rendered judgment for CIGNA.

The court found disturbing the gap allowed by the statute governing LPG licensing that allows someone to retain a LPG license despite cancellation of the mandatory insurance coverage. However, the court felt that such a problem should be remedied by the legislature, not the courts.¹⁰⁶¹ The court concluded that the insurer does not need to notify the Commission of its intent to cancel insurance before such insurance is effectively canceled.¹⁰⁶² The statutory requirement of such notice is for the benefit of the Commission in its licensing procedures. Moreover, the court felt that Caravan would have probably continued its activities even if the Commission had canceled its license upon receiving notice of cancellation of the insurance, seeing that Caravan continued its operations even after the Commission rejected its renewal application.¹⁰⁶³

In *Ranger Insurance Company v. Mijne*¹⁰⁶⁴ Potzner and Mijne died when the plane they were operating crashed. Potzner had rented the plane from Levelland Aviation, which had insurance through Ranger. The policy limit was \$100,000 per person, \$300,000 per occurrence. The estates of both men insisted that Ranger pay them each \$100,000. Ranger claimed that the policy excluded coverage for renter pilots and offered to pay only \$100,000. After no settlement could be reached, Ranger interpleaded the \$100,000. The district court concluded that the policy covered both pilots and passengers, but excluded renter pilots. Thus, it granted summary judgment for Ranger. The Fifth Circuit reversed and rendered judgment for Potzner.

The court of appeals disagreed with the district court's ruling that the policy excluded coverage for bodily injury to renter pilots. The policy did have a provision said "Your bodily injury and property damage coverage does not protect . . . [a]ny renter pilot." This provision, however, was found under the section describing the persons "protected" by the policy, rather than the things covered. According to the court, the term "protected" refers to those insured under the policy; that is, those persons who are legally required to pay damages which Ranger must cover.¹⁰⁶⁵ Thus, the court held,

1061. *Id.* at 690.

1062. *Id.* at 691.

1063. *Id.*

1064. 991 F.2d 240 (5th Cir. 1993).

1065. *Id.* at 244.

the policy would not provide coverage if Mijne sued Potzner as a result of the plane crash, but does cover the injuries suffered by renter pilots for which Levelland is obligated to pay.¹⁰⁶⁶

In *Vesta Insurance Co. v. Amoco Production Co.*¹⁰⁶⁷ Gonzales was seriously injured at an Amoco plant while in the employ of Cantu Lease. At the time, Gonzales was performing various oil field services that Cantu had contracted to perform for Amoco. In this contract Cantu agreed to defend, indemnify, and not hold Amoco and its insurers responsible for injuries to Cantu's employees, regardless of Amoco's negligence. Vesta was the excess liability insurer of Amoco. Under the terms of the insurance policy, Vesta was only liable to Amoco for an "ultimate net loss" that exceeded \$5 million. "Ultimate net loss" was defined as the total sum that Amoco and its insurers became obligated to pay because of personal injury claims.

Gonzales, as a result of his injuries, sued Amoco and eventually settled for \$6,215,000. Amoco paid \$2,715,000 and Cantu's insurer paid \$3,500,000. Amoco, claiming that Cantu acted as its insurer, made a claim upon Vesta that it reimburse Amoco \$1,215,000, the portion of the settlement exceeding \$5 million. Vesta claimed that Cantu was an indemnitor, not an insurer, and thus owed nothing to Amoco because its ultimate net loss was less than \$5 million. Even so, Vesta agreed to "loan/advance" to Amoco about \$798,000, representing a portion of the settlement that exceeded \$5 million. The parties then agreed to resolve their dispute via this declaratory judgment action.

This district court held that Vesta was obligated to Amoco under the excess policy. The court further held that Vesta was required to reimburse Amoco for its attorney's fees incurred in defending Gonzales' lawsuit. The Fifth Circuit reversed and rendered judgment in Vesta's favor.

The issue determining coverage was whether Cantu was an insurer of Amoco because, if it was, its contribution to the settlement would be considered part of Amoco's "ultimate net loss" as defined by the Vesta policy. The court, giving three reasons, held that Cantu was not Amoco's insurer. First, the court looked to the difference in the definitions of "insurance" and "indemnity." According to *Black's Law Dictionary*, "indemnity" means a "contractual or equitable right under which the entire loss is shifted from a tortfeasor who is only technically or passively at fault to another who is primarily or actively responsible."¹⁰⁶⁸ "Insurance," on the other hand, is defined as a "contract whereby, for a stipulated consideration, one party undertakes to compensate the other for loss on a specified subject by specified perils."¹⁰⁶⁹ From these definitions, the court concluded that there is a substantial distinction between a party bound by a contractual indemnity clause and an insurer.¹⁰⁷⁰ Second, the court looked to the definition of the "busi-

1066. *Id.*

1067. 986 F.2d 981 (5th Cir. 1993), *cert. denied*, 114 S. Ct. 80 (1993).

1068. *Id.* at 985 (quoting BLACK'S LAW DICTIONARY 769 (6th ed. 1990)).

1069. *Id.* (quoting BLACK'S LAW DICTIONARY 802 (6th ed. 1990)).

1070. *Id.* at 986.

ness of insurance" devised by the Supreme Court and found that Cantu's contract with Amoco did not include spreading and underwriting the risks of Amoco.¹⁰⁷¹ The court then looked to Texas law and noted that there was no evidence that Cantu complied with the statutory requirements for qualifications as an insurer or that any of Cantu's conduct fell within the definition of the "business of insurance" found in article 1.14-1, § 2 of the Texas Insurance Code.¹⁰⁷²

Thus, the court held that one who only contractually agrees to indemnify another is not an insurer of that person.¹⁰⁷³ Because Cantu's payment was not made as Amoco's insurer, Amoco's ultimate net loss was less than \$5 million — the amount above which Vesta became liable.

The court next held that Vesta was entitled to reimbursement for the "loan/advance" it had initially paid to Amoco under the policy. The court reasoned that, based on the policy's subrogation clause, Vesta's coverage applied only to losses in excess of \$5 million. Because Amoco had paid only \$2.7 million, Vesta was entitled to the recovery of funds it had improperly paid out under the policy. The court dismissed Amoco's argument that Vesta's right to subrogation did not accrue until Vesta paid under the insurance policy.¹⁰⁷⁴ The court reasoned that Amoco had already been indemnified for \$3.5 million by the contractor at the time Vesta made its loan/advance to Amoco. Therefore, the court stated, as Amoco no longer had a cause of action against the contractor, there was no cause of action to which Vesta could be subrogated when it improperly advanced money under the insurance policy.¹⁰⁷⁵

B. DUTY TO INDEMNIFY

In *E.B. Smith Co. v. United States Fidelity & Guaranty Co.*¹⁰⁷⁶ the court addressed the issue of the insurer's defense to payment for lack of reasonable notice of the lawsuit against its insured. In March of 1986, Smith was sued by Dettman. At the time, Smith had a comprehensive general liability policy issued by USF&G, but did not inform USF&G of the lawsuit until January of 1988. After USF&G refused to pay Smith's portion of the settlement of the Dettman lawsuit, Smith filed this suit against USF&G. USF&G filed a motion for summary judgment contending that, as a matter of law, Smith failed to comply with the notice, terms, and conditions of the liability policy. The policy required Smith to give notice of claims to USF&G "as soon as practicable" rather than within a certain number of days. The trial court granted the summary judgment in favor of USF&G and Smith appealed. The court of appeals reversed and remanded.

The court initially noted that the requirement that notice of the lawsuit be

1071. *Id.*

1072. *Id.*

1073. *Id.*

1074. *Id.* at 987.

1075. *Id.*

1076. 850 S.W.2d 621 (Tex. App.—Corpus Christi 1993, writ denied).

given to USF&G "as soon as practicable" was a condition precedent to liability.¹⁰⁷⁷ In the absence of waiver or other special circumstances, failure to perform the condition constitutes an absolute defense to liability on the policy.¹⁰⁷⁸ Thus, in order to be entitled to a summary judgment, USF&G had to establish, as a matter of law, that Smith's notice was not "as soon as practicable."

The court held that "as soon as practicable" means notice within a reasonable time, which is determined by the facts and circumstances in each particular case.¹⁰⁷⁹ The court noted that while twenty-two months may appear to be late notice, USF&G had not presented evidence of when, or for what, Smith was sued, nor any evidence of settlement. Thus, the court held that USF&G had not presented sufficient facts to establish that the notice was not given "as soon as practicable."¹⁰⁸⁰

In *Audubon Indemnity Co. v. Patel*¹⁰⁸¹ the court decided whether Audubon had a duty to cover Patel under a commercial insurance policy covering Patel's motel for damages suffered by a customer who was beaten by an intruder. Dockens, the motel customer, had filed suit against Patel in state court and Audubon responded with this declaratory judgment action. The court determined that the assault and battery exclusion precludes any coverage arising out of the assault and battery committed on Dockens even if Patel is found liable for negligence.¹⁰⁸²

In *P.G. Bell Co. v. United States Fidelity & Guaranty Co.*¹⁰⁸³ Bell sued USF&G, after it obtained a judgment against USF&G's insured, for breach of contract and the duty of good faith and fair dealing and for violations of the DTPA. USF&G filed a motion for summary judgment contending that Bell could not maintain any causes of action against USF&G because it did not have a contract with Bell, it did not owe a duty of good faith and fair dealing to Bell, the terms of the insurance policy were not complied with, and the statute of limitations barred the claims. The trial court granted this motion and rendered judgment in favor of USF&G. The court of appeals reversed and remanded for trial.

USF&G argued that Bell could not maintain an action for breach of contract because there was no contract between USF&G and Bell. However, Bell was a third-party judgment creditor bound by the rights, duties, and obligations of the insured under the terms and conditions of the contract between the insurance company and the insured. The court, therefore, held that once Bell acquired a default judgment against the insured for damages done to property covered by the USF&G policy, Bell had a cause of action against USF&G for payment of those damages up to the policy limits.¹⁰⁸⁴

1077. *Id.* at 625.

1078. *Id.*

1079. *Id.*

1080. *Id.*

1081. 811 F. Supp. 264 (S.D. Tex. 1993).

1082. *Id.* at 265.

1083. 853 S.W.2d 187 (Tex. App.—Corpus Christi 1993, no writ).

1084. *Id.* at 190.

Bell next argued that the trial court erred by finding that the terms and conditions of the insurance policy were not complied with. The policy required that before an action could be brought against USF&G, it had to have notice of the accident giving rise to the claim. USF&G argued that Superior failed to give it notice of the claim, and this failure to comply with the policy's notice provision should be imputed to Bell. The court noted, however, that the policy provided that failure to give notice of the action would not bar liability under the policy unless it prejudiced USF&G. The court held that an insured's failure to notify the insurer of a claim filed against it by a third-party would not constitute prejudice to it unless that notice was given after a default judgment was taken against the insured.¹⁰⁸⁵ The evidence showed that USF&G learned of Bell's claims against Superior almost three years before trial. Bell, rather than Superior, sent USF&G a copy of its petition and had its attorney discuss the case with USF&G. USF&G argued that for notice to be sufficient, it had to be provided by Superior, the insured. The court disagreed and held that notice of the occurrence or action need not come from the insured, but could come from the injured party.¹⁰⁸⁶ Therefore, there was a fact question of whether USF&G was prejudiced by the timing of the notice.

Bell next argued that the trial court erred by ruling that the statute of limitations barred its claims. Apparently, the trial court found that Bell's claims accrued at the time USF&G refused to defend Superior. The court of appeals disagreed, holding that Bell's claim did not accrue until Superior's obligation to pay was finally determined at the time the default judgment was taken against it.¹⁰⁸⁷ The court relied on the policy provision that no action would lie against the insurer unless, as a condition precedent thereto, the amount of the insured's obligation to pay shall have been finally determined by judgment against the insured after actual trial. Because Bell filed its lawsuit within two years of securing the default judgment, the court held that limitations did not bar this action.

C. BURDEN OF PROOF

In *Bituminous Casualty Corp. v. Vacuum Tanks, Inc.*¹⁰⁸⁸ the court addressed the issue of proving the terms of an insurance policy when the actual policy is missing. Vacuum Tanks (VTI) was sued to contribute to the clean-up of pollution sites. Bituminous refused VTI's request for a defense because it could not determine coverage under the policies it had issued to VTI as none could be located. The district court declared that a defense was owed based upon the coverage described in a specimen policy. The Fifth Circuit reversed.

The court first cited the general proposition that the insured has the burden to prove the terms of the contract in order to establish coverage under

1085. *Id.* at 191.

1086. *Id.* at 192.

1087. *Id.*

1088. 975 F.2d 1130 (5th Cir. 1992).

the policy.¹⁰⁸⁹ Typically, this is done by introducing the policy into evidence. If, as in this case, a policy cannot be located, the insured can resort to secondary evidence to prove the terms of the policy.¹⁰⁹⁰ This alternative, according to the court, requires evidence of policy terms, not just evidence of the existence of a policy.¹⁰⁹¹ The court determined that VTI failed to prove the actual terms of the policy because the specimen policy was introduced for the limited purpose of demonstrating the contents of Bituminous's file.¹⁰⁹²

In *New Hampshire Insurance Co. v. Martech USA, Inc.*¹⁰⁹³ insurers of all-risk marine policies sought a declaration that they had no liability to their insured for equipment damage. The policies issued to Martech were effective from April 1986 to April 1988. In January 1988, Martech received unconfirmed information that some of its equipment had been damaged. Martech was instructed to prepare written documentation of the losses and make a claim. About a year later Martech provided a report of its losses. The claim was denied for lack of timely notice, lack of proof that the loss occurred during the policy period, and various policy exclusions.

The district court, resorting to Texas rather than maritime law, placed the burden on Martech to prove that the loss occurred during the policy period and that the exclusions did not apply. Consequently the court granted summary judgment for the insurers. Martech appealed, arguing that the court should have applied maritime law which places the burden on the insurer to prove the applicability of policy exclusions.

The court of appeals held that it did not matter which law was applied since under both federal maritime law and article 21.58 of the Texas Insurance Code the burden is on the insurer to prove the applicability of policy exclusions.¹⁰⁹⁴ The question left for the court to decide was who has the burden to prove that a loss occurred within the policy period. That is, is this a matter of exclusion for the insurer to prove or a precondition to coverage for the insured to prove. The court concluded that the insured must first prove that the loss occurred during the policy period. If such is proven, the burden then shifts to the insurer to prove any policy exclusion.¹⁰⁹⁵ Martech did not show when the loss occurred, only that it may have occurred during the policy period. The court held that unconfirmed rumors of loss are insufficient to satisfy Martech's burden and thus affirmed the summary judgment.¹⁰⁹⁶

1089. *Id.* at 1132.

1090. *Id.*

1091. *Id.*

1092. *Id.* at 1133.

1093. 993 F.2d 1195 (5th Cir. 1993).

1094. *Id.* at 1199.

1095. *Id.* at 1200.

1096. *Id.*

XII. PROPERTY INSURANCE

A. COVERAGE ISSUES

1. *What Is "Hail"?*

In *Commonwealth Lloyds Insurance Co. v. Downs*¹⁰⁹⁷ the issue was whether the loss to Downs' horse-barn and covered arena was caused by hail. A severe winter storm caused ice to accumulate on the roof of Downs' covered horse arena, causing the roof to collapse and kill five horses belonging to a tenant. On the proof of loss submitted to Commonwealth by Downs, he described the loss as being caused by ice. The adjuster for Commonwealth determined that the loss was not a covered peril under the policy, and denied the claim.

Downs filed suit against Commonwealth seeking, inter alia, a declaratory judgment that the collapse due to ice was covered by the policy. The jury found in favor of Downs on all issues. The court then awarded Downs a judgment of \$200,000 for violations of the Insurance Code and breach of the duty of good faith and fair dealing, but denied him recovery under his causes of action for breach of contract and DTPA violations. The court of appeals reversed and rendered a take-nothing judgment.

The court first addressed the issue of whether the cause of the property damage was a covered peril under the terms of the insurance contract. The policy provided coverage for losses caused by hail but excluded losses caused by rain or snow. The policy did not mention ice or sleet, nor did it define the term "hail." It was undisputed that the damage to the arena was caused by an accumulation of ice. Downs, however, argued that the accumulated ice was caused by ice pellets or sleet, which come within the commonly understood definition of "hail." Commonwealth's position was that the ice pellets did not come within the accepted definition of "hail," and therefore, there was no coverage.

The court concluded that the policy was ambiguous because the term "hail" is susceptible to more than one reasonable construction.¹⁰⁹⁸ As such, the construction that most favors the insured must be adopted. The court further held that extraneous evidence was properly introduced at trial to determine the intended meaning of the term "hail" and whether the property damage fell within the policy coverage.¹⁰⁹⁹ The testimony revealed that the property damage was caused either by ice, freezing rain, snow, or sleet, or a combination of these weather conditions. Downs attempted to equate hail with sleet or ice pellets. Because there was no evidence that the damage was actually caused by hail, the court held that there was no evidence to support the jury's finding that the weather conditions listed under the insurance policy were the dominant causes of the damage.¹¹⁰⁰

Downs argued that sleet was included within the meaning of "hail," citing

1097. 853 S.W.2d 104 (Tex. App.—Fort Worth 1993, writ denied).

1098. *Id.* at 110.

1099. *Id.*

1100. *Id.* at 114.

*Evana Plantation v. Yorkshire Insurance Co.*¹¹⁰¹ and *Southall v. Farm Bureau Mutual Insurance Co.*¹¹⁰² The court refused to adopt the reasoning of these two cases, finding them distinguishable. One distinction was that the policies in those cases specifically excluded ice from coverage for hail, whereas there was no such exclusion in Downs' policy.¹¹⁰³ Furthermore, in *Southall* there was undisputed testimony that "hail" includes sleet, and that the sleet on the roof was small hail.¹¹⁰⁴ In this case, however, the court noted that while all agreed that Downs' roof was damaged by an accumulation, there were many conflicting opinions regarding whether the ice was actually "hail."¹¹⁰⁵

The court, while correctly stating that when a policy is ambiguous, the interpretation favoring coverage must be adopted,¹¹⁰⁶ failed to abide by this rule. The court held that the policy was ambiguous because "hail" was susceptible to more than one interpretation, but then refused to adopt the insured's construction of the term so as to include ice pellets or sleet.¹¹⁰⁷ This was so, even though there was much testimony by experts, even those brought by Commonwealth, that "hail" includes ice pellets and hard snow (the dictionary definition).

2. Exclusion Based on Arson by Insured

In *American General Fire & Casualty Co. v. McInnis Book Store, Inc.*¹¹⁰⁸ the McInnis Book Store, along with its contents, was destroyed by a fire. McInnis Book Store's insurer, American General, refused to pay for the loss, contending that the owner, Lynam, had intentionally set the fire because the store was suffering financially. The McInnis Book Store then sued American General for breach of contract, breach of the duty of good faith and fair dealing, violations of article 21.21, and the DTPA. The contract claim was severed and tried separately from the remaining claims. The jury found that Lynam did not intentionally set the fire and that the store suffered compensable losses of \$143,000. Accordingly, the trial court entered judgment for McInnis Book Store, including prejudgment interest and attorney's fees. The court of appeals affirmed.

American General complained of jury prejudice due to the inclusion of exhibits revealing that Lynam had been acquitted of arson. At the time the exhibits were offered, the court admitted them into evidence on the condition that McInnis Book Store's attorney would delete the material referring to the criminal trial. This was never done, however, and the exhibits were given to the jury in their original form. The court concluded that, while it

1101. 58 So. 2d 797 (Miss. 1952).

1102. 632 S.W.2d 420 (Ark. 1982).

1103. *Commonwealth Lloyds*, 853 S.W.2d at 111.

1104. *Id.*

1105. *Id.*

1106. *See National Union Fire Ins. Co. v. Hudson Energy Co.*, 811 S.W.2d 552, 555 (Tex. 1991).

1107. *Commonwealth Lloyds*, 853 S.W.2d at 114.

1108. 860 S.W.2d 484 (Tex. App.—Corpus Christi 1993, no writ).

was the offering party's duty to ensure that the objectionable/inadmissible material was excised, in this case American General could show no harm because the exhibits were not viewed by the jury until after a verdict had been reached.¹¹⁰⁹

The court upheld the jury's finding that Lynam did not intentionally set the fire was not against the great weight and preponderance of the evidence.¹¹¹⁰ The record revealed conflicting evidence and sharply disputed testimony on this issue. The court, however, noted that reversal is only justified if the verdict is so contrary to the overwhelming weight and preponderance of the evidence that it is clearly wrong and manifestly unjust.¹¹¹¹ Therefore, the court refused to reverse the jury verdict.

The court further held that the evidence supporting the jury's award of damages was not so weak that the award of damages was unjust.¹¹¹² The evidence showed that the bookstore had an inventory of \$70,000 at the time of the fire and that damage to the inventory was \$46,000. Damage to furniture, computers, and other fixtures was assessed at \$38,750. Damage to leasehold improvements was \$16,600. American General paid the lienholder \$38,000, leaving a \$63,000 lost contents claim. Moreover, Lynam testified that lost earnings were computed in accordance with the policy to be in excess of \$80,000 — the policy limit. The court found that this evidence supported the jury findings of \$63,000 in destroyed property and \$80,000 in lost earnings.¹¹¹³

Finally, the court held that McInnis Book Store was entitled to recover attorney's fees. American General argued that TEX. CIV. PRAC. & REM. CODE ANN. § 38.006 precluded the award of attorney's fees in this case. The court held, however, that § 38.006 precludes the recovery of attorney's fees only for claims against insurance companies that are allowed under other statutes. Section 38.006 does not preclude the recovery of attorney's fees in a breach of contract action against an insurance company because no other statute authorizes such a recovery.¹¹¹⁴

In *The Travelers Companies v. Wolfe*¹¹¹⁵ Maryon Wolfe brought suit to collect her share of the proceeds under a multi-peril policy. At a time when Maryon and Ralph Wolfe were married they used community assets to begin a business under the name of Computer Creations Unlimited. Ralph obtained insurance for personal property through Travelers. This policy was issued showing the named insured as Ralph T. Wolfe d/b/a Computer Creations Unlimited.

In 1985, the Wolfes incorporated their business as Computer Creations Unlimited, Inc. with each of them owning 500 shares of stock. In January of 1986, Ralph renewed the insurance policy without changing the name of the

1109. *Id.* at 488-89.

1110. *Id.* at 489-90.

1111. *Id.* at 489.

1112. *Id.* at 490.

1113. *Id.*

1114. *Id.* at 491.

1115. 838 S.W.2d 708 (Tex. App.—Amarillo 1992, no writ).

insured. On November 30, 1986, the property at Computer Creations Unlimited, Inc. was destroyed by fire. On March 23, 1987, Travelers denied the claim stating that Computer Creations Unlimited, Inc. was not the named insured and that the fire resulted from fraudulent, dishonest, or criminal acts of Mr. Wolfe.

On May 18, 1987, Maryon and Ralph were divorced and their community estate divided. Ralph was awarded all the corporate stock as his separate property and Maryon retained all rights she had to file an insurance claim for losses incurred as a result of the fire. Furthermore, it was provided that the proceeds that Maryon might receive would be her sole and separate property.

The jury found that the fire was started by Ralph and that Maryon neither directly nor indirectly participated in the arson. The trial court rendered judgment awarding Maryon about \$54,000. The court of appeals affirmed.

Travelers, relying on *Jones v. Fidelity & Guaranty Insurance Corp.*,¹¹¹⁶ argued that Maryon could not recover under the policy for destroyed community property because Ralph willfully set fire to the property. The rationale behind *Jones* was that any recovery by the innocent spouse of community property would also benefit the wrongdoing spouse. This court held, however, that the Texas Supreme Court reexamined *Jones* in *Kulubis v. Texas Farm Bureau Underwriters Insurance Co.*¹¹¹⁷ and allowed the innocent spouse to recover insurance proceeds after her husband set fire to their jointly owned mobile home. The court noted that in *Kulubis*, the mobile home was not community property because it was a gift to both of them. Therefore, their undivided one-half interest was the separate property of each of them.

Travelers argued that since the property destroyed in this case was community, rather than separate property, *Jones* still controlled. Travelers relied upon two cases out of the Fifth Circuit where the court refused to extend *Kulubis* to allow an innocent spouse any recovery on a policy insuring community property willfully destroyed by the other spouse.¹¹¹⁸ The court noted, however, that the Fifth Circuit's decisions did not control the outcome of this case since they were contrary to the statement of Texas law as announced by the Texas Supreme Court.¹¹¹⁹ The court further noted that in *Kulubis*, the supreme court stated that "[w]e are not to be understood as holding that an innocent spouse is barred from recovering under an insurance policy covering community property."¹¹²⁰

In this case, the court held that Maryon was entitled to receive one-half of the insurance proceeds for the loss occasioned by the fire since she had no role in the fire.¹¹²¹ Such recovery for Maryon would not benefit Ralph, the

1116. 250 S.W.2d 281 (Tex. Civ. App.—Waco 1952, writ ref'd).

1117. 706 S.W.2d 953 (Tex. 1986).

1118. See *Norman v. State Farm Fire & Cas. Co.*, 804 F.2d 1365 (5th Cir. 1986); *Webster v. State Farm Fire & Cas. Co.*, 953 F.2d 222 (5th Cir. 1992).

1119. *Wolfe*, 838 S.W.2d at 712.

1120. *Id.* (citing *Kulubis*, 706 S.W.2d at 955).

1121. *Wolfe*, 838 S.W.2d at 712.

wrongdoer, because the proceeds were her separate property by virtue of the final divorce decree.

3. *Conditions Precedent/Burden of Proof*

In *Love of God Holiness Temple Church v. Union Standard Insurance Co.*¹¹²² the Love of God Holiness Temple Church sued Union Standard Insurance Company after it denied the church's claim for water damage to its building under Union Standard's insurance policy. The church also sought damages for violations of article 21.21. The trial court granted Union Standard's motion for instructed verdict on the article 21.21 claim, and the jury found that the church's damage was not caused by an event covered by the policy. The trial court, therefore, rendered a take-nothing judgment. The court of appeals affirmed.

The church argued that it was relieved from proving that the loss was within the coverage of the policy because Union Standard failed to deny that the church had complied with all conditions precedent, as alleged by the church. The court recognized that a plaintiff who pleads that all conditions precedent necessary to recovery have been fulfilled needs only to prove compliance with those conditions precedent that are specifically denied by the defendant.¹¹²³ Conditions precedent include giving notice of a claim or loss, the timely filing of a proof of loss, filing suit within a specified time, and timely forwarding suit papers to a liability insurer, but not the promise of the insurer to pay if a loss is covered by the general terms of the policy.¹¹²⁴ The court, therefore, held that because the existence of coverage was an essential element of the plaintiff's case, the church had the burden of pleading and proving coverage.¹¹²⁵ The church did plead that the damage to its building was caused by wind and hail, and thus covered by the policy. The church, however, did not introduce any evidence to prove the same. In fact, Union Standard presented evidence by three experts that the damage was not caused by wind or hail. Because coverage was an essential element of the church's cause of action, and because it failed to prove that element, the court held that the church was not entitled to an instructed verdict.¹¹²⁶

The church next argued that because Union Standard did not plead any affirmative defenses, the trial court should not have allowed it to present evidence on the issue of causation. The court held, however, that lack of coverage was not an affirmative defense, but was an essential element of the insured's case.¹¹²⁷ Thus, Union Standard's general denial put in issue whether there was coverage under the policy.

1122. 860 S.W.2d 179 (Tex. App.—Texarkana 1993, writ requested).

1123. *Id.* at 180.

1124. *Id.*

1125. *Id.* at 181.

1126. *Id.*

1127. *Id.*

XIII. 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.*¹¹²⁸ the Texas Supreme Court affirmed the decision of the court of appeals that an excess carrier can maintain a *Stowers* cause of action against a primary carrier based on the theory of equitable subrogation. General Rent-A-Car was sued for injuries and death allegedly resulting from a blow-out of a defective tire on one of its rental cars. General had primary coverage through Canal Insurance and excess coverage with First State Insurance and American Centennial Insurance. Canal investigated and defended the suit, hiring the firm of Giessel, Stone, Barker & Lyman to defend General. Because of alleged mishandling of the litigation by trial counsel, the excess insurers settled for \$3.7 million.

The two excess carriers, First State and American Centennial, then brought suit against Canal, the law firm handling the defense, and two of the firms attorneys for negligence, gross negligence, breach of the duty of good faith and fair dealing, and violations of the DTPA and article 21.21 of the Insurance Code. The trial court granted summary judgment, denying all claims as barred by the statute of limitations and determined that the primary insurer and its counsel owed no duties to the excess carriers. The court of appeals reversed the judgment as to Canal, but affirmed as to defense counsel on the basis of statute of limitations.¹¹²⁹ The supreme court affirmed in part and reversed in part.

The issue presented to the supreme court was whether an excess insurance carrier has a cause of action against a primary carrier and trial counsel for mishandling a claim. The court concluded that such a right does exist, but only indirectly. According to the court, the insurer paying a loss under a policy becomes equitably subrogated to any cause of action the insured may have against a third-party responsible for the loss.¹¹³⁰ Because an insured has a right to sue the primary carrier for a wrongful refusal to settle a claim within the policy limits (the *Stowers* duty), the court held that an excess carrier, because of equitable subrogation, can maintain the same action.¹¹³¹

The policy behind allowing the excess carrier to bring the insured's *Stowers* claim is to encourage fair and reasonable settlement of lawsuits.¹¹³² If the excess carrier had no remedy, the primary insurer would have less incentive to settle within policy limits. The court also held that equitable subrogation would prevent an unfair distribution of losses between primary and excess insurers and would discourage primary carriers from gambling with the excess carrier's money when potential judgments approached the pri-

1128. 843 S.W.2d 480 (Tex. 1992).

1129. 810 S.W.2d 246 (Tex. App.—Houston [1st Dist.] 1991), *aff'd in part, rev'd in part*, 843 S.W.2d 480 (Tex. 1992).

1130. *American Centennial*, 843 S.W.2d at 482.

1131. *Id.* at 483.

1132. *Id.* at 482-83.

mary insurer's policy limits.¹¹³³

The court held that the recognition of a cause of action for equitable subrogation would not impose new or additional burdens on the primary carrier because it already had a duty to protect the interest of the insured.¹¹³⁴ The court further clarified that it was not recognizing a direct duty running from the primary to the excess insurer.¹¹³⁵ Because the excess carrier's cause of action against the primary insurer is identical to the insured's, the court held that it is also subject to any defenses asserted against an insured, including the refusal to settle and the failure to cooperate.¹¹³⁶ The court also noted that it was not deciding whether the doctrine of equitable subrogation would extend to permit an excess carrier to bring DTPA and Insurance Code actions against a primary insurer.¹¹³⁷

The supreme court next determined that the court of appeals erred by finding that the action against the attorneys was barred by the statute of limitations.¹¹³⁸ The court of appeals held that the excess insurers' cause of action accrued at the time of the alleged malpractice. The supreme court, relying on *Hughes v. Mahaney & Higgins*,¹¹³⁹ held that the statute of limitations on a legal malpractice claim is tolled until all appeals on the underlying claim are exhausted.¹¹⁴⁰

The court next concluded that an excess carrier is equitably subrogated to an insured's cause of action against its counsel, because the attorney owes the insured a duty of unqualified loyalty in providing the defense.¹¹⁴¹ The court held, however, that the excess insurer can enforce only those existing duties counsel owes to the insured. The court felt that without equitable subrogation, an attorney might escape the consequences of legal malpractice because the insured would have little incentive to sue the attorney as long as the judgment or settlement was within the excess carrier's policy limits.¹¹⁴² Equitable subrogation would, therefore, allow the party actually harmed by the legal malpractice (the excess carrier) to enforce the insured's right to competent representation. The court once again stressed that it was not deciding whether a malpractice claim could be assigned, but was solely deciding that the doctrine of equitable subrogation allows an excess carrier to sue in the place of the insured.¹¹⁴³

Justice Hecht, joined by Chief Justice Phillips and Justices Gonzalez, Cook, and Cornyn, authored a concurring opinion wherein they agreed that an excess carrier could be equitably subrogated to an insured's rights against a primary insurance carrier and counsel for negligently investigating, prepar-

1133. *Id.* at 483.

1134. *Id.*

1135. *Id.*

1136. *Id.*

1137. *Id.*

1138. *Id.* at 483-84.

1139. 821 S.W.2d 154 (Tex. 1991).

1140. *American Centennial*, 843 S.W.2d at 483-84.

1141. *Id.* at 484.

1142. *Id.* at 485.

1143. *Id.* at 485 n.6.

ing to defend, trying, or settling a case brought against the insured. While the majority did not decide whether any other causes of action were available to an excess carrier by subrogation, the concurring justices held that the excess carrier's only cause of action was for negligence, and none under the DTPA or Insurance Code.¹¹⁴⁴ The concurring justices also stated that the primary carrier was entitled to assert any defense available against either the insured or the excess carrier.

*International Insurance Co. v. Dresser Industries, Inc.*¹¹⁴⁵ is seemingly at odds with *American Centennial*. In this case, the Dallas court held that the insured and the primary insurance carrier do not have contractual or common law duty to the excess carrier to make reasonable attempts to settle a claim or lawsuit within the primary insurance limits.¹¹⁴⁶

Dresser was self-insured, retaining absolute and complete management and control of the handling and defense of all claims and lawsuits made or brought against it. Through a complicated arrangement, Fidelity and Casualty Co. had the appearance of a liability insurance carrier fronting as Dresser's primary insurer. International provided excess insurance to Dresser. International filed this action against Dresser and Fidelity seeking a declaratory judgment that International was not obligated to pay a claim that Dresser had submitted under its excess insurance policy. The claim arose from a judgment entered against Dresser in a products liability lawsuit (*Snyder*) that International's excess policy covered. International claimed that it was excused from payment because Dresser and/or Fidelity had breached alleged duties to International to settle the underlying lawsuit within the limits of Fidelity's primary policy. The trial court granted Dresser's and Fidelity's motion for partial summary judgment. Thereafter, the trial court decided the remaining issues and entered a final judgment in favor of Dresser and Fidelity except as to their claim for attorney's fees, which the trial court denied. The court of appeals affirmed.

Initially, International argued that by virtue of an agreement between Dresser and International, Dresser had a duty to settle the *Snyder* case within the limits of Fidelity's primary coverage. The court, however, refused to interpret the agreement in such a way. When considered as a whole, the agreement between Dresser and International (called "The Guiding Principles for Insurers of Primary and Excess Coverage") did not impose on Dresser a contractual duty to settle the *Snyder* case within primary limits.¹¹⁴⁷ In fact, the Guiding Principles provided that the excess carrier must refrain from coercive or collusive conduct designed to force settlement, and that the excess carrier shall never make formal demand upon a primary insurer that the latter settle a claim within its policy limit.

International next argued that Dresser owed a common law duty to International to make reasonable attempts to settle the *Snyder* lawsuit within pri-

1144. *Id.* at 486.

1145. 841 S.W.2d 437 (Tex. App.—Dallas 1992, writ denied).

1146. *International Ins.*, 841 S.W.2d at 445.

1147. *Id.* at 443.

mary or self-insured limits. The court rejected this argument relying on *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*¹¹⁴⁸ In *Safeway Stores* the California Supreme Court rejected the argument that the insured owed an excess carrier any duty that would require an insured contemplating settlement to put the excess carrier's financial interest on at least an equal footing with its own.¹¹⁴⁹ The court also noted that *Safeway Stores* had been reaffirmed in California and continues to be cited with approval by other courts outside California.¹¹⁵⁰ International, however, did not cite a case that recognized a cause of action by an excess insurer against its insured for failing to settle a lawsuit below the threshold of the excess policy.

Furthermore, the court noted that International charged Dresser a \$900,000 premium based on its calculation of the probability that Dresser might be exposed to a liability beyond the primary layer.¹¹⁵¹ International knew that, in products liability claims, Dresser controlled its own defense and settlement. Thus, the verdict in the *Snyder* case was precisely the risk that International, as well as Dresser, contracted to insure. The court further noted that one of the reasons excess insurance is purchased is to provide a pool of money in the event that the decision is made to take the gamble of litigating.¹¹⁵² To accept International's argument would impose on Dresser the financial risk of protecting excess insurers.

The court also rejected International's argument that Fidelity owed a duty to International for the acts of Dresser since Fidelity assigned its contractual obligations to control the investigation, defense, and settlement of products liability lawsuits against Dresser to Dresser itself.¹¹⁵³ The court once again made mention that International had full knowledge of the arrangement whereby Dresser became a self-insurer handling all matters with respect to claims and litigation. Thus, the court declined to impose upon Fidelity a duty to take control of the *Snyder* lawsuit away from Dresser and settle it against Dresser's will on terms favorable to International's interests.¹¹⁵⁴ In fact, the court cited another case involving Dresser and Fidelity where it was decided that Fidelity did not have a duty to settle a products liability claim brought against Dresser since Dresser had exclusive control over such claims.¹¹⁵⁵

B. LIABILITY OF PRIMARY CARRIER TO INSURED FOR EXCESS JUDGMENTS — STOWERS

In *American Physicians Insurance Exchange v. Garcia*¹¹⁵⁶ Dr. Garcia sued

1148. 610 P.2d 1038 (Cal. 1980).

1149. *International Ins.*, 841 S.W.2d at 444 (quoting *Safeway Stores*, 610 P.2d at 1043).

1150. *International Ins.*, 841 S.W.2d at 444-45.

1151. *Id.* at 444.

1152. *Id.*

1153. *Id.* at 446.

1154. *Id.*

1155. See *Certain Underwriters at Lloyd's London v. Fidelity & Cas. Ins. Co.*, 789 F. Supp. 927 (N.D. Ill. 1992), *rev'd*, 4 F.3d 541 (7th Cir. 1993).

1156. 37 Tex. Sup. Ct. J. 561 (March 9, 1994).

one of his liability carriers for its failure to settle after he was sued in a medical malpractice case by Cardenas. Garcia's treatment of Cardenas extended from 1980 through 1983, invoking liability policies issued by ICA and APIE. Both insurers initially agreed to share equally the cost of defending Garcia and to allocate any settlement or verdict in proportion to the amounts of their coverage. Five days before trial, APIE notified Garcia that it would no longer provide coverage because the plaintiff's pleadings then on file did not allege any acts of negligence occurring during APIE's policy period. When the trial began five days later, Cardenas filed an amended petition alleging acts of negligence occurring during APIE's coverage, but APIE declined to reenter the case. That same day, Garcia and Cardenas agreed to an assignment of Garcia's claims against the insurers, whereby Cardenas agreed to look only to the proceeds of the insurance policies to satisfy any judgment against Garcia. In a non-jury trial, the court rendered judgment against Garcia in the amount of \$2,235,483.30, plus interest and costs.

While the medical malpractice cause was on appeal, Garcia sued ICA and APIE, alleging negligence and mishandling his defense in the underlying suit, breach of the insurance contracts by abandoning his defense and failing to investigate, negotiate, and settle the suit, DTPA violations, Insurance Code violations, breach of fiduciary duty, and breach of the covenant of good faith and fair dealing. Before this 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.

When the suit against APIE was tried, the jury found APIE was negligent, acted with heedless and reckless disregard for Garcia's rights, committed unfair practices in the business of insurance, and committed unconscionable conduct, which was done knowingly and was a proximate cause of damages to Garcia. The jury found the failure to defend and provide coverage was a "false, misleading, and deceptive act or practice." The jury also found ICA was negligent and allocated responsibility of eighty-four percent (84%) to ICA and sixteen percent (16%) to APIE. Finally, the jury awarded Garcia actual damages of \$2,235,000 and additional and exemplary damages of \$250,000, along with attorney's fees of \$820,500. The trial court rendered judgment against APIE and a related company, APSG, jointly and severally in the amount of \$1,331,574. Among other things, the court of appeals modified the trial court's judgment to increase the amount of the judgment for Dr. Garcia and otherwise affirmed the trial court's judgment.¹¹⁵⁷

When the Texas Supreme Court issued its first opinion in this case the sole issue was whether the pretrial execution of a covenant not to execute between Cardenas and Garcia necessarily negated all of Garcia's damages stemming from APIE's breach of its duty to defend and settle the medical

1157. 812 S.W.2d 25 (Tex. App.—San Antonio 1991), *rev'd*, 37 Tex. Sup. Ct. J. 561 (March 9, 1994).

malpractice case. The court decided that it did not. About fourteen months after its original decision the court issued an opinion on rehearing which did not even reach this issue because it concluded that APIE did not breach its *Stowers* duty.¹¹⁵⁸ According to the court, the *Stowers* duty is not triggered unless: "the claim against the insured is within the scope of coverage, the demand is within the policy limits, and the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and the degree of the insured's potential exposure to an excess judgment."¹¹⁵⁹

In this case, the court determined that the limits of the APIE policy were \$500,000.¹¹⁶⁰ The court then concluded that because APIE had never been given the opportunity to settle for \$500,000 or less that it did not breach its *Stowers* duty to settle.¹¹⁶¹ The court thus felt that it did not need to decide whether the covenant not to execute negated all of Garcia's damages.¹¹⁶²

The dissent, led by Justice Hightower (who had authored the original majority opinion), however took on this issue and maintained that a covenant not to execute would not negate an insured's damages. Justice Hightower gave four reasons why a covenant not to execute would not preclude the assignee of an insured from recovering damages, even those in excess of those in policy limits, from the insurer.

First, the use of a covenant not to execute provides insurers a strong incentive to give due consideration to the interests of its insureds.¹¹⁶³ Quoting from *Foremost County Mutual Insurance Co. v. Home Indemnity Co.*,¹¹⁶⁴ the dissent wrote that where the insurer refuses to provide a defense, the insured often can protect himself only with a covenant not to execute.¹¹⁶⁵ Without such a covenant, the insured would either have to pay the plaintiff enough to settle the claim, or would have to incur defense costs himself, even though the insurer is contractually responsible for payment of such costs. If a covenant not to execute absolved the insurer of liability, the plaintiff would have no incentive to enter into such a covenant. Furthermore, without the availability of such a covenant, there might be nothing to deter an insurer to give due regard to its insured's interest.

Second, allowing recovery of the excess judgment despite the existence of a covenant not to execute, deters insurers from breaching their duties.¹¹⁶⁶

1158. *American Physicians Ins. Exch. v. Garcia*, 37 Tex. Sup. Ct. J. 561, 571 (March 9, 1994).

1159. *Id.* at 566.

1160. Garcia argued that because his treatment of Cardenas spanned three policy periods, the limits of each policy should be stacked to afford \$1,500,000 in coverage. The court would not allow the policies to be stacked because they did not overlap and because the alleged injury was indivisible. Thus, the maximum coverage provided to Garcia was \$500,000. *Garcia*, 37 Tex. Sup. Ct. J. at 570-71.

1161. *Id.* at 571. The court also decided, with little or no analysis, that breach of the *Stowers* duty is not a violation of article 21.21 of the Insurance Code or the DTPA.

1162. *Id.* at 561 n.1.

1163. *Garcia*, 37 Tex. Sup. Ct. J. at 582 (Hightower, J., dissenting).

1164. 897 F.2d 754 (5th Cir. 1990).

1165. *Garcia*, 37 Tex. Sup. Ct. J. at 582 (Hightower, J., dissenting).

1166. *Id.*

Justice Hightower opined that an insurer would have little motivation to fulfill its duties under the insurance contract if the insured's only remedy was contract damages. In fact, if there was not recovery for the excess judgment, there would be more of an incentive for the breach of the contract than its performance.

The third reason listed by Justice Hightower is that covenants not to execute are supported by the public policy favoring settlements and minimizing the insured's potential damages.¹¹⁶⁷ By using a covenant not to execute, an insured is able to settle his dispute with another person by turning the insurer's wrongful conduct into a bargaining strength in dealing with the claimant. Justice Hightower feels that it is better to allow an injured claimant to collect from the party who engaged in false, misleading and deceptive acts and caused those damages — the insurance company — rather than the victim of those acts — the insured.¹¹⁶⁸

Fourth, the policy considerations supporting covenants not to execute in the bad faith context are similar to those underlying the *Stowers* cause of action.¹¹⁶⁹ If an insurance company refuses to settle within the policy limits, and a judgment is subsequently rendered in excess of the policy limits, the insurer is liable for the amount of the judgment. Therefore, when the insured assigns a *Stowers* claim to an injured claimant, a covenant not to execute does not eliminate damages for the insurer's failure to settle — it simply shifts the burden of recovery for those damages from the insured to the injured claimant.¹¹⁷⁰

The dissent also attacks the majority's statement that APIE never had the opportunity to settle for its policy limits. According to Justice Hightower, APIE "had every opportunity to attempt to settle for \$500,000.00, but it never made any attempts to facilitate settlement."¹¹⁷¹ Justice Hightower felt it was within the *Stowers* duty to require an insurer, upon being presented with a settlement demand, even one greater than policy limits, to exercise reasonable attempts to negotiate a settlement.¹¹⁷² According to Justice Hightower, APIE never evaluated the settlement value of the case or engaged in reasonable negotiations to settle the matter. Thus, the dissent would have affirmed the judgment against APIE.

In *Allstate Insurance Co. v. Carter*¹¹⁷³ the court determined that an insurance company is liable to its insured for any negligence of attorneys in conducting the affairs of the insured with reference to litigation and/or claims made against the insured. Allstate issued a policy of automobile liability insurance to Johnston. Clinton, while driving Johnston's, car ran over and severely injured Carter, a minor. Clinton had liability insurance through National County Mutual, but was also covered by Johnston's Allstate policy

1167. *Id.* at 583.

1168. *Id.*

1169. *Id.*

1170. *Id.* at 584.

1171. *Id.* at 579.

1172. *Id.* at 580.

1173. 855 S.W.2d 97 (Tex. App.—Corpus Christi), *writ dismiss'd*, 859 S.W.2d 367 (Tex. 1993).

while driving Johnston's car. Without filing suit, the Carters agreed to settle for the value of Clinton's coverage under the National County and Allstate policies: \$20,000 and \$25,000 respectively. Allstate agreed. The parties then filed a friendly suit to have the settlement approved by a court.

At the hearing to finalize the agreement, Allstate's attorneys added a previously undiscussed provision to the proposed settlement agreement requiring the Carter's to indemnify Allstate, National County Mutual, Clinton, and Johnston for all costs incurred by them in the litigation of any future claims asserted against them arising from this accident. The Carters refused to settle because of the indemnity provision. The Carters then nonsuited the friendly action against Clinton and filed a personal injury suit against him. Clinton was ultimately found liable for \$2.825 million, and the Carters acquired any cause of action Clinton would have against Allstate. The Carters then brought a *Stowers* action against Allstate and its attorneys.

The parties filed stipulations agreeing that the sole issue to be considered was Allstate's purported wrongdoing with regard to the settling of this case prior to January 1, 1987. The parties further stipulated that should the jury find Allstate guilty of wrongdoing, the insurance company would be liable for the full \$2.825 million judgment the Carters held against Clinton. The jury found that Allstate was negligent in its failure to settle, failed to promptly and equitably pay the claim when liability was reasonably clear, and breached its good faith and fair dealing. The trial court thus entered judgment against Allstate in favor of the Carters for \$2.825 million. The court of appeals affirmed.

On appeal Allstate argued that because the parties stipulated that only those alleged wrongdoings committed by Allstate prior to January 1, 1987, would be the subject of the lawsuit, the jury questions should have been so restricted in time. The court held that because there was no evidence offered of wrongdoing by Allstate after January 1, 1987, there was no error in submitting the case to the jury upon broad form questions.¹¹⁷⁴ In fact, all the evidence regarding Allstate's failure to adequately represent its insured centered on the company's insistence on the indemnity language and the aborted settlement attempt that occurred on May 30, 1986.

Allstate also complained about the trial court's instruction to the jury regarding the negligence of its attorneys as being redundant and unfairly prejudicial. The instruction read:

You are further instructed that when an insurance company hires attorneys, pursuant to an insurance contract, to represent an insured with regard to such claims, then the insurance company is responsible for the conduct of the attorneys. Therefore, the insurance company is liable to the insured for any negligence of the attorneys conducting the affairs of the insured with reference to the claims.¹¹⁷⁵

The court found that the instruction was proper as it was substantially similar to the jury instruction approved in *Ranger County Mutual Insurance*

1174. *Id.* at 101.

1175. *Id.*

Co. v. Guin.¹¹⁷⁶ The *Guin* instruction read:

[T]he insurance company is as responsible to the insured for the conduct of the sub-agent [attorney] with reference to the litigation as the insurance company is for its own conduct. Therefore, the insurance company is liable to the insured for damages caused to the insured, if any, by the negligence, if any, of the sub-agent in conducting the affairs on the insured with reference to litigation.¹¹⁷⁷

The court of appeals held that this instruction was proper because it explained that an agency relationship existed and then explained the extent of that agency relationship to the jury.¹¹⁷⁸

XIV. PREEMPTION OF STATE LAW

A. EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

1. *How Far Does ERISA's Preemption Extend?*

In *District of Columbia v. Greater Washington Board of Trade*¹¹⁷⁹ the Greater Washington Board of Trade, a nonprofit corporation that sponsors health insurance coverage for its employees, filed this action seeking to enjoin the enforcement of a law enacted by the District of Columbia requiring employers who provide health insurance for their employees to provide equivalent health insurance coverage for injured employees eligible for workers' compensation benefits on the ground that the law is preempted by ERISA. The district court held that this law was not preempted because it also relates to a workers' compensation plan, which is exempt from ERISA coverage. The court of appeals reversed, holding that ERISA preempts a law that relates to a covered plan regardless of whether the law also relates to an exempt plan. The United States Supreme Court affirmed the judgment of the court of appeals.

Initially, the Court held that the District of Columbia's law requiring employers to provide health insurance coverage at the same benefit level that the employee had at the time the employee received, or was eligible to receive, workers' compensation benefits related to an ERISA plan, as it specifically referred to welfare benefit plans. Therefore, on that basis alone, the law is preempted by ERISA and it makes no difference that the law also relates to ERISA-exempt workers' compensation plans.¹¹⁸⁰ According to the Court, the exemptions from ERISA coverage do not limit the preemptive sweep of ERISA once it is determined that the law in question relates to a covered plan.

In *Corcoran v. United Healthcare, Inc.*¹¹⁸¹ the Fifth Circuit held that Louisiana wrongful death statute is preempted by ERISA. Florence Corcoran, as an employee of South Central Bell Telephone Co., was a member of Bell's

1176. 723 S.W.2d 656 (Tex. 1987).

1177. *Id.* at 658.

1178. *Carter*, 855 S.W.2d at 102.

1179. 113 S. Ct. 580 (1992).

1180. *Id.* at 583-84.

1181. 965 F.2d 1321, 1333 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992).

Medical Assistance Plan, which provided medical benefits to its employees. The Plan was administered by Blue Cross and Blue Shield of Alabama. Under a portion of the Plan known as the "Quality Care Program" (QCP), participants had to obtain advance approval for overnight hospital admissions in certain medical procedures, and had to obtain approval on a continuing basis once they were admitted to a hospital, or plan benefits, to which they were otherwise entitled, would be reduced. QCP was administered by United Healthcare. United performed a form of cost containment services known as utilization review.

In early 1989, Mrs. Corcoran became pregnant and as her delivery date neared, her obstetrician, Dr. Collins, ordered her hospitalized so that he could monitor the fetus around the clock. In accordance with the QCP portion of the Plan, Dr. Collins sought precertification from United for Mrs. Corcoran's hospital stay. Despite Dr. Collins' recommendation, United determined that hospitalization was not necessary and, instead, authorized ten hours per day of home nursing care. Mrs. Corcoran entered the hospital on October 3, 1989, but because United had not precertified her stay, she returned home on October 12. On October 25, during a period of time when no nurse was on duty, the baby went into distress and died.

Mrs. Corcoran and her husband, Wayne, filed a wrongful death action in Louisiana state court alleging that their unborn child died as a result of various acts of negligence committed by Blue Cross and United. The case was removed to federal court on the grounds that it was preempted by ERISA and that there was complete diversity among the parties.

Shortly thereafter, Blue Cross and United moved for summary judgment arguing that ERISA preempted the Corcorans' claims. The district court granted the motion, holding that the ERISA preemption extended to this wrongful death claim because the ERISA plan was the source of the relationship between the Corcorans and Blue Cross and United. The Fifth Circuit affirmed.

Relying on § 514(a) of ERISA, the court held that all state laws that relate to (have a connection with or reference to) employee benefit plans are preempted by ERISA.¹¹⁸² The most obvious class of preempted state laws are those that are specifically designed to affect ERISA-governed employee benefit plans. But, said the court, a law is not safe from preemption merely because it does not target employee benefit plans.¹¹⁸³ The court did note that some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law relates to the Plan. Thus, run-of-the-mill state law claims are not preempted.¹¹⁸⁴

The court next observed that the common law causes of action asserted by the Corcorans are not that species of law specifically designed to affect ER-

1182. *Id.* at 1329.

1183. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (common law tort in contract causes of action are preempted); *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209 (5th Cir.), *cert. denied*, 113 S. Ct. 68 (1992) (common law fraud in negligent misrepresentation claims are preempted).

1184. *See Mackey v. Lanier Collection Agency & Serv, Inc.*, 486 U.S. 825 (1988).

ISA plans since they are not premised on the existence of an ERISA plan. Therefore, the court found it necessary to assess the significance of the effects the Corcorans' claims would have upon the ERISA plan.

The Corcorans argued their claims would have no effect on the Plan since they were based on United's erroneous medical decision that Mrs. Corcoran require hospitalization during the last month of her pregnancy. The Corcorans argued that ERISA should not preempt their claims because their claims involved the exercise of traditional state authority and were based on a law of general application, which, although it affects relations between principal ERISA entities, is not designed to affect the ERISA relationship.

United, on the other hand, argued its decision concerning Mrs. Corcoran was not primarily a medical decision, but instead was a decision made in its capacity as a plan fiduciary about what benefits were authorized under the Plan. Thus, the Corcorans were complaining about improper processing of a claim for benefits due under the Plan, and ERISA would preempt all state laws relating to these matters.

The Fifth Circuit, while agreeing with the Corcorans that United did make medical decisions and gave medical advice, also held that this was done in the context of making a determination about the availability of benefits under the Plan. Accordingly, the court held that a Louisiana tort action asserted by the Corcorans for the wrongful death of their child allegedly resulting from United's erroneous medical decision was preempted by ERISA.¹¹⁸⁵ The court noted the result of its decision to preempt a state law in favor of ERISA, was to deny any remedy to the Corcorans for the death of their child. The court held, however, that the lack of an ERISA remedy did not preclude a state law from being preempted by this federal law.

The Corcorans, relying on *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*,¹¹⁸⁶ argued that the Louisiana wrongful death statute should not be preempted by ERISA because it is a state law involving the exercise of traditional state authority. The court rejected this argument since ERISA, itself makes no distinction between traditional or nontraditional nature of the state laws for purposes of preemption. Furthermore, the fact that states traditionally have regulated in a particular area has not stopped courts from applying the ERISA preemption to these laws.¹¹⁸⁷ Furthermore, the court held that since the wrongful death statute affects relations among principal ERISA entities, and the purpose of the Corcorans' lawsuit was to hold United liable for the actions it took in connection with its duties under the Plan, the court saw no way around the ERISA preemption.¹¹⁸⁸

In the alternative, the Corcorans argued that the damages they sought were available as "other appropriate equitable relief" under ERISA

1185. *Corcoran*, 965 F.2d at 1332.

1186. 793 F.2d 1456 (5th Cir. 1986), cert. denied, 479 U.S. 1034 (1987).

1187. *Corcoran*, 965 F.2d at 1334. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (wrongful discharge action preempted); and *Christopher*, 950 F.2d at 1218 (fraud action preempted).

1188. *Corcoran*, 965 F.2d at 1334.

§ 502(a)(3). The Corcorans urged the court to engraft principles from the law of trusts onto the enforcement scheme of ERISA and develop a federal common law in fashioning "other appropriate equitable relief" as suggested by Justice Brennan in his concurring opinion in *Massachusetts Mutual Life Insurance Co. v. Russell*.¹¹⁸⁹ Justice Brennan encouraged courts faced with claims for extracontractual damages to determine, first, to what extent state and federal trust and pension law provided for the recovery of damages beyond any benefits that had been withheld and, second, to consider whether extracontractual relief would conflict with ERISA in any way.¹¹⁹⁰ The goal that Justice Brennan would allow for "other appropriate equitable relief" was to make the plaintiff whole. United argued, on the other hand, that "other appropriate equitable relief" is limited to only declaratory and injunctive relief and does not include money damages.

The Fifth Circuit held that the characterization of equitable relief as encompassing damages necessary to make the plaintiff whole may be consistent with the trust law principles that were incorporated into ERISA and that guide its interpretation. The court also suggested that this view may be consistent with the common law contract doctrine that assists in interpreting ERISA. However, according to the court, the Corcorans sought a form of extracontractual damages that is never awarded for breach of trust duties, and is granted in only the most limited of circumstances for breach of contract. The court, therefore, held that the emotional distress and mental anguish damages sought by the Corcorans were not recoverable as "other appropriate equitable relief" under § 502(a)(3) of ERISA.¹¹⁹¹

In reaching this conclusion, the court looked to the patient/physician relationship to determine what types of extracontractual damages could be recovered for breach of trust duties and a breach of contract. The court noted that patients and their physicians can enter into contracts, and physicians may incur liability for breach. However, there can be no recovery against a physician on a contractual theory unless there is an express agreement to perform a particular service or to achieve a specific cure. Some courts have allowed damages for emotional injury within the contemplation of the parties when a physician breaches a contract with a patient.

The court held that there was not a true doctor/patient relationship between Mrs. Corcoran and United to support a contractual theory of recovery. Furthermore, there was no express agreement for a particular service or a particular result that served as a prerequisite as a contract-based recovery.¹¹⁹²

The court also concluded that Mrs. Corcoran could not sue United for breach of fiduciary duty since she was not in a doctor/patient relationship with United. Furthermore, courts have not allowed patients to sue their doctors under an independent breach of fiduciary duty theory. Therefore,

1189. 473 U.S. 134 (1985).

1190. *Id.* at 157-58.

1191. *Corcoran*, 965 F.2d at 1338.

1192. *Id.* at 1337.

the court concluded that contract and trust principles would not allow the Corcorans to recover the mental anguish damages they sought.¹¹⁹³

The court concluded its opinion by stating that it was troubled by the result it felt ERISA compelled since it left the Corcorans without a remedy. According to the court, because of ERISA, there was an absence of liability rules in this case, and, thus, no incentive for ERISA plans to utilize high quality utilization review. If there is no accountability, the conduct is bound to be substandard. The court also lamented that this result will increase the tension between the Plan (which has an interest not to pay claims) and the beneficiary (whose interest is payment), since there is no deterrence for incorrect denials of coverage. The court concluded by calling for Congress to reevaluate ERISA, since the courts are not allowed to alter the statute as written by Congress.¹¹⁹⁴

The issue in *NGS American, Inc. v. Barnes*¹¹⁹⁵ was whether article 21.07-6 of the Texas Insurance Code, as applied to third-party administrators of ERISA-governed insurance plans, is preempted by ERISA. MASCO, a Michigan corporation, established a self-funded employee benefit plan (MASCO Plan), to provide medical and other benefits to its employees. The MASCO Plan is an employee benefit plan within the meaning of the Employee Retirement Income Security Act (ERISA). NGS, also a Michigan corporation, is the third-party administrator of the MASCO Plan.

NGS and MASCO brought this suit to enjoin Barnes, in his capacity as Commissioner of Insurance for the State of Texas, from enforcing article 21.07-6 of the Texas Insurance Code against NGS and MASCO. The district court granted summary judgment in favor of NGS and MASCO, holding that article 21.07-6, insofar as it relates to administrators of ERISA-governed insurance plans, is preempted by ERISA and thus, cannot be enforced against NGS and MASCO. The Fifth Circuit affirmed.

ERISA regulates employee benefit plans and preempts all state laws that relate to employee benefit plans. ERISA, however, contains a savings clause that provides that the ERISA preemption does not extend to state laws that regulate insurance. The Commissioner argued that article 21.07-6 regulates the business of insurance and is, therefore, not preempted by ERISA. The court held that a statute must pass a two-prong test in order to fall within the savings clause. First, the statute must meet the common sense definition of an "insurance regulation." Second, the statute: (1) must spread the policyholder's risk; (2) must be an integral part of the policy relationship between the insurer and insured; and (3) must regulate the practices limited to entities within the insurance industry.¹¹⁹⁶ The Commissioner argued that article 21.07-6 regulates insurance by regulating the administrators of insurance plans. The court held, however, that because the administrators perform no risk-bearing function, regulating them under article 21.07-6 does

1193. *Id.* at 1338.

1194. *Id.* at 1338-39.

1195. 998 F.2d 296 (5th Cir. 1993).

1196. *Id.* at 299.

not spread risk among the policy holders. Therefore, article 21.07-6 does not pass the test of regulating insurance under ERISA.¹¹⁹⁷

The Commissioner next argued that article 21.07-6 does not relate to an ERISA plan. The Commissioner argued that article 21.07-6 is a licensing statute that applies to administrators regardless of whether they contract to provide services to conventional insurance products or ERISA plans. The court found that article 21.07-6 does far more than merely license administrators. This statute allows the Commissioner to review financial statements of the administrator and all written agreements between the administrator and various insurers and plans. It also requires the administrators to file an annual report with the Commissioner and allows the Commissioner access to the administrators' books and records for purposes of examination, audit, and inspection. The court held that it was these burdens of compliance with conflicting state regulations that Congress sought to eliminate by enacting ERISA. Thus, according to the court, article 21.07-6 impermissibly relates to NGS in its role as administrator for the MASCO Plan and to that extent, the article is preempted by ERISA.¹¹⁹⁸

Thus, the court concluded that article 21.07-6 is preempted by ERISA as it applies to third-party administrators of ERISA-governed insurance plans in their capacity as third-party administrators of ERISA-governed insurance plans.¹¹⁹⁹ The court noted that its holding does not preclude the Texas Commissioner of Insurance from enforcing article 21.07-6 against third-party administrators of non-ERISA-governed insurance plans, or against third-party administrators of both ERISA and non-ERISA-governed plans in their capacity as administrators of non-ERISA-governed plans.¹²⁰⁰

In *Manahan v. Meyer*¹²⁰¹ Thomas Manahan was covered by a group life insurance policy issued to Haworth, Inc., his employer, by Safeco Life Insurance Company. While hospitalized, two days before his death, Manahan changed the beneficiary of the policy from his two minor children to his fiancée, Meyer. Safeco paid the policy proceeds to Meyer.

Mr. Manahan's children sued Meyer, Haworth, and Safeco alleging that the change in beneficiary was invalid because Manahan lacked mental capacity and was unduly influenced by Meyer, and that Haworth acted with Meyer to change the beneficiary, breached its fiduciary duty by failing to investigate the change in beneficiary, and negligently processed the claim and delivered the proceeds to Meyer. Alternatively, the children alleged a cause of action under ERISA, claiming that they were beneficiaries seeking the recovery of money from Haworth and Safeco that had been wrongfully paid to Meyer.

The trial court granted summary judgment for Haworth and Safeco concluding that ERISA preempted the children's claims. The claims against

1197. *Id.*

1198. *Id.* at 300.

1199. *Id.*

1200. *Id.*

1201. 862 S.W.2d 130 (Tex. App.—Houston [1st Dist.] 1993, writ requested).

Meyer were tried and a jury found in favor of the children. The trial court entered a judgment n.o.v. for Meyer based solely on ERISA preemption. The court of appeals affirmed in part and reversed and rendered in part.

Mr. Manahan's children first argued that neither Haworth nor Safeco proved that the benefit plan was governed by ERISA. Before an employee benefit plan is governed by ERISA, the employer must be engaged in activity affecting interstate commerce.¹²⁰² According to the children's pleadings, Haworth, a Michigan corporation with its home office in Michigan, bought insurance from Safeco, whose home office is in Washington, to cover Manahan and other Haworth employees working in Texas. Thus, the court found that the children admitted that Haworth was engaged in interstate commerce.¹²⁰³

Additionally, before ERISA applies, the employee benefit plan must meet the definition found in ERISA as any plan, fund, or program established or maintained for the purpose of providing its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death, or unemployment.¹²⁰⁴ The children asserted in their pleadings that Haworth furnished a group life insurance policy for its employees, that Manahan was an employee of Haworth, that the Safeco group policy insured his life, and that after Manahan's death, Haworth processed the claim and the payment through its employee relations administrator. The court held that the pleadings established an employee welfare benefit plan under ERISA.¹²⁰⁵

Mr. Manahan's children next argued that the summary judgment was improper, even if there was an ERISA plan, because state and federal courts have concurrent jurisdiction under 29 U.S.C. § 1132(e)(1) of suits brought to recover ERISA benefits. The court held, however, that the children's claims did not fall within the scope of this section as they did not seek to recover benefits under a plan, to enforce rights under a plan, or clarification of rights to future benefits.¹²⁰⁶ Instead, their state law claims alleged improper administration of an employee benefit plan, which is within the exclusive jurisdiction of the federal court. The court held that the allegations of improper handling and processing of a claim for benefits is a matter of exclusive federal jurisdiction and thus, a summary judgment was proper.¹²⁰⁷

The Manahan children next argued that their cause of action against Safeco under Texas Insurance Code article 3.48 was not preempted by ERISA because it regulates the business of insurance. Article 3.48 provides that a life insurer, upon the death of the insured, and in the absence of receipt of notice of an adverse claim to the proceeds, shall pay the proceeds to the designated beneficiary and by doing so will be discharged from all liability

1202. 29 U.S.C. § 1003(a).

1203. *Manahan*, 862 S.W.2d at 133.

1204. 29 U.S.C. § 1002(1).

1205. *Manahan*, 862 S.W.2d at 133.

1206. *Id.* at 134.

1207. *Id.*

under the policy.¹²⁰⁸ The court held that the claim under article 3.48 was preempted by ERISA even assuming that article 3.48 regulates the business of insurance because the ERISA savings clause cannot save from preemption a state law that provides remedies not provided by ERISA.¹²⁰⁹ The Manahan children alleged that Safeco violated article 3.48 by paying Meyer after receiving notice of an adverse claim. The court found that this cause of action was one for improper claims processing and thus, preempted by ERISA.¹²¹⁰

The court next turned to the state law claims against Meyer. The jury found that Manahan lacked mental capacity to change the beneficiary and that Meyer secured the change by undue influence. The jury awarded \$40,000 in exemplary damages. The trial court first granted judgment for the Manahan children, but then granted a judgment n.o.v. on the basis that the claim was preempted by ERISA. The Manahan children argued on appeal that the claim did not relate to an employee benefit plan.

A law relates to an employee benefit plan if it has a connection or reference to such a plan. Typically the words "relate to" are construed expansively, but some state laws may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law relates to the plan.¹²¹¹ The Manahan children argued that their claim against Meyer was wholly unrelated to ERISA or so remotely related that it was not preempted. Meyer argued that the Manahan children's undue influence claim directly related to an ERISA plan because it would determine the beneficiary under an ERISA plan.

The court disagreed with Meyer, finding that the Manahan children's claim would not change the beneficiary under the plan.¹²¹² The court further held that this claim would not frustrate the Congressional objective of preventing inconsistent state laws from regulating employee benefit plans.¹²¹³ According to the court, this case did not involve a state testamentary law that varied from state to state. The court could find no state that recognized changes in beneficiary designations made by mental incompetence and none that recognized changes made by undue influence. The court also determined that a judgment against Meyer would have no effect on the plan, the employer, or the administrator. Thus, the court held that the claim did not relate to an ERISA plan.

The court, therefore, reversed the judgment n.o.v. and rendered judgment in accordance with the jury's verdict.

In *Cook-Fort Worth Children's Medical Center v. Wal-Mart Associates Group Health Plan*¹²¹⁴ Medical Center filed suit against Wal-Mart in state court alleging various state causes of action, including violations of article

1208. TEX. INS. CODE ANN. art. 3.48 (Vernon 1981).

1209. *Manahan*, 862 S.W.2d at 135.

1210. *Id.*

1211. *Id.*

1212. *Id.* at 136.

1213. *Id.*

1214. 823 F. Supp. 418 (N.D. Tex. 1993).

21.21 of the Insurance Code. Medical Center alleged that it provided services to a dependent child of an ERISA plan participant based on Wal-Mart's representations that the patient had insurance coverage. Once the patient submitted the claims, however, Wal-Mart refused to pay the bills. After the Medical Center filed suit, Wal-Mart removed to federal court contending that ERISA preempted the Medical Center's claims. Medical Center then filed a motion for remand, which the court granted.

The court held that removal is proper if a case falls within the original federal question jurisdiction of the United States District Court. According to the court, an action arises under federal law when a federal cause of action completely preempts a state cause of action. The court held that Medical Center's claims did not come within the scope of a federal cause of action under ERISA because Medical Center was not a participant or beneficiary of an ERISA plan.¹²¹⁵ Therefore, the claims could not be recharacterized as ERISA claims.

The court further explained that the requirement that the removed action be within the scope of the federal cause of action means that, even when federal law preempts state law, removal is not proper unless federal law also supplants state law with a federal claim. The court held that ERISA did not appear to provide Medical Center an alternative cause of action, and thus Wal-Mart's assertion of preemption was defensive only and did not give rise to federal jurisdiction.¹²¹⁶

2. *Contract Interpretation/Standard of Review*

In *Gorman v. Life Insurance Co. of North America*¹²¹⁷ the court addressed the issue of whether the beneficiary of a life insurance policy was entitled to benefits. After Dale Gorman was killed in a traffic accident, his wife, Pamela, filed a claim with Life Insurance Company of North America (LINA) to recover \$250,000 in life insurance benefits. This life insurance policy was provided to Dale Gorman as part of an employee benefit plan provided by his employer, Tenneco. The policy provided coverage as long as the employee was in "travel or sojourn" for the employer at the time of death. LINA denied the claim, contending that Gorman was not in "travel or sojourn," for his employer at time of his death. Pamela Gorman sued Tenneco and LINA alleging breach of contract, fraud, breach of fiduciary duty, breach of the duty of good faith and fair dealing, negligence, deceptive trade practices, and violations of article 21.21 of the Insurance Code. The jury found that Dale Gorman was in "travel or sojourn" for Tenneco at the time of his death, that Tenneco misrepresented material facts, that Tenneco breached its fiduciary duty, and that LINA breached its duty of good faith and fair dealing. Nevertheless, the trial court granted the defendants' motion for judgment n.o.v.

When this case originally went before the court of appeals, it was deter-

1215. *Id.* at 419.

1216. *Id.* at 420.

1217. 859 S.W.2d 382 (Tex. App.—Houston [1st Dist.] 1993, no writ).

mined that all of the claims were preempted by ERISA.¹²¹⁸ This decision was appealed to the supreme court, which held that all of Gorman's claims against Tenneco and all claims against LINA except for the breach of contract claim were preempted by ERISA.¹²¹⁹ The supreme court further held that there was some evidence to support the jury's finding that Dale Gorman was in the "travel and sojourn" of Tenneco at the time of his death. The supreme court then remanded the case to the court of appeals to review LINA's point that the evidence was factually insufficient to support the jury's finding that Gorman was in the "travel and sojourn" of Tenneco at the time of his death.

LINA argued that while there may have been some evidence that Gorman was in the "travel and sojourn" of Tenneco, this evidence was insufficient to support the jury's finding. The evidence reviewed by the court revealed the following: On the morning of the accident, Gorman attended a job-related seminar in Houston. As he left the seminar at noon, several witnesses heard him state that he had a meeting to attend at the Tenneco building and that he would probably return to the seminar after the meeting. Gorman left the meeting at the Tenneco building around 3:00 p.m. and told some people that he needed to leave early to return to the seminar. As he left the office, he informed two secretaries that he was returning to the seminar and in the elevator remarked to another employee that his day was not yet over.

About 15 minutes after he left Tenneco, Gorman was killed at the corner of Garrow and York. According to the court, the route that Gorman was taking was a possible, though unlikely, route back to either the seminar or his home. The more probable explanation was that Gorman was in route to the offices of his former employer, Brown & Root. Gorman's supervisor testified that Gorman had authority to go anywhere he felt useful for the accomplishment of his tasks. There was also evidence that information available at Brown & Root could have been helpful on Gorman's projects at Tenneco.

The court held that this evidence was sufficient to support the jury's finding that Dale Gorman was in the "travel and sojourn" of his employer.¹²²⁰ Accordingly the court held that Pamela Gorman was entitled to recover the \$250,000 in insurance benefits from LINA. The court further held that Gorman was entitled to reasonable attorney's fees, which were proven at trial to be \$135,000. The court then remanded the case to the trial court for a determination of whether Gorman was entitled to prejudgment interest.

The issue before the court in *Southern Farm Bureau Life Insurance Co. v. Moore*¹²²¹ was the proper standard for reviewing benefits determinations made by administrators of ERISA plans. Moore worked for Southern Farm and she and her husband were covered under a group life policy. Mr. Moore

1218. See *Gorman v. Life Ins. Co. of N. Am.*, 752 S.W.2d 710 (Tex. App.—Houston [1st Dist.] 1988), *rev'd in part*, 811 S.W.2d 542 (Tex.), *cert. denied*, 112 S. Ct. 88 (1991).

1219. *Gorman v. Life Ins. Co. of N. Am.*, 811 S.W.2d 542 (Tex.), *cert. denied*, 112 S. Ct. 88 (1991).

1220. *Gorman*, 859 S.W.2d at 388.

1221. 993 F.2d 98 (5th Cir. 1993).

suffered a seizure because of a brain tumor while driving his van, resulting in a crash causing his death. Southern Farm refused to pay under the policy based on a policy exclusion that excluded from coverage a loss that results from or is contributed to by a disease of the mind or body. Based on a jury verdict, the district court rendered judgment for Moore. The Fifth Circuit reversed and rendered judgment for Southern Farm.

The court first had to determine the appropriate standard of review. Relying on *Firestone Tire & Rubber Co. v. Bruch*,¹²²² the court held that a de novo review of the administrator's interpretation of the policy is appropriate when the plan does not give the administrator discretionary authority to interpret the plan terms.¹²²³ The court held, however, that an abuse of discretion review should be used when reviewing the administrator's factual determinations.¹²²⁴ Thus, the court would review the administrator's interpretation of the policy de novo and determine whether administrator's factual determination of the cause of Mr. Moore's death amounted to an abuse of discretion.

The court then concluded that in evaluating whether the administrator abused his discretion in making the factual determination that the tumor caused or contributed to Mr. Moore's death, the court could consider only the evidence available to the administrator when he made his decision.¹²²⁵ However, the court could consider other evidence, unavailable to the plan administrator, when making a de novo review of his interpretation of the policy exclusion.¹²²⁶

Moore argued that the policy exclusion precludes recovery only when the disease or bodily infirmity is a concurring proximate cause of the loss. The court held, however, that the clear language of the exclusion excluded a loss contributed to by a disease or infirmity of the body even though the disease or infirmity was not a proximate cause of the loss.¹²²⁷ Because Mr. Moore's death was caused or contributed to by the brain tumor, the court held that the policy excluded coverage and judgment should be rendered for Southern Farm.

3. Limitations

The issue in *Hogan v. Kraft Foods*¹²²⁸ was the statute of limitations applicable to a claim under ERISA. Hogan was employed at Anderson Clayton Foods from March 1948 to January 1984. On November 1, 1983, the trustees of Anderson's pension plan purchased five annuity insurance policies from Southwestern Life Insurance Co. to fund Hogan's accrued retirement benefits. In February and March of 1985, Hogan requested that Southwestern allow him to cash in or receive a lump sum payment on the five annuity

1222. 489 U.S. 101 (1989).

1223. *Southern Farm*, 993 F.2d at 100.

1224. *Id.* at 101.

1225. *Id.* at 102.

1226. *Id.*

1227. *Id.* at 103.

1228. 969 F.2d 142 (5th Cir. 1992).

policies. In March of 1985, Southwestern denied those requests. Hogan and his wife then sued Southwestern claiming that Hogan was entitled to cash in or receive a lump sum payment on the policies. Specifically, they alleged violations of ERISA, contending that Southwestern had denied their rights under the terms of the plan and had breached its fiduciary duties. The Hogans also asserted various state law claims including violations of the DTPA and article 21.21 of the Insurance Code.

The district court granted Southwestern's motion for summary judgment holding that the ERISA claims were barred by the applicable statute of limitations and that the state law claims were preempted by ERISA. On appeal, the Hogans argued that their state law claims affected the pension in only a tenuous or remote manner and were not preempted by ERISA. The court held that all of Hogan's state law claims were based on Southwestern's refusal to make a lump sum payment of benefits under the Employee Pension Benefit Plan and thus, related to a benefit plan. Therefore, all of the state claims were preempted by ERISA.¹²²⁹

Hogan next argued that his ERISA claims were not barred by the statute of limitations. According to the court, "[a]n ERISA cause of action accrues when a request for benefits is denied."¹²³⁰ In this case, the requested lump sum was denied in March of 1985, but suit was not filed until August 1989. ERISA does not provide a statute of limitations for a claim to enforce plan rights. The court applied the four-year Texas limitations statute governing suits sounding in contract, reasoning that Hogan's claim was most analogous to a breach of contract claim.¹²³¹ The court concluded that since suit had not been filed within four years of the denial of the benefits, Hogan's ERISA claim was barred by limitations.

Hogan next argued that his claim for benefits was governed by a six-year statute of limitations provided in section 413 (a) of ERISA. This six-year statute of limitations is available for cases of fraud or concealment. The court held that to establish fraudulent concealment, a party must show that the alleged wrongdoer had both actual knowledge that a wrong had occurred and a fixed purpose to conceal the wrong from the injured party.¹²³² According to the court, the summary judgment did not raise a fact issue of fraudulent concealment, and, therefore, the six-year statute of limitations was not applicable.

B. FEDERAL EMPLOYEES HEALTH BENEFITS ACT (FEHBA)

In *Burkey v. Government Employees Hospital Association*¹²³³ Burkey, a federal employee, alleged that GEHA breached its contractual obligation to pay her son's medical bills. The district court rendered judgment for Burkey under Louisiana law, which included amounts for the bills and damages and

1229. *Id.* at 144-45.

1230. *Id.* at 145.

1231. *Id.*

1232. *Id.*

1233. 983 F.2d 656 (5th Cir. 1993).

attorney's fees for the unreasonable delay in paying. The Fifth Circuit affirmed the judgment as to the medical bills, but reversed the judgment for damages and attorney's fees.

The court held that Louisiana law should not have been applied to this case because the Federal Employees Health Benefits Act (FEHBA)¹²³⁴ preempted state law.¹²³⁵ The FEHBA provides that:

The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall superseded and preempt any State or local law, or regulation issued thereunder, to the extent that such law or regulation is inconsistent with such contractual provision.¹²³⁶

The court found that Burkey's claims related to the nature or extent of coverage or benefits and related to the plan since they had a connection with or refer to the plan.¹²³⁷ The court further held that, like ERISA, the FEHBA broadly preempts state law tort and contract claims for benefits.¹²³⁸ Thus, Burkey could recover only the medical expenses since the FEHBA does not provide for the recovery of penalties or attorney's fees.

C. FEDERAL CROP INSURANCE ACT (FCIA)

In *Brown v. Crop Hail Management, Inc.*¹²³⁹ Brown was issued a crop insurance policy by Landmark through its general agent, Crop Hail Management. Landmark issued this policy under the auspices of a reinsurance contract it maintained with the Federal Crop Insurance Corporation (FCIC). FCIC agreed to reimburse Landmark for claims covered by the reinsurance contract. After Brown's claim for his lost his rice crop was denied, he filed suit in state court against Landmark and Crop Hail Management. The FCIC was never a party to the lawsuit. The defendants removed the case to federal claiming that Brown's state law claims were preempted by the Federal Crop Insurance Act (FCIA).¹²⁴⁰ Brown filed a motion to remand, which was denied by the court as it concluded that federal question jurisdiction existed because of federal preemption.

The court initially concluded that the FCIA, by its provisions, preempts all state law causes of action against either the FCIC or a FCIC reinsured entity.¹²⁴¹ According to the court, "section 1506(k) of the FCIA unequivocally demonstrates Congress' intent that the FCIC not be subject to suits grounded in state law unless the FCIC agrees to allow those suits."¹²⁴² Brown argued, however, that he had not sued the FCIC. The court, relying on a regulation promulgated by the USDA,¹²⁴³ held that even state actions

1234. 5 U.S.C. §§ 8901-14.

1235. *Burkey*, 983 F.2d at 660.

1236. 5 U.S.C. § 8902(m)(1).

1237. *Burkey*, 983 F.2d at 660.

1238. *Id.*

1239. 813 F. Supp. 519 (S.D. Tex. 1993).

1240. 7 U.S.C. §§ 1501-20.

1241. *Brown*, 813 F. Supp. at 526.

1242. *Id.* at 525.

1243. 7 C.F.R. § 400.352.

against FCIC reinsured parties are preempted by federal law.¹²⁴⁴

The court next considered whether the FCIA completely preempts state law in this area and cited a three part test to resolve this issue. For complete preemption, the FCIA must first create a "federal cause of action that replaces and protects the same interests as the preempted state law causes of action."¹²⁴⁵ The court noted that all of Brown's state causes of action arose from the failure to pay his crop insurance claim. The court held the first part of the test was met by section 1508(f) of the FCIA and 7 C.F.R. § 400.176(b) which gives the insured the right to sue the FCIC or the FCIC reinsured company in federal court to recover benefits wrongfully denied.¹²⁴⁶

The second part of the test is that the FCIA must provide a "jurisdictional grant to federal courts to enforce the cause of action created" by the statute.¹²⁴⁷ The court held this test was met in section 1508(f) of the FCIA which allows the cause of action to be brought in the federal district court of the district in which the farm is located.¹²⁴⁸ The court assumed that this jurisdictional grant would also apply to actions brought against FCIC reinsured companies.¹²⁴⁹

The final part of the test is that there must exist a clear congressional intent to make the preempted state claims removable to federal court.¹²⁵⁰ The court concluded that this test was met by section 1508(f) both creating a cause of action to take the place of the state law action and containing a specific jurisdictional grant to the federal courts to decide such causes of action.¹²⁵¹ The court acknowledged that the FCIA does not extend to FCIC reinsured companies, but found it inconceivable that suits against FCIC reinsured companies would not be preempted as suits against the FCIC would.¹²⁵²

*Wilson v. United States Department of Agriculture*¹²⁵³ was an action brought directly against the FCIC as well as the Agricultural Stabilization and Conservation Service (ASCS) for benefits allegedly due under a crop insurance policy. The district court dismissed the claim against the FCIC for Wilson's failure to give timely notice of his crop loss. The Fifth Circuit reversed.

In the spring of 1988 Wilson planted his rice crop. In May an inch of rain fell, but a drought ensued thereafter and the seed did not germinate according to schedule. In July torrential rains flooded the farm. Wilson then notified the insurance agent of some crop damage and adjusters from the FCIC were sent out to inspect the loss. In August 1988, the FCIC agent prepared

1244. *Brown*, 813 F. Supp. at 525.

1245. *Id.* at 526.

1246. *Id.*

1247. *Id.*

1248. *Id.*

1249. *Id.*

1250. *Id.* at 524, 526.

1251. *Id.* at 527.

1252. *Id.* at 528.

1253. 991 F.2d 1211 (5th Cir. 1993).

a loss form which stated that the rice crop was a total loss. The FCIC claimed that Wilson's notice of loss did not meet the ten day requirement in the FCIC's regulations.¹²⁵⁴ Wilson argued that he did not know that the crop was a total loss until the FCIC made that determination in August and thus his notice was timely.

The court noted that, according to the FCIC regulations, only the FCIC has the authority to make determinations regarding the extent of crop loss. Thus, the court suggested by a question that the ten day period for giving notice of the loss should start to run from the time the FCIC makes the loss determination. The court, consequently, decided that the Department of Agriculture was not entitled to a judgment as a matter of law that timely notice was not given.¹²⁵⁵

XV. INSURANCE AND ANTITRUST

In *Hartford Fire Insurance Co. v. California*¹²⁵⁶ the Court faced the issues of whether foreign reinsurers were subject to the Sherman Act and what constitutes a "boycott" for the purposes of § 3(b) of the McCarran-Ferguson Act. Nineteen states, and many private plaintiffs, filed complaints alleging that the defendants for domestic primary insurers, domestic companies that sell reinsurance to domestic trade associations; a domestic reinsurance broker; and reinsurers based in London violated the Sherman Act by engaging in various conspiracies aimed at forcing certain other primary insurers to change the terms of their standard domestic commercial general liability insurance policies to conform with the policies that the defendant insurers wanted to sell. After the actions were consolidated for litigation, the district court granted the defendants' motion to dismiss. It held that the conduct alleged fell within the grant of antitrust immunity contained in § 2(b) of the McCarran-Ferguson Act because it amounted to "business of insurance" and was regulated by state law within the meaning of that section. The district court also held that none of the conduct amounted to a "boycott" within the meaning of § 3(b) exception to the grant of immunity. The district court also dismissed the three claims that named only certain London-based defendants, invoking international comity.

The court of appeals reversed. Although it held the conduct involved to be "the business of insurance," it concluded that the defendants could not claim McCarran-Ferguson antitrust immunity for two reasons. The foreign reinsurers activities, the court of appeals reasoned, could not be regulated by state law within the meaning of § 2(b) and thus, they did not fall within that section's grant of immunity. Even if the conduct alleged fell within the scope of § 2(b), it also fell within the § 3(b) exemption for "acts of boycott, coercion, or intimidation." The court of appeals also concluded that the principle of international comity was no bar to exercising Sherman Act jurisdiction.

1254. 7 C.F.R. § 401.8(d)8.a.(4).

1255. *Wilson*, 991 F.2d at 1217.

1256. 113 S. Ct. 2891 (1993).

The Sherman Act makes every contract, combination, or conspiracy in unreasonable restraint of interstate or foreign commerce illegal.¹²⁵⁷ The McCarran-Ferguson Act provides that the regulation of the insurance industry is generally a matter for the states and that, "no act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance."¹²⁵⁸ Section 2(b) of the McCarran-Ferguson Act, however, provides that the Sherman Act applies to the business of insurance to the extent that such business is not regulated by state law and § 3(b) provides that nothing in the McCarran-Ferguson Act shall render the Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.¹²⁵⁹ The plaintiffs in this case filed suit alleging that the defendants, members of the insurance industry, conspired, in violation of § 1 of the Sherman Act, to restrict the terms of coverage of commercial general liability (CGL) insurance available in the United States. Thus, the Court was faced with the issue of whether the complaints alleged conduct falling within the "boycott" exception to the McCarran-Ferguson Act antitrust immunity.

According to the complaints, the object of the conspiracies was to force certain primary insurers to change the terms of their standard CGL insurance policies to conform with the policies the defendant insurers wanted to sell. The defendants wanted four changes. First, they wanted the policies changed from "occurrence" policies to "claims-made" policies, thereby obligating the insurer to pay defendant for only those claims made during the policy period. A "claims-made" policy is more advantageous for the insurer because when the policy period ends without a claim having been made, the insurer can be certain that the policy will not expose it to any further liability.

Second, the defendants wanted the "claims-made" policy to have a "retroactive date" provision that would further restrict coverage to claims based on incidents that occurred after a certain date. Such a provision would eliminate the risk that an insurer, by issuing a claims-made policy, would assume liability arising from incidents that occurred before the policy's effective date, but remain undiscovered, or caused no immediate harm.

Third, the defendants wanted to eliminate "sudden and accidental" pollution coverage from the CGL insurance policies. Finally, the defendants wanted legal defense costs to be counted against the stated policy limits. In the past the CGL policies provided that the insurer would bear the legal cost of defending covered claims against the insured without regard to the policy's stated limits of coverage.

The Court described how the defendants allegedly pressured the primary insurers to make the changes. Most primary insurers rely on outside support services for the type of insurance coverage they want to sell. The Insurance Services Office, Inc. (ISO), an association of approximately 1,400

1257. *Id.* at 2900; 15 U.S.C. § 1.

1258. *Id.* at 2900; 15 U.S.C. § 1012(b).

1259. *Id.* at 2900-01; 15 U.S.C. § 1013(b).

domestic property and casualty insurers, is the almost exclusive source of support services in this country for CGL insurance. ISO develops standard policy forms and files or lodges them with each state's insurance regulators; most CGL insurance written in the United States uses these forms. For each of its standard policy forms, ISO also supplies actuarial and rating information. It collects, aggregates, interprets, and distributes data on the premiums charged, claims filed and paid, and defense costs expended with respect to each form. On the basis of this data it predicts future loss trends and calculates advisory premium rates. Most ISO members cannot afford to continue to use a form if ISO withdraws the support services.

Another feature of the insurance industry that played a part in the alleged conspiracy was reinsurance. Often primary insurers purchase insurance to cover a portion of the risk they assume from the consumer. This reinsurance protects the primary insurer from catastrophic loss, and allows the primary insurer to sell more insurance than its own financial capacity might otherwise permit. Insurers who sell reinsurance themselves often purchase insurance to cover part of the risk they assume from the primary insurer. Such "retrocessional reinsurance" does for reinsurers what reinsurance does for primary insurers. Many of the defendants in this case are reinsurers or reinsurance brokers.

According to the allegations defendant Hartford Fire Insurance Company objected to the 1984 CGL forms proposed by the ISO and desired an elimination of the, "occurrence form, a retroactive date provision on the claims made form, elimination of sudden and accidental pollution coverage, and a legal defense cost cap." Allstate Insurance also expressed its desire for a retroactive date provision on the "claims-made" form. The ISO, however, rejected the changes proposed by Hartford and Allstate.

Soon thereafter, Hartford persuaded General Reinsurance Corporation (General Re), the largest American reinsurer, to take steps either to procure desired changes in the ISO CGL forms, or failing that, to derail the entire ISO CGL forms program. General Re took up the matter with its trade association, RAA, which created a special committee that met and agreed to boycott the 1984 ISO CGL forms unless a retroactive-date provision was added to the claims-made form, and a pollution exclusion and defense cost cap were added to both forms. RAA sent a letter to ISO announcing that its members would not provide reinsurance coverages written on the 1984 CGL forms. Hartford and General Re then enlisted a domestic reinsurance broker to give a speech to the ISO board of directors, in which he stated that no reinsurers would break ranks to reinsure the 1984 ISO CGL forms.

The four primary insurer defendants — Hartford, Aetna, Cigna, and Allstate — also encouraged key actors in the London reinsurance market, an important provider of reinsurance for North American risks, to withhold reinsurance for coverages written on the 1984 ISO CGL forms. As a consequence, many London based underwriters and reinsurance companies informed ISO of their intention to withhold reinsurance on the 1984 forms.

At least some of them told ISO that they would withhold reinsurance until ISO incorporated all four desired changes into the ISO CGL forms.

The 1984 ISO CGL forms were eventually withdrawn from the market place and replaced with forms containing the new provisions desired by the defendants. After ISO received regulatory approval of the new forms in most states where approval was needed, it eliminated its support services for the old form, rendering it impossible for most ISO members to continue to use the old forms.

The McCarran-Ferguson Act provides that the Sherman Act applies to the business of insurance to the extent that such business is not regulated by the state. The Court first considered whether the defendants were engaged in the business of insurance and if so whether that business is regulated by state law. The Court held that the phrase "the business of insurance," does not refer to a single entity, but refers to a particular practice or activity, thus not every activity of an insurance company will constitute the business of insurance.¹²⁶⁰

The Court then stated the three criteria that determined whether a particular practice is part of the business of insurance exempted from antitrust laws: (1) whether the practice has the effect of transferring or spreading a policy holder's risk; (2) whether the practice is an integral part of the policy relationship between the insured and the insurer; and (3) whether this practice is limited to entities within the insurance industry.¹²⁶¹ The Court agreed with the court of appeals that the defendants' conduct was within the business of insurance.¹²⁶² The court of appeals held, however, that because the domestic insurers acted in concert with foreign reinsurers, their activities were not regulated by state law. The Supreme Court disagreed and held that the domestic insurers did not give up the McCarran-Ferguson exemption simply because they acted with foreign reinsurers who were not regulated by state law.¹²⁶³

Even if the defendant insurers' conduct was in the business of insurance regulated by state law, the Sherman Act still could apply if they engaged in agreements to boycott, acts of boycott, and coercion within the meaning of § 3(b) of the McCarran-Ferguson Act. Justice Scalia writing for the majority of the Court on this issue, concluded that a "boycott" for purposes of § 3(b) of the McCarran-Ferguson Act occurs where, in order to coerce a person into certain terms on one transaction, parties refuse to engage in other, unrelated transactions with that person.¹²⁶⁴ It is not a boycott, but rather a concerted agreement to terms, where parties refuse to engage in a particular transaction until the terms of that transaction are agreeable. Under this definition of boycott, the Court held that it was not a boycott for the reinsurers to refuse to reinsure coverages written on the ISO CGL forms

1260. *Id.* at 2901.

1261. *Id.*

1262. *Id.*

1263. *Id.* at 2903.

1264. *Id.* at 2912.

until the desired changes were made because the terms of the primary coverages were central elements of the reinsurance contract.¹²⁶⁵ However, it would be a boycott if the reinsurers threatened to withdraw entirely from the business of reinsuring United States insurers who wrote on the occurrence form. Thus, if the reinsurers withheld reinsurance on all CGL forms — even forms having no objectionable terms — the Court held that might amount to a boycott.¹²⁶⁶ The Court found that many of the allegations in the complaints did describe conduct that could amount to a boycott and held that the complaint should not have been dismissed.

The next issue of the Court to decide was whether the Sherman Act could be applied to conduct of the London reinsurers. On this issue Justice Souter wrote the opinion for the majority. The Court first held that it was well-established that the Sherman Act applies to foreign conduct that is meant to produce, and did in fact produce, some substantial effect in the United States.¹²⁶⁷ Such conduct was alleged in this case because the reinsurers engaged in unlawful conspiracies to effect the market for insurance in the United States.

The London reinsurers argued that jurisdiction should have been declined under the principle of international comity. They argued that application of United States antitrust laws to the London reinsurance market would lead to significant conflict with English law and policy. The Supreme Court found, however, that the application of United States antitrust law would not significantly conflict with British law and policy because British law does not require the London reinsurers to act in a way prohibited by the law of the United States.¹²⁶⁸ Furthermore, the Court could not find that compliance with the laws of both countries was impossible. The Court, therefore, held that there was no reason to refrain from the exercise of jurisdiction on the grounds of international comity.¹²⁶⁹

XVI. MISCELLANEOUS

A. RECEIVERSHIP PROCEEDINGS

In *United States Department of the Treasury v. Fabe*¹²⁷⁰ the Court was asked to decide whether the Ohio statute governing the liquidation of insolvent insurance companies, the counterpart to article 21.28 of the Texas Insurance Code, was preempted by federal law granting the United States first priority with respect to a bankrupt debtor's obligations. The Court noted that the Ohio statute would be preempted under exempt from preemption under the McCarran-Ferguson Act.¹²⁷¹ According to the Court, the purpose of McCarran-Ferguson is to allow the states to regulate the business of

1265. *Id.* at 2914.

1266. *Id.* at 2917.

1267. *Id.* at 2909.

1268. *Id.* at 2910.

1269. *Id.* at 2911.

1270. 113 S. Ct. 2202 (1993).

1271. 15 U.S.C. § 1011-15.

insurance.¹²⁷² Thus, the only question for the Court was whether the Ohio statute was enacted "for the purpose of regulating the business of insurance."¹²⁷³ Relying on *SEC v. National Securities, Inc.*¹²⁷⁴ the Court held that this phrase refers to statutes aimed at protecting or regulating, directly or indirectly, the relationship between the insurance company and the insured.¹²⁷⁵ Finding the Ohio statute to be such a statute, the Court held that the federal priority statute must yield to the Ohio statute to the extent the Ohio statute furthers the interests of policyholders.¹²⁷⁶

The Treasury Department argued that the Ohio statute did not regulated the business of insurance because it did not meet any of the three factors for determining what constitutes the business of insurance as articulated in *Union Labor Life Insurance Co. v. Pireno*.¹²⁷⁷ These three factors are: "1) whether the practice has the effect of transferring or spreading a policyholder's risk; 2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and 3) whether the practice is limited to entities within the insurance industry."¹²⁷⁸

The Court held that the Ohio statute did satisfy these three factors. According to the Court, the business of insurance is not confined to the writing of insurance contracts, but extends to the actual performance of these contracts.¹²⁷⁹ Thus, the Ohio statute, even though it does not prescribe the terms of insurance contracts or set the premium rates, does regulate the business of insurance because it is designed to carry out the enforcement of insurance contracts by ensuring the payment of policyholders' claims despite the insurance company's intervening bankruptcy.¹²⁸⁰

Moreover, the three factors set forth in *Pireno* were done so in the context of determining what conduct was exempt from antitrust laws under the second clause § 2(b) of the McCarran-Ferguson Act. In this case, the Court focused on the first clause of § 2(b) which commits laws "enacted . . . for the business of insurance" to the states.¹²⁸¹ The Court, therefore, refused to equate laws "enacted . . . for the business of insurance" with the "business of insurance" itself.¹²⁸² Thus, the Court determined that the laws "enacted . . . for the business of insurance" should not be so narrowly circumscribed as the "business of insurance" which is exempt from antitrust laws.¹²⁸³

The Court concluded that the preference accorded by the Ohio statute to the expenses of administering the insolvency proceeding is reasonably necessary to further the goal of protecting policyholders, since liquidation could

1272. *Fabe*, 113 S. Ct. at 2207.

1273. *Id.* at 2208.

1274. 393 U.S. 453, 460 (1969).

1275. *Fabe*, 113 S. Ct. at 2208.

1276. *Id.*

1277. 458 U.S. 119 (1982).

1278. *Id.* at 129.

1279. *Fabe*, 113 S. Ct. at 2209.

1280. *Id.*

1281. *Id.*

1282. *Id.* at 2209-10.

1283. *Id.* at 2209.

not commence without payment of administrative costs.¹²⁸⁴ However, the preferences conferred upon employees and other general creditors do not escape preemption because their connection to the ultimate aim of insurance is too tenuous.¹²⁸⁵

The issue before the court in *Latter v. Autry*¹²⁸⁶ was whether an injured person, who has received other insurance payments in excess of the tortfeasor's policy limits, is entitled to recover from a guaranty fund when the tortfeasor's insurer is in receivership. Latter, while at work, was struck by a car driven by Kingham. Latter received over \$41,000 from Liberty Mutual, his employer's workers' compensation carrier. Kingham had an automobile policy with American Pacer which had a \$20,000 per person per accident limit. After American Pacer was placed in receivership, Latter filed a proof of claim to recover the \$20,000. The receiver denied the claim and Latter filed this lawsuit. The trial court granted summary judgment to Autry, the receiver of American Pacer and the court of appeals affirmed.

Initially, the court noted that the lawsuit was governed by the Texas Property and Casualty Insurance Guaranty Act, which devises a mechanism for the payment of "covered claims" when insurers become insolvent. The Guaranty Act's purpose is to provide the injured person the same recovery, up to a ceiling of \$100,000, he or she would have had if the insurer had remained solvent.¹²⁸⁷ If American Pacer were solvent, Latter could receive up to the \$20,000 policy limit. However, because Liberty Mutual paid over \$41,000 in workers' compensation benefits and medical expenses, it had a subrogation lien on the \$20,000. The Guaranty Act provides that a subrogation lien in excess of the policy limits is excluded from the definition of a covered claim and must be paid out of the insolvent insurer's assets rather than the guaranty fund.¹²⁸⁸ Thus, the court held that Latter's claim was in reality a subrogation claim by Liberty Mutual and because it exceeded the limits of the American Pacer policy, the claim was not payable out of the guaranty fund.¹²⁸⁹

In *Bailey v. Brodhead*¹²⁹⁰ the court addressed the issue of whether a person must file a timely suit against the insured of an insurer in receivership before he or she can file suit against the receiver for denying a claim. This appeal actually involved two cases involving the same issue. In both cases there was a person injured in a car accident by persons insured by National County Mutual. Within two years of each accident National County Mutual was placed in receivership due to insolvency. Neither of the injured people filed suit against the tortfeasors; instead, they filed a claim with the receiver within two years of the accident. The receiver denied both claims and the injured persons filed suit against the receiver challenging the denials.

1284. *Id.* at 2212.

1285. *Id.*

1286. 853 S.W.2d 836 (Tex. App.—Austin 1993, no writ).

1287. *Id.* at 838.

1288. *Id.*

1289. *Id.* at 839.

1290. 838 S.W.2d 922 (Tex. App.—Austin 1992, no writ).

These lawsuits were filed within ninety days of the denial but more than two years after the accidents. The trial courts granted summary judgment for the receiver in both cases, finding that the lawsuits were time-barred. The court of appeals reversed and remanded for trial.

The court noted that article 21.28 of the Insurance Code allows a receiver to approve a claim only if the proof reasonably suggests that the claimant would be able to obtain a judgment against the insured.¹²⁹¹ This requires the claimant, according to the court, to file a claim against the receiver before limitations have run on the cause of action against the insured.¹²⁹² Thus, it is the time at which the claim is made against the receiver, not when suit is filed against the receiver, that a court must use to determine whether an action is time-barred.¹²⁹³

The court further noted that article 21.28, while requiring a claim to be made with the receiver before suing on such claim, does not require the claimant to file a separate lawsuit against the insured.¹²⁹⁴ Moreover, even if suit is filed against the insured and a judgment obtained after the receivership has begun, that judgment is inadmissible in a later suit to prove the insured's liability or the amount of damages.¹²⁹⁵ Thus, the court refused to require the potentially useless act of suing the insured before suit can be brought against the receiver.

In *Pool v. Durish*¹²⁹⁶ the court considered whether an injured person, who had given a full and complete release to the insured, could pursue any recovery from the receiver of the insolvent insurer. The Pools sued Maul for medical malpractice, whose malpractice carrier later was placed in receivership. After filing a claim with the receiver, the Pools settled with Maul. Although the settlement agreement stated that the Pools could pursue the claim with the receiver, it also stated that they agreed to a full, complete and final discharge and release of Maul. The receiver rejected the Pools's claim on the basis that they no longer had a viable cause of action against Maul. The Pools then filed this lawsuit against the receiver. The trial court granted summary judgment in favor of the receiver and the court of appeals affirmed.

The court held that when a person releases an insured from liability no cause of action is retained against the insurer because, of course, the insurer's contractual obligation is contingent on the insured's liability to the other person.¹²⁹⁷ The Pools argued that this rule did not apply to them because the settlement agreement expressly reserved their right to proceed against the receiver. The insurmountable problem, however, was that the Pools agreed to release Maul from any and all claims they might have against him—unlike the cases relied on by the Pools where the injured per-

1291. *Id.* at 924.

1292. *Id.*

1293. *Id.*

1294. *Id.* at 925.

1295. *Id.*

1296. 848 S.W.2d 722 (Tex. App.—Austin 1992, writ denied).

1297. *Id.* at 723.

sons did not give unconditional releases.¹²⁹⁸ Thus, according to the court, the Pools retained no claim against Maul or against his insurer.¹²⁹⁹

B. FIDELITY BONDS

In *Texas Pacific Indemnity Co. v. Atlantic Richfield Co.*¹³⁰⁰ Atlantic Richfield (ARCO) brought suit as the assignee of a fidelity bond issued to Amarco Petroleum by Texas Pacific. The bond insured Amarco against employee dishonesty, which later occurred when Amarco's principals stole over four million dollars worth of petroleum products, much of which belonged to ARCO. The jury found that Texas Pacific breached the fidelity bond and a judgment was rendered in favor of ARCO. Texas Pacific argued to the court of appeals, as it did to the trial court, that ARCO was not the proper plaintiff because the fidelity bond contained a provision prohibiting the assignment of Amarco's interest therein. The court held that the anti-assignment clause should have been enforced as there was no showing by ARCO that it was ambiguous, illegal, against public policy, or otherwise void.¹³⁰¹ A refusal to enforce this provision would result in an impermissible enlargement of the bond by implication or construction beyond the actual terms of the agreement.¹³⁰²

In *United States Fire Insurance Co. v. FDIC*¹³⁰³ United States Fire sought a declaration that a fidelity bond it had issued to protect Empire Savings and Loan from employee fraud and dishonesty automatically terminated when Empire was placed in supervision. The district court granted summary judgment in favor of United States Fire and the Fifth Circuit affirmed. The bond provided that it would automatically terminate "immediately upon the taking over of the Insured by a receiver or other liquidator or by State or Federal officials." The FDIC argued that this provision was contrary to public policy, was ambiguous, and that a takeover did not occur. The Fifth Circuit dismissed these arguments as each had been previously rejected by the court in *Sharp v. FSLIC*.¹³⁰⁴ The court further held that a takeover did indeed occur even though Empire placed itself under voluntary supervisory control by the Texas Savings and Loan Commission. The court found that Empire, in doing so, was prohibited from engaging in activities that are core functions of a savings and loan. Since another entity assumed control or management of Empire, the court held that a takeover did occur.¹³⁰⁵

In *Matter of World Hospitality Ltd.*¹³⁰⁶ Fidelity & Casualty issued a fidelity bond to World to cover losses that result from dishonest or fraudulent acts of World's employees. At a time when World was experiencing finan-

1298. *Id.*

1299. *Id.* at 724.

1300. 846 S.W.2d 580 (Tex. App.—Houston [14th Dist.] 1993, writ denied).

1301. *Id.* at 583.

1302. *Id.*

1303. 981 F.2d 850 (5th Cir. 1993).

1304. 858 F.2d 1042 (5th Cir. 1988).

1305. *United State Fire Ins.*, 981 F.2d at 851.

1306. 983 F.2d 650 (5th Cir. 1993).

cial problems, World made over fifty payments or transfers to Wohl, World's chief executive officer and major shareholder. World also paid some of Wohl's debts. World then filed for bankruptcy. The bankruptcy trustee then brought an action against Wohl and Fidelity alleging that Wohl made fraudulent conveyances and that Fidelity should cover such losses. The bankruptcy court held that the transfers were fraudulent conveyances but found that Wohl was not an employee of World since it did not have the power to control him. Consequently, the bankruptcy court held that Fidelity was not liable under the bond. The Fifth Circuit affirmed.

The court noted that the bond covered only the dishonest acts of World's employees, a term that was defined therein as one over whom World had the right to govern and direct in the performance of his or her services. The court determined that Wohl, as the majority shareholder, was not under the control of World, but rather he controlled the corporation.¹³⁰⁷ The court explained that the acts of a person like Wohl, who owns a controlling interest in the corporation, are treated as the acts of the corporation. Thus, to allow the corporation to recover for the owner's fraudulent conduct would allow the corporation to recover for its own fraudulent conduct. The bond, however, was designed only to insure the corporation against the employees' acts.¹³⁰⁸

C. SURETY BONDS

In *Lawyers Surety Corp. v. Royal Chevrolet, Inc.*¹³⁰⁹ the court addressed the issue of whether a surety bond issued to a car dealer covered bad checks as well as bad bank drafts. Don Lancaster, doing business as Lancaster Motors, posted a \$25,000 bond before receiving a dealer's license in accordance with statute.¹³¹⁰ This bond was issued by Lawyers Surety. After the checks Lancaster wrote to purchase a number of used cars from Royal Chevrolet were returned for insufficient funds, Royal Chevrolet sued him and recovered a judgment in excess of \$25,000. Lawyers Surety refused to pay the claim submitted by Royal Chevrolet claiming that it was a surety only for Lancaster's bad bank drafts, not bad checks.

Royal Chevrolet then sued Lawyers Surety alleging violations of the DTPA and the Insurance Code. At trial, the parties stipulated to \$25,000 in actual damages. The jury found in favor of Royal Chevrolet and the trial court rendered judgment for Royal Chevrolet. The court of appeals affirmed.

The statute requiring a car dealer to post a bond, provides that the bond shall be:

approved as to form by the attorney general and shall be conditioned on the applicant's payment of all valid bank drafts drawn by the applicant

1307. *Id.* at 652.

1308. *Id.*

1309. 847 S.W.2d 624 (Tex. App.—Texarkana 1993, writ denied).

1310. TEX. REV. CIV. STAT. ANN. art. 6686(a)(1-A)(vii) (Vernon Supp. 1993).

for the purchase of motor vehicles . . . ¹³¹¹

Lawyers Surety argued that the term "bank draft" did not include a "check" and, therefore, it was not liable for the judgment against Lancaster.

The court defined a "draft" as an instrument executed by one party instructing a second party to pay a certain amount to a third party.¹³¹² According to the court, a check is a draft that is payable on demand, while a bank draft is a draft executed by a bank.¹³¹³ Thus, the court held that a bank draft under this statute should be interpreted to include checks.¹³¹⁴ Otherwise, a surety like Lawyers Surety would never be liable for a dealer that regularly purchased automobiles with checks. The court noted that this interpretation was consistent with a subsequent amendment to the statute that conditions payment of claims on a bond on the purchasing dealer's payment of all valid bank drafts, including checks.¹³¹⁵

D. TORTIOUS INTERFERENCE/ABUSE OF PROCESS/BUSINESS DISPARAGEMENT/RICO

*In re Burzynski*¹³¹⁶ was a mandamus proceeding brought to direct the district court to reinstate all the claims Dr. Stanislaw Burzynski, the owner-operator of Burzynski Research Institute (BRI), had brought against Aetna Life Insurance Company. Burzynski had alleged that during the course of an underlying lawsuit, Aetna and its attorneys committed various fraudulent acts. BRI was engaged in the business of treating terminally ill cancer patients with a non-FDA approved treatment. BRI claimed the treatment was covered by its patients' health insurance policies. However, in the mid-1980's, Aetna allegedly began denying BRI patients' insurance claims to reduce its claims exposure. Following the death of a patient, Burzynski intervened as plaintiff-assignee in a suit against Aetna for the reimbursement of medical expenses.¹³¹⁷ The underlying suit eventually ended in a summary judgment for both sides.

Burzynski then brought this lawsuit contending that the following occurred during the course of *Burzynski I*:

- (1) Aetna filed a frivolous RICO claim against BRI;
- (2) Aetna's attorneys sent a letter to thirty-five insurers urging them to stop paying BRI claims because they were "worthless" and "unreimbursable;"
- (3) an Aetna consultant created Emprise, Inc. for the unstated purpose of generating negative reviews of Burzynski's cancer treatment in order to bolster Aetna's position in denying coverage for the treatment;
- (4) Aetna filed false and misleading *ex parte* discovery motions in order to get privileged claims information from other insurers;

1311. *Id.*

1312. *Lawyers Surety*, 847 S.W.2d at 627.

1313. *Id.*

1314. *Id.*

1315. *Id.*

1316. 989 F.2d 733 (5th Cir. 1993).

1317. See *Burzynski v. Aetna Life Ins. Co.*, No. H-89-3976 (S.D. Tex. April 1, 1992) (hereinafter *Burzynski I*).

- (5) Aetna served frivolous subpoenas and notices of deposition on third-party researchers in an effort to dissuade and intimidate them from researching the type of treatment used by Burzynski; and
- (6) Aetna gave false information to a United States Attorney in an effort to gain leverage in its litigation with Burzynski.¹³¹⁸

Accordingly, Burzynski alleged causes of action against Aetna for tortious interference with contract; tortious interference with prospective business relations; abuse of process; business disparagement; a violation of the Texas Insurance Code; a violation of the Illinois consumer fraud statute; and a RICO violation. The district court dismissed the entire complaint on the grounds that Texas law afforded an absolute privilege to communications made in a court proceeding. Alternatively, the district court dismissed, without prejudice, each cause of action under FED. R. CIV. P. § 12(b)(6) for failure to state a claim. On appeal to the Fifth Circuit, the court rejected Aetna's discovery privilege defense due to the possibility of Aetna's "ulterior, malicious motives," and remanded for the reassessment of each of Burzynski's causes of action.¹³¹⁹

On remand, the district court took no action on its prior dismissals without prejudice, failed to call for answers by Aetna, and simply dismissed all of Burzynski's causes of action. Burzynski petitioned for, and obtained, a writ of mandamus to direct the district court to reinstate all claims and call for answers thereto. The Fifth Circuit granted Burzynski's petition for rehearing to examine the viability of each cause of action.

The court held that Burzynski had a valid claim for tortious interference with contract; the requirements of which are "(1) a contract, (2) an intentional act, calculated to cause damage to the plaintiff, that interferes with the contract, and (3) proximate cause of actual damages to the plaintiff."¹³²⁰ The court reasoned that several BRI patients had insurance contracts with various insurance companies to which Burzynski and BRI could be construed as third-party beneficiaries. The letter sent by Aetna's attorneys to the thirty-five insurers urging them to stop paying BRI claims suggested an intent to cause damage to BRI. The fact that several insurers subsequently ceased payments to BRI was sufficient to allege that Aetna proximately caused BRI's financial injury. The district court, therefore, erred, said the court, in dismissing Burzynski's action for tortious interference with contract.¹³²¹

The court next held that Burzynski stated a valid claim for tortious interference with business relations; the elements of which are "(1) a reasonable probability that the plaintiff would have gotten a contract, (2) malicious and intentional action by the defendant that aborted the prospective business relationship, and (3) actual harm to the plaintiff."¹³²² Burzynski sufficiently pleaded that the letter by Aetna's attorneys to the thirty-five insurers may

1318. *In re Burzynski*, 989 F.2d at 737.

1319. *See Burzynski v. Aetna Life Ins. Co.*, 967 F.2d 1063 (5th Cir. 1992).

1320. *Burzynski*, 989 F.2d at 738.

1321. *Id.* at 738-39.

1322. *Id.* at 739.

have resulted in the denial of coverage to BRI patients and interfered with the prospective business relations between BRI and the insurers. In addition, the pleadings sufficiently alleged proximate cause by Aetna and actual damages to Burzynski.

However, the court held that Burzynski failed to plead a viable action for abuse of process. Citing *Baubles & Beads v. Louis Vuitton, S.A.*,¹³²³ the court listed the requirements for abuse of process as (1) an illegal or improper use of the process by the defendant; (2) an ulterior motive by the defendant; and (3) damage to the plaintiff by the illegal act.¹³²⁴ The court reasoned that Burzynski failed to state that Aetna illegally or improperly used the process. Although Burzynski contended that the subpoenas and notices of deposition to the researchers were used for intimidation, he failed to show the existence of an improper use of the process after the issuance of the discovery. Concluding that mere bad intentions were insufficient, as a matter of law, to support a claim for abuse of process, the court affirmed the dismissal of the claim with prejudice.¹³²⁵

The court next held that Burzynski pleaded the necessary elements for a business disparagement claim, which are "(1) publication of disparaging and false words, (2) with malice, (3) which cause special damages, and (4) lack of privilege."¹³²⁶ The court stated that the circumstances surrounding the letter Aetna's attorneys mailed to the thirty-five insurers, urging that they cease payment for BRI's "worthless" and "unreimbursable" claims, sufficiently supported a claim for business disparagement.¹³²⁷

Finally, the court held that Burzynski failed to properly plead a RICO violation under 18 U.S.C. § 1962(a), (b), (c), and (d). The court noted that RICO claims require: ". . . a person who engages in . . . a pattern of racketeering activity, . . . connected to the acquisition, establishment, conduct, or control of an enterprise."¹³²⁸ The court reasoned that Burzynski failed to plead a "pattern" of acts by Aetna that constituted or threatened long-term criminal activity. Specifically, the pleadings failed to state that Aetna's acts amounted to, or threatened, continuing racketeering activity from either repeated conduct or past conduct projecting a threat of repetition into the future.¹³²⁹

The court noted that all of the alleged predicate acts took place as part of the *Burzynski I* litigation, which had ended. In addition, the conduct did not constitute or threaten long-term criminal activity. The court then reasoned that collectively Aetna, its attorneys, and its consultant, lacked the continuity required for an "association in fact" enterprise.¹³³⁰ According to

1323. 766 S.W.2d 377, 378 (Tex. App.—Texarkana 1989, no writ).

1324. *Burzynski*, 989 F.2d at 739.

1325. *Id.* at 740.

1326. *Id.* (citing *Hurlbut v. Gulf Atlantic Life Ins. Co.*, 749 S.W.2d 762, 766 (Tex. 1987)).

1327. *Burzynski*, 989 F.2d at 740.

1328. *Id.* at 741 (quoting *Delta Truck & Tractor, Inc. v. J.I. Case Co.*, 855 F.2d 241, 242 (5th Cir. 1988), *cert. denied*, 489 U.S. 1079 (1989)).

1329. *Burzynski*, 989 F.2d at 742.

1330. *Id.* at 743.

the court "two individuals who join together for the commission of one discrete criminal offense have not created an 'association-in-fact' enterprise, even if they commit two predicate acts during the commission of this offense, because their relationship to one another has no continuity."¹³³¹ The court concluded that, as pleaded, Aetna's alleged "association-in-fact" enterprise lacked the requisite continuity under RICO. Burzynski, therefore, failed to properly plead the statutory requirements of both a "pattern of racketeering activity" and a RICO "enterprise." Accordingly, the court dismissed Burzynski's RICO action without prejudice to allow for an amendment of the pleadings.¹³³²

XV. INSURANCE CODE AMENDMENTS OF 1993

As part of its sunset legislation, the 1993 Legislature passed H.B. 1461 amending the Insurance Code.¹³³³ This piece of legislation restructured the Department of Insurance in many ways, including the abolition of the three member State Board of Insurance and centralizing its power in the Commissioner of Insurance. With respect to private litigation, the Legislature made several significant changes and refused to make other changes.

Article 21.21, § 1(a) was amended to delete the reference to the federal McCarran-Ferguson Act, thus eliminating the argument that the "business of insurance" covered by article 21.21 is more limited than the expansive definition in section 2(a) of article 1.14-1 would indicate.¹³³⁴ Not only did it delete the reference to McCarran-Ferguson in article 21.21, H.B. 1461 reenacted, with minor changes, the expansive definition of the insurance business in article 1.14-1,¹³³⁵ which includes claims handling¹³³⁶ along with virtually every other kind of conduct. Moreover, prior to final passage of H.B. 1461, the Legislature deleted an amendment added by the House that would have precluded article 21.21 suits based on violations of Department of Insurance regulations.¹³³⁷

The significance of H.B. 1461 is readily seen. Against the backdrop of *Vail*,¹³³⁸ which relied on the definition of the "insurance business" in article 1.14-1 to hold that claims settlement practices were within the "business of insurance" in article 21.21, and the court of appeals' opinion in *Watson v. Allstate Insurance Co.*,¹³³⁹ which did likewise while recognizing the potential application of the McCarran-Ferguson test, the Legislature has *repealed* the

1331. *Id.* (quoting *Montesano v. Sea First Commercial Corp.*, 818 F.2d 423, 427 (5th Cir. 1987)).

1332. *Burzynski*, 989 F.2d at 744.

1333. H.B. 1461, § 20.17, page 400, line 27 through page 401, line 9. H.B. 1461 became law on September 1, 1993 and appears as Chapter 685 in Vernon's Session Laws.

1334. This was the argument made by the insurer in *Watson v. Allstate Ins. Co.*, 828 S.W.2d 423 (Tex. App.—Fort Worth 1992), *rev'd*, 37 Tex. Sup. Ct. J. 408 (Jan. 12, 1994).

1335. H.B. 1461, § 3.031.

1336. TEX. INS. CODE ANN. art. 1.14-1, § 2(a)(6) (Vernon Supp. 1993).

1337. H.B. 1461 (Engrossed House version) Engrossed Rider No. 4

1338. *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129 (Tex. 1988).

1339. 828 S.W.2d 423 (Tex. App.—Fort Worth 1992), *rev'd*, 37 Tex. Sup. Ct. J. 408 (Jan. 12, 1994).

reference to McCarran-Ferguson in article 21.21's "purpose" clause and *re-enacted* the "insurance business" definition in article 1.14-1 without material change. Only by actually inserting the style of the case into the statute itself could the Legislature have more clearly evidenced its intent to adopt the *Vail* holding that the "business of insurance" in article 21.21 is determined by the definition of the "insurance business" in article 1.14-1.¹³⁴⁰ Because this definition specifically includes the "investigation or adjustment of claims or losses" without distinguishing between "first-party" and "third-party," it covers *all* claims or losses. Accordingly, when the definition is applied to article 21.21 as *Vail* requires, it means that article 21.21 covers *all* claims or losses. It also means that, if in the handling of *any* claim "[a]ny person . . . [sustains] actual damages as a result of another's engaging" in unfair claims settlement acts or practices as defined by the Insurance Code or regulation, that person "may maintain an action against the person or persons engaging in such acts or practices."¹³⁴¹

Consistent with its clear intent to keep *Vail* intact, the Legislature rejected an amendment passed by the House that, while not mentioning unfair claims practices, would have insulated them from private suits. Stated simply, the amendment precluded private suits based on conduct defined unfair by any regulation. Obviously, this would prevent a suit based on conduct violating the unfair claims settlement practices regulation.¹³⁴² But it would also prevent a suit based on the Unfair Claims Settlement Practices Act.¹³⁴³ Article 21.21-2 is actionable because the article 21.21 *regulation* prohibits conduct defined as unfair by "other provisions of the Insurance Code . . ."¹³⁴⁴ By eliminating suits based on a regulation, the amendment would have banned *all* unfair claims settlement practices suits under article 21.21.¹³⁴⁵

In light of the amendments that were offered but rejected, the amendments that were made and the reenactment of portions of the Insurance

1340. See also *Great Am. Ins. Co. v. North Austin Mun. Util. Dist. No. 1*, 850 S.W.2d 285, 288-89 (Tex. App.—Austin 1993, writ requested) rejecting as "an illogical construction" the insurer's argument that the definition of "insurance business" in article 1.14-1 did not apply to the "business of insurance" in article 21.21. The insurer contended, among other things, that "neither article refers to each other." *Id.* Though not mentioned by the court of appeals, this is simply not true. The 1991 Legislature specifically incorporated into article 1.14-1 the definition of "person" in article 21.21. TEX. INS. CODE art. 1.14-1, § 3(a) (Vernon Supp. 1993) (" 'person' shall mean that which is defined in Section 2(a), Article 21.21, of this code"). Moreover, article 1.14-1 expressly authorizes the commissioner to initiate administrative proceedings whenever "a person or insurer . . . has engaged in or is threatening to engage in an unfair method of competition or an unfair or deceptive act or practice as defined by article 21.21 of this code or a rule or regulation promulgated under Article 21.21 of this code" *Id.* § 3A(a). No better example exists of statutes in *pari materia*.

1341. TEX. INS. CODE ANN. art. 21.21 § 16(a) (Vernon Supp. 1993) (emphasis added).

1342. 28 TEX. ADMIN. CODE § 21.203 (West 1988).

1343. TEX. INS. CODE ANN. art. 21.21-2 (Vernon Supp. 1993).

1344. 28 TEX. ADMIN. CODE § 21.3 (West 1988) (emphasis added).

1345. Because article 21.21 creates a special, statutory remedy, any repeal or amendment of the remedy governs pending litigation. See *La Sara Grain Co. v. First Nat'l Bank of Mercedes*, 673 S.W.2d 558, 567 (Tex. 1984).

Code, it seems clear that any effort to narrow the scope of article 21.21 causes of action by judicial "construction" of the statute should be rejected.¹³⁴⁶

1346. "The deletion of a provision in a pending bill disclose[d] the legislative intent to reject the proposal." *Camacho v. Samaniego*, 831 S.W.2d 804, 814 (Tex. 1992) (quoting *Smith v. Baldwin*, 611 S.W.2d 611, 616-17 (Tex. 1980)).