FILED
14-0721
6/23/2017 8:55 AM
tex-17797838
SUPREME COURT OF TEXAS
BLAKE A. HAWTHORNE, CLERK

No. 14-0721

IN THE
SUPREME COURT OF TEXAS

USAA TEXAS LLOYDS COMPANY,
Petitioner,

v.

GAIL MENCHACA,
Respondent.

On Petition for Review from the
Thirteenth Court of Appeals at Corpus Christi/Edinburg, Texas
Cause No. 13-13-00046-CV

PETITIONER USAA TEXAS LLOYDS COMPANY'S AMENDED MOTION FOR REHEARING

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REASONS TO GRANT REHEARING

The Court has undertaken an admirable and monumental task: harmonizing decades of bad-faith jurisprudence. Despite the Court's noble effort, confusion stubbornly endures.

Litigants, both in this case[1] and others, disagree on key aspects of the Court's holding. One insurer believes the opinion highlighted "the limited availability of statutory damages in the absence of a breach of contract claim."[2] An insured counters that *Menchaca* allows recovery of "additional policy benefits" for statutory violations, even absent a finding that the insurer breached the contract.[3] Another has told the Fourth Court of Appeals that *Menchaca* "expressly repudiated" the independent injury rule and held instead that "an independent injury is only necessary in instances where the policyholder cannot demonstrate any policy benefits were withheld, for instance, when the claim was not even covered."[4] Such

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[1] *See, e.g.*, Jess Krochtengel, *Texas High Court Pens New Rules in USAA, Policyholder Row*, LAW360 (Apr. 7, 2017) (quoting Menchaca's counsel as stating that "the court's analysis actually should have led it to an affirmance"), App. 1.

[2] Brief of Appellee, *Marchbanks v. Liberty Ins. Corp.*, No. 14-17-00004-CV, in the Fourteenth Court of Appeals of Texas, 2017 WL 2295583, at *20 (filed May 16, 2017).

[3] *See* Plaintiffs' Sur-Reply in Opposition to Defendants' Motion for Summary Judgment at 7–8, *Bonilla v. State Farm Lloyds*, No. DC–14–05918, in the 134th District Court of Dallas County, (filed Apr. 25, 2017), App. 2.

[4] Brief of Appellants, *Biasatti v. GuideOne National Insurance Company*, No. 07-17-00044, in the Seventh Court of Appeals of Texas, 2017 WL 2303155 at *50, *52 (filed May 18, 2017).

discord—just ten weeks after the opinion's release—portends an exponential escalation in litigation on these issues.

Commentators are equally puzzled. One headline announces, "No Bad Faith Claim Without Breach of Contract, Texas High Court Rules."[5] Another article states that the key question *Menchaca* decided "is whether the insured was entitled to receive benefits under the policy, not whether the policy was breached."[6]

Almost all agree that the opinion exacerbates, rather than alleviates, confusion:

- Some lawyers "think the court actually muddied the waters and the ruling will stir up significant amounts of follow-on litigation."[7]

- "The *Menchaca* decision is likely to open new paths to potential recovery for creative plaintiff's counsel, further complicate coverage and damages analysis, and result in significant follow up litigation …."[8]

- "[T]he *Menchaca* decision raises many more questions than it answers. The Court did not give any guidance on when an act of statutory bad faith will be the 'cause' of the loss of policy benefits. … The Court did not discuss the proper jury submission to entitle an insured to recover policy benefits under the entitled-to-benefits rule."[9]

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[5] Rae Theodore, "*No Bad Faith Claim Without Breach of Contract, Texas High Court Rules,*" 12 No. 26 WESTLAW JOURNAL INSURANCE BAD FAITH 1 (Apr. 26, 2017), App. 3.

[6] Krochtengel, *Texas High Court Pens New Rules*, App. 1.

[7] Jess Krochtengel, *Texas Ruling Could Mean Bigger Paydays for Policyholders*, LAW360 (Apr. 11, 2017), App. 4.

[8] Matthew M. Haar, *New Bad Faith Guidance in Texas*, Insurance Practice Alert, Saul Ewing Law Firm (April 2017), App. 5.

[9] Thompson Coe, L.L.P., *Texas Supreme Court Attempts to Clarify Statutory Bad Faith Liability* (Apr. 4, 2017), App. 6.

- "The Texas Supreme Court now believes that it has 'clarified' the issues in [*Menchaca*], a case in which the court, while recognizing that its prior language could have been clearer, recognized no concern with the rules stated in *Vail* and *Castañeda* standing side by side. … While these rules seems [sic] relatively straightforward, it is not necessarily clear that the court has once and for all clarified anything."[10]

- "Some commentators are already saying *Menchaca* is unwieldy or will present challenges in its application. Others are saying the ruling muddies the waters more than clarifies the issues and rules."[11]

It has been thirty years since this Court decided *Vail*;[12] twenty years since *Castañeda*.[13] While some issues in this area may still need clarification, the legal questions in this case rest on settled facts, with extensive briefing and well-sourced authority from both sides. The parties' path to review has been long, difficult, and expensive. This Court should answer the question the parties briefed and render judgment.

If the Court does remand, it should address the opinion's inconsistencies and provide additional guidance for retrial. How should the case have been submitted, and what answers under that submission would support a judgment for Menchaca? As things now stand, the retrial may also be in vain. Even more significantly, parties

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[10] Fletcher Farley, *The Texas Supreme Court "Clarifies" The Law Regarding Recovery of Damages in First Party Bad Faith Claims* (Apr. 19, 2017), App. 7.

[11] Lee Shidlofsky et al., *Bad Faith—Alive and Well in Texas! Who Knew?*, http://www.shidlofskylaw.com/blogs/blog18.html (Apr. 14, 2017), App. 8.

[12] *Vail v. Tex. Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129 (Tex. 1988).

[13] *Provident Am. Ins. Co. v. Castañeda*, 988 S.W.2d 189 (Tex.1998).

and lawyers litigating the thousands of hailstorm cases winding their way through Texas courts need further direction from this Court.

I. The opinion presents seemingly contradictory standards.

A. "Entitled to benefits": a breach by any other name?

Liability on a contract requires proof that a party did not comply with—or breached—the contract. *See, e.g., 1/2 Price Checks Cashed v. United Auto. Ins. Co.*, 344 S.W.3d 378, 384 (Tex. 2011) ("[A] contract [is] a promise or a set of promises for the breach of which the law gives a remedy ….") (quoting RESTATEMENT (SECOND) OF CONTRACTS § 1).

Menchaca seemingly imposes different terminology, at least for an award of contract benefits for a statutory violation. Rather than inquiring about an insurer's failure to comply with the insurance policy, *Menchaca* appears to require a finding "that the insured had a right to benefits under the policy." *USAA Texas Lloyds Co. v. Menchaca*, No. 14–0721, 2017 WL 1311752, at *7 (Tex. Apr. 7, 2017), App. 9. But much of the Court's opinion, and the logic behind it, suggest that denial of a right to benefits is really the same standard as a breach, making the question one of semantics, not substance.

Menchaca acknowledges as much: "if the policy does cover the loss, the insurer *necessarily breaches* the policy if it fails to pay benefits for the loss because the insured is *entitled to those benefits*." *Menchaca* at *7 (emphasis added). If an insured "has a right" to benefits under the policy, and the insurer does not pay them,

the insurer has breached the contract. *See, e.g.*, RESTATEMENT (SECOND) OF CONTRACTS § 235(2) ("When performance of a duty under a contract is due any nonperformance is a breach."). This governs both coverage and valuation disputes. If an insurer denies a claim that is in fact covered, the insurer has breached the policy. *See Transp. Ins. Co. v. Moriel*, 879 S.W.2d 10, 17 (Tex. 1994) ("An insurer's nonpayment of a covered claim ordinarily is a breach of contract …."). Likewise, if an insurer denies a claim that is in fact above the deductible, the insurer has breached the policy. *See id.*

In *Menchaca*'s wake, some litigants have asserted that the opinion drew a distinction between uncovered claims and those that are below the insured's deductible. *See, e.g.*, Letter Brief, *Pounds v. Liberty Lloyds of Texas Ins. Co.*, No. 14-16-00263-CV, in the Court of Appeals for the Fourteenth District of Texas at Houston, 2017 WL 1399342, at *3 (Apr. 13, 2017) ("The *Menchaca* opinion equates 'entitled to policy benefits' with coverage, not with breach. Everyone agrees that he suffered a covered loss; the only disagreement is about the amount of that loss. … [N]either breach nor independent injury is a prerequisite to statutory bad faith liability when a claim is covered."). Yet *Menchaca* never articulates that distinction; in fact, it suggests the opposite. *Menchaca* at *7 ("[I]f the policy does cover the loss, the insurer necessarily breaches the policy if it fails to pay benefits for the loss because the insured is entitled to those benefits.") (emphasis added).

Even if the Court did find a distinction between coverage disputes and valuation disputes, the difference cannot be outcome-determinative. How is an insurer's erroneous decision to deny a claim as below the deductible any different from an erroneous decision to deny a claim as caused by flood or rising water rather than by a bursting pipe? In both instances, when an insurer decides that a claim is not covered and a factfinder later determines from sufficient evidence that it is, the insurer has breached its policy. Treating one decision as qualitatively distinct from the other has neither logical sense nor legal force.

In short, breach and entitlement to benefits are but two sides of the same coin. In discussing *Castañeda*, for example, the Court equated a failure to prove breach with a non-entitlement to policy benefits. The Court observed that *Castañeda* "relied on the fact that the insured 'did not plead and *did not obtain a determination* [*that the insurer*] *was liable for breach* of the insurance contract.'" *Menchaca* at *9 (emphasis added). Thus: "*Castañeda* stand[s] for the general rule that an insured cannot recover policy benefits as damages for an insurer's extra-contractual violation *if the policy does not provide the insured a right to those benefits*." *Id*. (emphasis added).

Moreover, the Court pointedly rejected Menchaca's argument that her policy-benefits claim under the Insurance Code was independent of her breach-of-contract claim:

> Menchaca contends that she can recover policy benefits as damages resulting from USAA's statutory violation because that claim is independent from her claim for policy breach. … *The reason we reject Menchaca's independent-claims argument*—indeed the very reason for the general rule—derives from the fact that the Insurance Code only allows an insured to recover actual damages 'caused by' the insurer's statutory violation.

Id. at *6 (emphasis added).

But other parts of this Court's opinion take an emphatically different turn. For example, the Court says that while an insured must prove a right to benefits under the policy, she need not *also* establish breach:

> While an insured cannot recover policy benefits for a statutory violation unless the jury finds that the insured had a right to the benefits under the policy, the insured does not *also* have to establish that the insurer breached the policy by refusing to pay those benefits.

Menchaca at *7. Contrary to much of the Court's language, this sentence suggests that the concepts are distinct, so that an insured can recover policy benefits even when a jury has failed to find that the insurer breached the policy. While the Insurance Code indeed imposes duties on insurers additional to those under the contract, the Code has never required an insurance company to pay contract benefits when there has been no breach.

Menchaca, consistent with previous decisions, recognized an insured's limited Benefits-Lost Rule, permitting recovery of policy benefits even absent a breach, but that rule does not apply here. The rule allows "an insured [to] recover benefits as actual damages under the Insurance Code even if the insured has no right

to those benefits under the policy, *if the insurer's conduct caused the insured to lose that contractual right.*" *Menchaca* at *9. The Court has recognized this principle in cases involving an insurer's misrepresentation of policy coverage, waiver or estoppel of the right to deny coverage, or a statutory violation that caused the insured to lose a contractual right to benefits that it otherwise would have had. *Id*. Here, the jury answered "No" when asked if USAA misrepresented a material fact or policy provision regarding coverage, CR1:666, and Menchaca has not challenged that determination. She has not alleged nor proven waiver or estoppel, and she does not contend that she can recover policy benefits even though she has no right to them under the policy; indeed, her argument rests on the premise that *the policy* compels USAA's payment of policy benefits. *See, e.g.*, Respondent's Brief at 1 (arguing that her damages consist of "policy benefits wrongfully withheld").

Benefits-Lost Rule aside, the only way an insured can recover policy benefits is to establish liability on the contract. If an insured is entitled to benefits and the insurer does not pay, the insurer breaches the contract—***no matter the reason for the denial***. The "entitled to benefits" inquiry therefore subsumes breach, but does not replace it. Therefore, an insured cannot prove her "entitlement to benefits" without establishing her insurer's breach.

While parts of *Menchaca* reiterate this clear distinction, other parts seem to blur or even eliminate it. In consecutive paragraphs, the Court first suggests that breach is a necessary component of a claim for policy benefits, and then opines that

breach is irrelevant to a bad faith claim seeking those benefits. First, the Court stated:

> Although we have clarified today that ***Menchaca did not have to prevail on her breach-of-contract claim to recover policy benefits for a statutory violation***, the confusing nature of our precedent precludes us from faulting USAA for the position it has maintained throughout this litigation.

Id. at *15 (emphasis added).

But in the very next paragraph, it says:

> As with USAA's argument, we conclude that the confusing nature of our precedent ***precludes us from faulting Menchaca for asserting throughout this litigation that she did not have to prove breach***.

Id. (emphasis added).

So the critical question—the one USAA and Menchaca have fully briefed[14]—endures: must a litigant seeking to recover policy benefits, whether on a contract claim or a statutory violation, prove that the insurer failed to comply with the policy? *Menchaca* says yes, and *Menchaca* also says no. Left uncorrected, this inconsistency will plague these disputes, precluding summary judgment in appropriate cases and yielding confusing, perhaps contradictory verdicts after a full trial.

[14] *See* Petitioner's Brief at xiii; Respondent's Brief at xiii.

B. Because the governing standards are now unclear, parties do not know how to try or submit these cases, and fundamental questions remain unanswered.

By rejecting Menchaca's breach claim, the jury agreed with USAA that Menchaca's damages were less than her deductible. Thus, the jury appropriately rejected Menchaca's claim that USAA "failed to comply" with its obligations under the policy. *See Menchaca* at *14 (recognizing that evidence supported jury's answer). Indeed, this Court *agreed* that the jury's "No" answer was *material* and that the trial court erred in disregarding it. *Id*.

Given that the breach submission was "material," and the evidence supported the jury's no-liability answer, it is difficult to conceive of how Menchaca could ever be entitled to *contractual* policy benefits. But that is the interpretation Menchaca's counsel currently advances in a different case, citing *Menchaca*. *See supra,* n.2. Such an argument can only be advanced because of the Court's suggestion that something less than breach can entitle an insured to recover policy benefits, *e.g.*, *Menchaca* at *7, *15, despite its recognition in other parts of the opinion that "the Code does not create insurance coverage or a right to payment of benefits that does not otherwise exist under the policy," *id*. at *3.

And where, as here, parties submit contractual-breach questions separately from questions about Insurance Code violations, *Menchaca* invites fatal conflicts in the jury's answers. If "breach" governs an award of contractual damages, while "entitled to benefits" permits policy-benefits recovery for Insurance Code violations,

what happens when a jury says no to the former and yes to the latter? *See id*. at *14 ("Question 1 [on breach] was material because Menchaca sued USAA for breach of the insurance policy as well as for statutory violations), *7 ("The second rule … is that an insured who establishes a right to receive benefits under an insurance policy can recover those benefits as 'actual damages' under the statute if the insurer's statutory violation causes the loss of the benefits.").

Menchaca never explains whether its "entitled to benefits" inquiry differs from breach, and if so, *how* it differs. *Menchaca* gives each party ample ammunition to support its argument, as the excerpts from recent briefs and commentaries demonstrate, but it leaves them no closer to resolution than they were before the Court accepted review.

II. USAA is entitled to rendition.

The Court's remand exacerbates the confusion. *Menchaca* did not change the way a contractual-breach claim should be tried or submitted to a jury. Although Menchaca offered evidence to support the issue of breach, submitted to the jury at her request, the jury failed to find in her favor. Menchaca's inability to prove breach means that she is not entitled to benefits under the policy. The inquiries must be one and the same, as *Menchaca*'s discussion of *Castañeda* recognized. *Id*. at *9. Furthermore, *Menchaca* also cautioned that "*Vail* should not be read … as suggesting that an insured can recover benefits for a statutory violation when the insured fails to establish and the insurer does not concede that the insured has a

contractual right to the benefits." *Id*. at *8 n.18. Here, Menchaca failed to establish, and USAA did not concede, that Menchaca had a contractual right to policy benefits.

Because Menchaca sought no damages other than policy benefits, such as mental anguish, destruction of evidence, or loss of time and opportunity, no factual disputes remain.[15] The jury's answer to the contract question established there was no uncompensated covered damage. It logically follows that non-existent damage cannot then be "brought into existence" by a statutory violation. Based on this record, if the Court's discussions of *Castañeda* and *Vail* mean what they say, judgment should be rendered for USAA. A remand for Menchaca to retry her case is nothing more than a second "bite at the apple." *Kerr-McGee Corp. v. Helton*, 133 S.W.3d 245, 260 (Tex. 2004) (rendering judgment because remand involved "time and expense of additional proceedings" that would merely provide "an opportunity for another bite at the apple").

Menchaca's inability to prove that USAA's liability on the contract precludes her recovery of policy benefits, whether on a contract claim or for a statutory violation. USAA is entitled to judgment under *Menchaca*'s General, Entitled-to-Benefits, and No-Recovery Rules.

[15] Menchaca explicitly disclaimed mental anguish and consequential damages. RR6:7–10.

III. *Menchaca* calls into question *Castañeda*'s holding that "failure to investigate a claim is not a basis for obtaining policy benefits," and the Court's attempts to distinguish *Castañeda* are misplaced.

As noted, *Menchaca* affirms (1) *Castañeda*'s rule that an insured's failure to prove liability on the policy precludes recovery of policy benefits for a statutory violation; and (2) that *Vail* does not authorize a policy-benefits award if "the insured fails to establish and the insurer does not concede" the insured's right to those benefits. *Menchaca* at *8 n.18, *9. Those holdings entitle USAA to rendition.

Yet, even though it embraced parts of *Castañeda*, the *Menchaca* opinion altered others. The Court distinguished *Castañeda*'s discussion of "the damages that might be recoverable if an insurer failed to adequately investigate a claim" on the grounds that, unlike other portions of the opinion, this discussion was not predicated on an assumption of coverage:

> On that issue, we held that an insurer's 'failure to properly investigate a claim is not a basis for obtaining policy benefits,' but we did not assume that coverage existed when deciding that separate issue.

Id. at *9. But *Castañeda* cannot be distinguished on that ground.

Castañeda need not have assumed coverage existed because the insurer in that case did not contest coverage in this Court. At trial, the insurer asserted two coverage defenses: that Castañeda's illness (1) manifested itself before coverage was effective; and (2) involved her gallbladder. The jury rejected both, and, on appeal, the insurer did not challenge the jury's answers. Petitioner's Application for Writ of Error at Ex. A, 11–12, *Provident Am. Ins. Co. v. Castañeda*, No. 96–0249,

in the Supreme Court of Texas (filed Apr. 10, 1996), App. 11; Response to Application for Writ of Error at 43, *Provident Am. Ins. Co. v. Castañeda*, No. 96–0249, in the Supreme Court of Texas (filed May 16, 1996), App. 12.[16] That meant that the insurer could no longer assert noncoverage as a defense; it had to win by challenging the jury's findings for plaintiffs under the Insurance Code.

Having lost on its no-coverage defenses, the insurer challenged the failure-to-investigate finding on causation grounds. App. 11 at 1–2 (urging that there was no evidence the insurer's actions were the producing cause of damage). The insurer's argument in this respect was premised not merely on an assumption that Castañeda's claims were covered, but also that the insurer wrongly denied them. The insurer argued instead that statutory recovery was limited to damages *other than* policy benefits, as only such independent damages could be *caused by* the statutory violation. *Id*. at 39–40 (arguing that insured could not recover under Insurance Code because she failed to prove injury "other than the injury that would always occur when an insured is not promptly paid").

This Court decided *Castañeda* on precisely that issue. Using familiar language of causation, *Castañeda* observed that an insurer's failure to pay benefits owed caused contract, but not statutory, damages: "none of" the insurer's "actions or inactions" in investigating the plaintiff's claim "was the producing cause of any

[16] The Court may take judicial notice of its case file in *Castañeda*, which is housed at the State Archives. TEX. R. EVID. 201(d); *see also id.*, 201(b), (c). All cited materials are appended hereto.

damage *separate and apart from those that would have resulted from a wrongful denial of the claim*." 988 S.W.2d at 198 (emphasis added).

The Fifth Circuit and many Texas courts thus reasonably concluded that *Castañeda* overruled *Vail*. *See* USAA Brief on the Merits at 21 and Reply Brief on the Merits at 19–22.[17] It is also why *Castañeda* was widely interpreted as imposing an "independent injury" requirement for recovery of damages for statutory violations.

Menchaca alters *Castañeda*'s causation analysis. Instead of requiring proof of harm different from what "would have resulted from a wrongful denial of the claim," *Castañeda*, 988 S.W.2d at 198, portions of *Menchaca* appear to permit recovery of policy benefits if an insurer's statutory violation causes the loss of the benefits—even (paradoxically) without proof of breach, *Menchaca* at *7. *Castañeda* is not distinguishable. *Menchaca* quietly recasts that part of it, replacing *Castañeda*'s causation requirement with a nebulous standard that suggests an insurer may be liable for policy benefits even absent evidence that it breached the policy. And the Court nowhere explains how, absent that proof, an Insurance Code violation can cause the loss of policy benefits.

[17] Two weeks before *Menchaca* issued, United States District Judge Lee Rosenthal reached the same conclusion. *See Metro Hosp. Partners, Ltd. v. Lexington Ins. Co.*, No. CV-H-15-1307, 2017 WL 1106271, at *5 (S.D. Tex. Mar. 24, 2017).

IV. If rendition is not ordered, further explanation is required for the remand to be productive.

If the Court abides by its remand decision, returning this case to the trial court without changing the opinion leaves both parties in a quandary. Menchaca, USAA, and the trial court must guess how to submit this case to the jury. Should there be, as the opinion holds, distinct questions about breach (to establish liability for contract benefits) and also whether an insured is entitled to benefits (as a precursor to an insurer's liability for contract benefits for a statutory violation)? Or should the breach inquiry instead be replaced with a question about whether the insured is entitled to benefits under the policy, a finding that would establish the insurer's liability for contract benefits *and* be a necessary predicate to recovery of policy benefits for a statutory violation?

Without guidance on these issues, or an answer to whether the jury's answers conflicted in the first trial, it is unclear how to conduct a second trial. In Question 1, the jury refused to find that USAA breached the policy. App. 10 at 4. In Question 2, the jury found that USAA refused to pay Menchaca's claim without conducting a reasonable investigation, and that USAA's actions caused Menchaca to suffer damages that happened to exceed the amount of the policy's deductible. *Id*. at 5. This Court reinstated the jury's answer to Question 1 as being *material* to Menchaca's contract claim. So if USAA did not breach the policy, can it nevertheless owe policy benefits because its investigation was not adequate? If a

faulty investigation meant that USAA did not pay Menchaca benefits she was owed—and that is the only way Menchaca could recover even under the *Menchaca* standard—that would be a policy breach. That means that the answers to Questions 1 and 2 would have to fatally conflict.

USAA fully briefed this issue and showed that Menchaca intentionally accepted those "contradicting" answers without asking the court to require the jury to attempt a reconciliation. RR11:6–8 (Menchaca's counsel: "I don't think there's irreconcilable conflict with the answers … ."); *see also St. Paul Fire & Marine Ins. Co. v. Murphree*, 357 S.W.2d 744, 748–49 (Tex. 1962) (recognizing that complaint regarding fatal conflict was waived by failure to object). This Court could have resolved this issue by holding that, even if the answers conflicted, USAA is entitled to judgment because Menchaca did not preserve the issue for review. But if the remand suggests that the two answers can be harmonized, the Court should say so. This is the only way the parties will understand the standard the Court has set.

CONCLUSION AND PRAYER

This Court shouldered a "duty to settle the conflicts in order that the confusion will as nearly as possible be set at rest." *Menchaca* at *1 (citation omitted). But in doing so, the Court left unresolved the sole question on which this case turns. Whatever else it does, the Court should render a judgment that answers whether, under the circumstances presented here, USAA must pay policy benefits when it has not breached the policy. The question of breach—submitted and material to the

disposition—has been settled. Menchaca did not challenge the jury's rejection of her claim, nor did she argue or present evidence of damages apart from policy benefits. The question deserves an answer.

Though it admitted to one instance where in previous cases it "could have made the point more clearly," *id*. at *8, the Court's opinion overruled no cases nor disapproved of any holdings. Under the Court's pre-*Menchaca* jurisprudence, or as tested against its five-principled approach, Menchaca cannot show how she has any workable theory of recovery. Given the parties' proof and the jury's verdict, the proper disposition is a take-nothing judgment.

USAA prays that this Court grant rehearing, withdraw its April 7, 2017 opinion, reverse the court of appeals' judgment, and render judgment that Menchaca take nothing. Alternatively, USAA requests that the Court provide additional guidance regarding the standards for recovery, including the proper way to submit contested questions to the jury, in this case and others like it.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Based on a word count run in Microsoft Word 2013, this amended motion contains 4,470 words, excluding the portions of the amended motion exempt from the word count under Texas Rule of Appellate Procedure 9.4(i)(1).

/s/ *Wallace B. Jefferson*
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CERTIFICATE OF SERVICE

I hereby certify that on June 23, 2017, this Amended Motion for Rehearing was served via electronic service through eFile.TXCourts.gov on Respondents through counsel of record, listed below:

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APPENDIX

Tab Item

APPENDIX 1

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Texas High Court Pens New Rules In USAA, Policyholder Row

By Jess Krochtengel

Law360, Dallas (April 7, 2017, 7:43 PM EDT) -- The Texas Supreme Court on Friday ordered a new trial for a USAA Lloyds Texas policyholder who accuses the insurer of acting in bad faith by refusing to investigate damage from Hurricane Ike and wants to recoup damages despite a jury finding USAA did not breach the policy, in a ruling that also aims to clear up confusion over contractual disputes by setting out new rules.

In its ruling, the court did not say whether the insurer or policyholder Gail Menchaca should ultimately win. The justices acknowledged that prior rulings had caused "substantial confusion" among lower courts and said confusion about the interplay between claims for breach of an insurance policy and claims of wrongdoing under the Texas Insurance Code had so impacted the case that justice requires a new trial.

The ruling sets out five "distinct but interrelated" rules governing the interplay between contractual insurance disputes and allegations of statutory wrongdoing.

"I feel like we have achieved a victory," Jennifer Hogan of Hogan & Hogan, who represented Menchaca, said Friday. "I am very happy for Ms. Menchaca. I think that the court's analysis actually should have led it to an affirmance, but if the court believes a new trial is fair then we will go back for the trial."

Counsel for USAA did not immediately respond to requests for comment Friday.

In her suit, Menchaca claimed USAA acted in bad faith under the Texas Insurance Code by failing to conduct a reasonable investigation into her claim her home was damaged by the hurricane. The insurer had determined she sustained only $700 in damage to her home, far less than the policy's deductible, but Menchaca claimed if they had properly investigated, they would have been on the hook for thousands' worth of damage to the property.

A jury had found USAA did not fail to comply with the terms of Menchaca's policy. But it also found USAA had engaged in unfair or deceptive practices in violation of the Insurance Code by refusing her claim without performing a reasonable investigation, and awarded $11,350 in damages, equivalent to what it said USAA should have paid in policy benefits, plus $130,000 in attorneys' fees.

USAA appealed, arguing the jury's finding it didn't breach the policy precludes Menchaca from recovering policy benefits as damages for the statutory violation. The justices disagree, saying in an 8-0 opinion written by Justice Jeff Boyd that the key question is whether the insured was entitled to receive benefits under the policy, not whether the policy was breached.

"While an insured cannot recover policy benefits for a statutory violation unless the jury finds that the insured had a right to the benefits under the policy, the insured does not also have to establish that the insurer breached the policy by refusing to pay those benefits," the court said.

The court's five rules for evaluating similar cases are: First, an insured can't recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a

right to receive those benefits. Second, an insured who establishes a right to receive benefits under the policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits.

Third, even if the insured cannot establish a present contractual right to policy benefits, the insured can recover benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right. Fourth, if an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits.

And fifth, an insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

USAA is represented by Wallace B. Jefferson, Rachel A. Ekery and Charles T. Frazier Jr. of Alexander Dubose Jefferson & Townsend LLP.

Menchaca is represented by Jennifer Bruch Hogan, Richard P. Hogan Jr. and James C. Marrow of Hogan & Hogan.

The case is USAA Texas Lloyd's Co. v. Gail Menchaca, case number 14-0721, in the Supreme Court of the State of Texas.

--Editing by Pamela Wilkinson.

APPENDIX 2

CAUSE NO. DC-14-05918

ANA BONILLA AND JUAN GUZMAN,	§	**IN THE DISTRICT COURT OF**
Plaintiffs,	§	
	§	
v.	§	**DALLAS COUNTY, TEXAS**
	§	
STATE FARM LLOYDS, OWEN COCKRELL, AND LUIS ORTIZ III,	§	
Defendants.	§	**134TH JUDICIAL DISTRICT**

PLAINTIFFS' SUR-REPLY IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON PLAINTIFFS' EXTRA-CONTRACTUAL CLAIMS

TO THE HONORABLE DALE TILLERY:

COME NOW, Ana Bonilla and Juan Guzman ("Plaintiffs") and file this, *Plaintiffs' Sur-Reply in Opposition to Defendants' Motion for Summary Judgment on Plaintiffs' Extra-Contractual Claims ("Sur-Reply"),* and in further support of denying the *Motion for Summary Judgment on Plaintiffs' Extra-Contractual Claims* ("MSJ") filed by Defendants State Farm Lloyds ("State Farm"), Owen Cockrell ("Cockrell"), and Luis Ortiz III ("Ortiz") (collectively, "Defendants"), Plaintiffs would show this Honorable Court as follows:

ARGUMENT & AUTHORITIES

1. In their MSJ, Defendants contend that summary judgment on Plaintiffs' extra-contractual claims for Defendants' violations of Chapter 541 of the Texas Insurance Code, fraud, and conspiracy to commit fraud and State Farm's breach of the common law duty of good faith and fair dealing should be granted because Plaintiffs did not secure a verdict against State Farm on their breach of contract cause and cannot show that they have suffered an injury independent of nonpayment of policy benefits as a result of any bad faith committed by Defendants. More specifically, Defendants argue that the jury verdict and final judgment in favor of State Farm in

the severed breach of contract cause establish that State Farm is not liable for breaching the insurance contract with Plaintiffs and that in the absence of a valid, underlying breach of contract claim, the only way Plaintiffs can prevail on their extra-contractual claims against Defendants for statutory and common-law bad faith is if Plaintiffs can show that Defendants' bad faith conduct caused Plaintiffs to sustain some injury independent of nonpayment of policy benefits. As demonstrated below, Defendants' argument is premised on a misinterpretation and/or misapplication of Texas law, and, pursuant to the Supreme Court's recent opinion in *USAA Tex. Lloyds Co. v. Menchaca*[1], Plaintiffs are not required to present evidence of an independent injury in order to prevail on their statutory and common law bad faith claims against Defendants.

2. *Menchaca* is first-party insurance claim dispute case where the insured-plaintiff brought claims for breach of contract, common law bad faith, and statutory bad faith pursuant to Chapters 541 and 542 of the Texas Insurance Code against its homeowners' insurer, USAA, for damages resulting from USAA's mishandling, underpayment and denial of properly-covered windstorm damages to plaintiff's home caused by Hurricane Ike.[2] After a jury trial, the jury returned a verdict wherein they answered "no" to the question of whether USAA failed to comply with the terms of the insurance policy with respect to the plaintiff's Ike claim.[3] However, the jury answered "yes" when asked whether USAA engaged in unfair or deceptive practices such as paying a claim without conducting a reasonable investigation with respect to the insurance claim, and awarded policy benefits as damages for the unfair or deceptive practices.[4] USAA moved for judgment in its favor arguing that because the jury failed to find that USAA failed to comply with the policy

[1] *Menchaca*, No. 14-0721, 2017 Tex. LEXIS 361 (Tex. April 7, 2017). **A copy of the *Menchaca* opinion is attached hereto as "Exhibit A" for the Court's convenience.**
[2] *Id.* at *3-4.
[3] *Id.* at *4.
[4] *Id.*

terms, Ms. "Menchaca could not recover policy for 'bad faith or extra-contractual liability as a matter of law.'"[5] USAA maintained that Ms. Menchaca could not recover policy benefits for a statutory violation unless she also obtained a finding that USAA breached the insurance policy or that USAA's statutory violation caused an injury independent of her right to benefits.[6]

3. In rejecting USAA's position that the jury's finding of no breach of contract precluded Ms. Menchaca from recovering policy benefits for her bad faith claims, the Supreme Court held:

> An insured's claim for breach of an insurance contract is "distinct" and "independent" from claims that the insurer violated its extra-contractual common-law and statutory duties. *See Liberty Nat'l Fire Ins. Co. v. Akin*, 927 S.W.2d 627, 629 (Tex. 1996) ("Insurance coverage claims and bad faith claims are by their nature independent."); *Twin City Fire Ins. Co. v. Davis*, 904 S.W.2d 663, 666 (Tex. 1995) (noting that a bad-faith claim is "distinct" from a suit for breach of the policy); *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995) ("[A] policy claim is independent of a bad faith claim."). A claim for breach of the policy is a "contract cause of action," while a common-law or statutory bad-faith claim "is a cause of action that sounds in tort." *Twin City*, 904 S.W.2d at 666; *see also Viles v. Sec. Nat'l Ins. Co.*, 788 S.W.2d 566, 567 (Tex. 1990) ("[A] breach of the duty of good faith and fair dealing will give rise to a cause of action in tort that is separate from any cause of action for breach of the underlying insurance contract."). But the claims are often "largely interwoven," and the same evidence is often "admissible on both claims." *Akin*, 927 S.W.2d at 630.
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> The primary question in this case is whether an insured can recover policy benefits as actual damages caused by an insurer's statutory violation absent a finding that the insured had a contractual right to the benefits under the insurance policy. Generally, the answer to this question is "no," but the issue is complicated and involves several related questions. In an effort to clarify these issues, we distill from our decisions five distinct but interrelated rules that govern the relationship between contractual and extra-contractual claims in the insurance context. First, as a general rule, an insured cannot recover policy benefits as damages for an insurer's statutory violation **if** the policy does not provide the insured a right to receive those benefits. **Second, an insured who establishes a right to receive benefits under the insurance policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits. Third, even if the insured cannot establish a present contractual**

[5] *Id.* at *5.
[6] *Id.* at *47.

> **right to policy benefits, the insured can recover benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right.** Fourth, if an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits. And fifth, an insured cannot recover *any* damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.[7]

The Court explained how these rules are based in an understanding of the important distinction between a finding that there was a "coverage" for the claim under the policy versus a finding that the insured "breach of the policy" and how each can affect an insured's right to recover policy benefits for an insurer's statutory bad faith:

> Relying on these decisions, USAA contends that the general rule applies here and Menchaca cannot recover policy benefits based on a statutory violation because the jury failed to find that USAA "breached" the insurance contract. In response, Menchaca argues that she can avoid the general rule by obtaining a finding that the policy "covers" her losses, and she did not have to obtain a finding that USAA "breached" the policy to recover under the statute. Our precedent is confusing on this point because we have actually used both phrases to describe the general rule. *See, e.g., JAW the Pointe*, 460 S.W.3d at 599 (holding that insured could not recover benefits as statutory damages because "the policy did not cover the insured's losses") (emphasis added); *Page*, 315 S.W.3d at 532 ("There can be no liability under [the Insurance Code] if there is no coverage under the policy.") (emphasis added); *Chrysler*, 297 S.W.3d at 254 (holding that insured could not recover extra-contractual damages because the insurer "did not breach the insurance contract") (emphasis added); *Boyd*, 177 S.W.3d at 920-21 (concluding that a take-nothing judgment on a breach-of-contract claim negated recovery of benefits as statutory damages); *Castañeda*, 988 S.W.2d at 201 (holding that insured could not recover statutory damages "equivalent to policy benefits" because she did not plead or establish that the insurer "was liable for breach of the insurance contract") (emphasis added); *Stoker*, 903 S.W.2d at 341 ("[T]here can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered.") (emphasis added).
>
> In one sense, no relevant distinction exists between "breach" and "coverage" in this context because no breach can occur unless coverage exists, and if there is coverage, there is necessarily a breach if the insurer fails to pay the amount

[7] *Id.* at *9-11 (emphasis added).

covered. If the policy does not cover the insured's loss, the insurer does not breach the policy by failing to pay benefits for that loss, because the insured is not entitled to those benefits. Conversely, if the policy does cover the loss, the insurer necessarily breaches the policy if it fails to pay benefits for the loss because the insured is entitled to those benefits. **In another sense, however, an important distinction does exist because USAA contends that Menchaca could not recover policy benefits unless she prevailed on her breach-of-contract claim. According to USAA, in other words, an insured can never recover policy benefits as damages for a statutory violation.**

We disagree. Although our prior decisions refer interchangeably to both "breach" and "coverage," our focus in those cases was on whether the insured was entitled to benefits under the policy, because an insurer's statutory violation cannot "cause" the insured to suffer the loss of benefits unless the insured was entitled to those benefits. **Thus, although we have referred to both "breach" and "coverage," what matters for purposes of causation under the statute is whether the insured was entitled to receive benefits under the policy. While an insured cannot recover policy benefits for a statutory violation unless the jury finds that the insured had a right to the benefits under the policy, the insured does not *also* have to establish that the insurer breached the policy by refusing to pay those benefits. As we explain further in the following section, if the jury finds that the policy entitles the insured to receive the benefits and that the insurer's statutory violation caused the insured to not receive those benefits, the insured can recover the benefits as "actual damages . . . caused by" the statutory violation.** *See* Tex. Ins. Code § 541.151.[8]

4. Finally, the *Menchaca* opinion states:

In short, *Stoker* and *Castañeda* stand for the general rule that an insured cannot recover policy benefits as damages for an insurer's extra-contractual violation if the policy does not provide the insured a right to those benefits. Vail announced a corollary rule: an insured who establishes a right to benefits under the policy can recover those benefits as actual damages resulting from a statutory violation. We clarify and affirm both of these rules today.[9]

Specifically, USAA has steadfastly maintained that Menchaca cannot recover policy benefits for a statutory violation unless she also obtains a finding that USAA "breached" the insurance policy or that USAA's statutory violation caused an injury independent of her right to benefits. At trial, USAA objected to the charge's failure to condition Question 2 on a "Yes" finding to Question 1 and objected to the submission of Question 3 on the ground that "Texas courts have held that extra[-]contractual damages need to be independent from policy

[8] *Id*. at *20-23.
[9] *Id*. at *29.

> damages." **After the jury returned its verdict, USAA argued that it should prevail because "the jury found 'NO' breach of contract" and awarded only policy benefits "for repairs to the property which Plaintiff and her experts testified were proximately caused by Hurricane Ike." After the trial court entered its judgment, USAA argued in its motion for new trial that Menchaca cannot recover in the absence of a finding of breach because she did not seek damages "separate and apart from those sought under the breach of contract theory." Although we have clarified today that Menchaca did not have to prevail on her breach-of-contract claim to recover policy benefits for a statutory violation**, the confusing nature of our precedent precludes us from faulting USAA for the position it has maintained throughout this litigation.[10]

5. In short, in *Menchaca,* the Supreme Court decidedly finds that insured need not secure a finding that his/her insurer breached the policy in order to be able to maintain and sustain his/her bad faith claims against the insurer. As the Court explicates, under Texas law, statutory and common law bad faith claims are causes of action in tort that are independent and separate from any cause of action for breach of the underlying insurance contract.[11] *Menchaca*, therefore, confirms what Plaintiffs have urged from the start, which is that Plaintiffs' claims for breach of the duty of good faith and fair dealing (i.e., common-law bad faith) and statutory bad faith (i.e., violations of Chapter 541 of the Insurance Code) are independent causes of action sounding in tort that can be maintained and sustained separate and apart from any cause of action for breach of the underlying insurance contract.

6. The Court makes clear in the *Menchaca* opinion that it endeavors to provide clarity on these prevailing issues in first-party insurance cases in the face of inconsistent opinions and interpretations of the Court's prior opinions by the lower courts and, in doing so, unambiguously states that there are "five distinct but interrelated rules that govern the relationship between contractual and extra-contractual claims in the insurance context."[12] The first and second rule alone

[10] *Id*. at *47-48 (emphasis added).
[11] *Id.* at *9-10.
[12] *Id.* at *10.

effectively extinguish the entire premise for Defendants' argument that Plaintiffs' extra-contractual claims should be dismissed on summary judgment: first, that "an insured can recover policy benefits, as actual damages, if the insured can show that a statutory violation under Chapter 541 committed by the insurer caused," which renders Defendants' contention that Plaintiffs must show an injury independent of nonpayment of policy benefits to prevail on their extra-contractual bad faith claims unequivocally meritless; and second, that while it is true that "an insured cannot recover policy benefits for a statutory violation unless the jury finds that the insured had a right to the benefits under the policy, the insured does not *also* have to establish that the insurer breached the policy by refusing to pay those benefits."[13] The second rule extinguishes another premise that is central to Defendants' MSJ, which is that, according to Defendants, under Texas law an insured cannot prevail on extra-contractual claims against its insurer without first demonstrating a valid, underlying breach of contract claim.

7. Here, Defendants have never disputed that Plaintiffs' hail claim was covered under their State Farm policy and, in fact, during the adjustment and settlement of the claim, State Farm admitted that Plaintiffs' home sustained covered storm damages.[14] As the Texas Supreme Court clarified, whether Plaintiffs' extra-contractual claims survive does not depend on Plaintiffs' ability to prevail on their breach of contract cause of action, or whether Plaintiffs secured a jury finding that State Farm breached the insurance contract but, rather, whether **Plaintiffs' claim for storm damages was covered under their State Farm policy.** Furthermore, the only thing that the jury verdict in Plaintiffs' breach of contract cause demonstrates is that the jury found that Plaintiffs did not show, by a preponderance of evidence, that State Farm breached the policy.[15] Like in

[13] *Id.* at *10-*11 (emphasis added, in part).
[14] *See* Defendants' Exhibits C, D, E, F, and G attached to their MSJ.
[15] *See* Jury Verdict executed in this case at p. 2, Exhibit B attached to Defendants' MSJ.

Menchaca, the jury was not asked whether Plaintiffs' claim for additional policy benefits asserted in this suit is covered or whether State Farm owes Plaintiffs policy benefits. And, again, just like in *Menchaca*, additional policy benefits owed to Plaintiffs can be the measure of Plaintiffs' recoverable actual damages for their extra-contractual claims—even in the absence of a finding that State Farm is liable for a breach of the insurance contract.

8. Simply stated, there has not been any finding here– by the jury or court – that State Farm does not owe Plaintiffs any additional policy benefits for which Plaintiffs have not already been paid. Accordingly, Defendants have not shown—and cannot show—that they are entitled to summary judgment on Plaintiffs' extra-contractual claims as a matter of law, and Defendants' MSJ must be denied.

PRAYER

WHEREFORE, PREMISES CONSIDERED, Plaintiff respectfully pray this Honorable Court to deny *Defendants' Motion for Summary Judgment on Plaintiffs' Extra-Contractual Claims*. Plaintiffs also pray for such other and further relief to which they may be justly entitled, at law or in equity.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing instrument has been served on all counsel of record on this 26th day of April, 2017, in accordance with the Texas Rules of Civil Procedure.

/s/ J. Ryan Fowler
J. Ryan Fowler

EXHIBIT
A

1 of 8 DOCUMENTS

USAA TEXAS LLOYDS COMPANY, PETITIONER, v. GAIL MENCHACA, RESPONDENT

No. 14-0721

SUPREME COURT OF TEXAS

2017 Tex. LEXIS 361

October 11, 2016, Argued
April 7, 2017, Opinion Delivered

NOTICE:

PUBLICATION STATUS PENDING. CONSULT STATE RULES REGARDING PRECEDENTIAL VALUE.

PRIOR HISTORY: [*1] ON PETITION FOR REVIEW FROM THE COURT OF APPEALS FOR THE THIRTEENTH DISTRICT OF TEXAS.

CASE SUMMARY:

OVERVIEW: HOLDINGS: [1]-In a dispute over a claim under a homeowner's insurance policy, the Supreme Court of Texas held that an insured cannot recover policy benefits as actual damages caused by an insurer's statutory violation under Tex. Ins. Code Ann. § 541.151 absent a finding that the insured had a contractual right to the benefits under the policy; [2]-An insured who establishes a right to receive benefits under the policy can recover those benefits as actual damages, if the insurer's statutory violation causes the loss of the benefits; [3]-The insured can recover benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the insured to lose the contractual right to benefits; [5]-The insured may recover damages for an independent injury even if the policy does not entitle the insured to receive benefits.

OUTCOME: Reversed and remanded.

LexisNexis(R) Headnotes

Insurance Law > Claims & Contracts > Policy Interpretation
Contracts Law > Contract Interpretation
Insurance Law > Claims & Contracts > Good Faith & Fair Dealing
Governments > Courts > Common Law
[HN1] An insurance policy is a contract that sets forth the respective rights and obligations to which an insurer and its insured have mutually agreed. An insurance policy defines the parties' rights and obligations. Generally, the court construes a policy using the same rules that govern the construction of any other contract. An insurance policy, however, is a unique type of contract because an insurer generally has exclusive control over the evaluation, processing, and denial of claims, and it can easily use that control to take advantage of its insured. Because of this inherent unequal bargaining power, the "special relationship" between an insurer and insured justifies the imposition of a common-law duty on insurers to deal fairly and in good faith with their insureds.

Insurance Law > Bad Faith & Extracontractual

Liability
Governments > Courts > Common Law
Insurance Law > Bad Faith & Extracontractual Liability > Settlement Obligations > Good Faith & Fair Dealing
Civil Procedure > Remedies > Damages
Insurance Law > Industry Regulation > Unfair Business Practices > Private Causes of Action
[HN2] The Texas Insurance Code supplements the parties' contractual rights and obligations by imposing procedural requirements that govern the manner in which insurers review and resolve an insured's claim for policy benefits. Tex. Ins. Code Ann. § 541.060(a) prohibits insurers from engaging in a variety of unfair settlement practices. The Texas Insurance Code grants insureds a private action against insurers that engage in certain discriminatory, unfair, deceptive, or bad-faith practices, and it permits insureds to recover actual damages caused by those practices, court costs, and attorney's fees, plus treble damages if the insurer "knowingly" commits the prohibited act. Tex. Ins. Code Ann. §§ 541.151, 541.152. "Actual damages" under the Insurance Code are those damages recoverable at common law, which include "benefit-of-the-bargain" damages representing the difference between the value as represented and the value received. But the Texas Insurance Code does not create insurance coverage or a right to payment of benefits that does not otherwise exist under the policy.

Governments > Courts > Common Law
Insurance Law > Bad Faith & Extracontractual Liability > Elements of Bad Faith
[HN3] A claim for bad-faith conduct that breaches the common-law duty can potentially result in three types of damages: (1) benefit of the bargain damages for an accompanying breach of contract claim, (2) compensatory damages for the tort of bad faith, and (3) punitive damages for intentional, malicious, fraudulent, or grossly negligent conduct.

Insurance Law > Bad Faith & Extracontractual Liability
Contracts Law > Breach > Causes of Action
Governments > Courts > Common Law
Governments > Legislation > Statutory Remedies & Rights
Torts > Business Torts > Bad Faith Breach of Contract
[HN4] An insured's claim for breach of an insurance contract is distinct and independent from claims that the insurer violated its extra-contractual common-law and statutory duties. Insurance coverage claims and bad faith claims are by their nature independent. A bad-faith claim is distinct from a suit for breach of the policy. A policy claim is independent of a bad faith claim. A claim for breach of the policy is a contract cause of action, while a common-law or statutory bad-faith claim is a cause of action that sounds in tort. A breach of the duty of good faith and fair dealing will give rise to a cause of action in tort that is separate from any cause of action for breach of the underlying insurance contract. But the claims are often largely interwoven, and the same evidence is often admissible on both claims.

Insurance Law > Bad Faith & Extracontractual Liability
Governments > Legislation > Statutory Remedies & Rights
Civil Procedure > Remedies > Damages
Insurance Law > Industry Regulation > Unfair Business Practices > Private Causes of Action
[HN5] Five distinct but interrelated rules that govern the relationship between contractual and extra-contractual claims in the insurance context. First, as a general rule, an insured cannot recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits. Second, an insured who establishes a right to receive benefits under the insurance policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits. Third, even if the insured cannot establish a present contractual right to policy benefits, the insured can recover benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right. Fourth, if an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits. And fifth, an insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

Governments > Legislation > Statutory Remedies & Rights
Insurance Law > Bad Faith & Extracontractual Liability > Payment Delays & Denials
Civil Procedure > Remedies > Damages

[HN6] The general rule is that an insured cannot recover policy benefits for an insurer's statutory violation if the insured does not have a right to those benefits under the policy. This rule derives from the fact that the Texas Insurance Code only allows an insured to recover actual damages "caused by" the insurer's statutory violation. Tex. Ins. Code Ann. § 541.151. There can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered.

Torts > Negligence > Causation > Proximate Cause
Insurance Law > Bad Faith & Extracontractual Liability
Governments > Legislation > Statutory Remedies & Rights
[HN7] The manner in which an insurance claim is investigated must be the proximate cause of damages before there can be a recovery under Tex. Ins. Code Ann. § 541.151.

Governments > Legislation > Statutory Remedies & Rights
Civil Procedure > Remedies > Damages
Insurance Law > Bad Faith & Extracontractual Liability
Insurance Law > Industry Regulation > Unfair Business Practices > Private Causes of Action
[HN8] While an insured cannot recover policy benefits for a statutory violation unless the jury finds that the insured had a right to the benefits under the policy, the insured does not also have to establish that the insurer breached the policy by refusing to pay those benefits. If the jury finds that the policy entitles the insured to receive the benefits and that the insurer's statutory violation caused the insured to not receive those benefits, the insured can recover the benefits as actual damages caused by the statutory violation. Tex. Ins. Code Ann. § 541.151.

Insurance Law > Bad Faith & Extracontractual Liability
Governments > Legislation > Statutory Remedies & Rights
Civil Procedure > Remedies > Damages
[HN9] An insurer's obligation to pay policy benefits and the insured's right to receive them derive solely from the insurance policy's terms: If the loss is covered, then the insurer is obligated to pay the claim according to the terms of the insurance contract. Because an insurer's statutory violation permits an insured to receive only those "actual damages" that are caused by the violation, the general rule is that an insured cannot recover policy benefits as actual damages for an insurer's statutory violation if the insured has no right to those benefits under the policy.

Insurance Law > Bad Faith & Extracontractual Liability
Governments > Legislation > Statutory Remedies & Rights
Civil Procedure > Remedies > Damages
[HN10] An insured who establishes a right to receive benefits under an insurance policy can recover those benefits as "actual damages" under Tex. Ins. Code Ann. § 541.151 if the insurer's statutory violation causes the loss of the benefits.

Insurance Law > Bad Faith & Extracontractual Liability
Governments > Legislation > Statutory Remedies & Rights
Contracts Law > Breach > Causes of Action
[HN11] Because the Texas Insurance Code provides that the statutory remedies are cumulative of other remedies, the insureds may elect to recover the benefits even though they also could have asserted a breach-of-contract claim.

Insurance Law > Bad Faith & Extracontractual Liability
[HN12] An insurer's failure to properly investigate a claim is not a basis for obtaining policy benefits.

Governments > Legislation > Statutory Remedies & Rights
Insurance Law > Bad Faith & Extracontractual Liability
[HN13] An insured who establishes a right to benefits under the policy can recover those benefits as actual damages resulting from a statutory violation.

Insurance Law > Bad Faith & Extracontractual Liability
Governments > Legislation > Statutory Remedies & Rights

Civil Procedure > Remedies > Damages

[HN14] An insured can recover benefits as actual damages under the Texas Insurance Code even if the insured has no right to those benefits under the policy, if the insurer's conduct caused the insured to lose that contractual right. The Supreme Court of Texas has recognized this principle in the context of claims alleging that an insurer misrepresented a policy's coverage, waived its right to deny coverage or is estopped from doing so, or committed a violation that caused the insured to lose a contractual right to benefits that it otherwise would have had. In each of these contexts, the insured can recover the benefits even though it has no contractual right to recover them because the benefits are actual damages caused by the insurer's statutory violation.

Civil Procedure > Remedies > Damages
Insurance Law > Bad Faith & Extracontractual Liability
Governments > Legislation > Statutory Remedies & Rights
Insurance Law > Claims & Contracts > Estoppel & Waiver > Misrepresentations
Insurance Law > Industry Regulation > Unfair Business Practices > Twisting

[HN15] An insurer that violates Tex. Ins. Code Ann. § 541.151 by misrepresenting that its policy provides coverage that it does not in fact provide can be liable under § 541.151 for such benefits if the insured is adversely affected or injured by its reliance on the misrepresentation. Although the policy does not give the insured a contractual right to receive the benefits, the insurer's misrepresentation of the policy's coverage constitutes a statutory violation that causes actual damages in the amount of the benefits that the insured reasonably believed she was entitled to receive.

Governments > Legislation > Statutory Remedies & Rights
Insurance Law > Bad Faith & Extracontractual Liability
Governments > Courts > Common Law
Civil Procedure > Remedies > Damages

[HN16] If an insurer's statutory violation causes an injury independent of the insured's right to recover policy benefits, the insured may recover damages for that injury even if the policy does not entitle the insured to receive benefits. Some extra-contractual claims may not relate to the insurer's breach of contractual duties to pay covered claims, and may thus give rise to different damages. If such damages result from an independent injury "caused by" the insurer's statutory violation, the insured can recover those damages, just as insureds have always been able to recover compensatory damages for the tort of bad faith under the common law. Thus, an insured can recover actual damages caused by the insurer's bad-faith conduct if the damages are separate from and differ from benefits under the contract.

Insurance Law > Bad Faith & Extracontractual Liability
Governments > Legislation > Statutory Remedies & Rights
Civil Procedure > Remedies > Damages

[HN17] The independent-injury rule applies only if the damages caused by an insurer's statutory violation are truly independent of the insured's right to receive policy benefits. It does not apply if the insured's statutory or extra-contractual claims are predicated on the loss being covered under the insurance policy, or if the damages flow or stem from the denial of the claim for policy benefits. When an insured seeks to recover damages that are predicated on, flow from, or stem from policy benefits, the general rule applies and precludes recovery unless the policy entitles the insured to those benefits.

Governments > Legislation > Statutory Remedies & Rights
Insurance Law > Bad Faith & Extracontractual Liability
Insurance Law > Industry Regulation > Unfair Business Practices > Private Causes of Action

[HN18] An insurer's statutory violation does not permit the insured to recover any damages beyond policy benefits unless the violation causes an injury that is independent from the loss of the benefits.

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JUDGES: JUSTICE BOYD delivered the opinion of the Court. JUSTICE JOHNSON did not participate in the decision.

OPINION BY: Jeffrey S. Boyd

OPINION

When this Court decides a case by announcing a rule of law, the decision serves as "binding precedent . . . when the very point is again presented in a subsequent suit between different parties." *Swilley v. McCain*, 374 S.W.2d 871, 875 (Tex. 1964). Yet as [*2] one of history's most renowned jurists once observed, "seldom will it happen that any one rule will exactly suit with many cases." 3 WILLIAM BLACKSTONE, COMMENTARIES *335 (1765). We have similarly acknowledged that "it is at best difficult to avoid some uncertainties in the law because of the varying facts attending the different cases." *Trapp v. Shell Oil Co.*, 145 Tex. 323, 198 S.W.2d 424, 427 (Tex. 1946). When our decisions create such uncertainties, "it is our duty to settle the conflicts in order that the confusion will as nearly as possible be set at rest." *Id.*

Today we endeavor to fulfill that duty in this case involving an insured's claims against her insurance company. The primary issue is whether the insured can recover policy benefits based on jury findings that the insurer violated the Texas Insurance Code and that the violation resulted in the insured's loss of benefits the insurer "should have paid" under the policy, even though the jury also failed to find that the insurer failed to comply with its obligations under the policy. Unfortunately, our precedent in this area has led to substantial confusion among other courts, and that confusion has permeated this case. In resolving this appeal, we seek to clarify our precedent by announcing [*3] five rules that address the relationship between contract claims under an insurance policy and tort claims under the Insurance Code. Ultimately, because the trial court and the parties lacked the clarity we provide today, and because their shared confusion prevented a proper resolution of these claims, we reverse the court of appeals' judgment and remand the case to the trial court for a new trial in the interest of justice.

I.

BACKGROUND

After Hurricane Ike struck Galveston Island in September 2008, Gail Menchaca contacted her homeowner's insurance company, USAA Texas Lloyds, and reported that the storm had damaged her home. USAA sent an adjuster to investigate Menchaca's claim, and the adjuster found only minimal damage. Based on the adjuster's findings, USAA determined that its policy covered some of the damage but declined to pay Menchaca any benefits because the total estimated repair costs did not exceed the policy's deductible.[1] About five months later, at Menchaca's request, USAA sent another adjuster to re-inspect the property. This adjuster generally confirmed the first adjuster's findings, and USAA again refused to pay any policy benefits. Menchaca sued USAA for breach of the [*4] insurance policy and for unfair settlement practices in violation of the Texas Insurance Code.[2] As damages for both claims, she sought only insurance benefits under the policy, plus court costs and attorney's fees.[3]

1 The policy's declaration page provides that the policy covers "only that part of the loss over the deductible stated," and then lists the deductible amounts for "wind and hail" and for "all other perils."

2 Menchaca initially alleged a fraud claim, but it was not submitted to the jury. She also sued the first adjuster who inspected her property but later nonsuited those claims. Although the policy provided for an appraisal process to resolve disputes over the amount of covered losses, it appears that neither party ever invoked that alternative method for resolving this dispute. *See* S.W.3d at n.9.

3 As damages for USAA's alleged breach of the insurance contract, Menchaca sought the "benefit of her bargain" under the policy, "which is the amount of her claim [for policy benefits], together with attorney fees." As damages for USAA's alleged statutory violations, she sought "actual damages, which include the loss of the benefits that should have been paid pursuant to the policy, mental anguish, court costs[,] and attorney's fees."

She later disclaimed any mental anguish or consequential damages.

The parties tried the case to a jury. Question 1 of the jury charge, which addressed Menchaca's breach-of-contract claim, asked whether USAA failed "to comply with the terms of the insurance policy with respect to the claim for damages filed by Gail Menchaca resulting from Hurricane Ike." The jury answered "No." Question 2, which addressed Menchaca's statutory claims, asked whether USAA engaged in various unfair or deceptive practices, including whether USAA refused "to pay a claim without conducting a reasonable investigation with respect to" that claim. As to that specific practice, the jury answered "Yes."[4] Question 3 asked the jury to determine Menchaca's damages that resulted from either USAA's failure to comply with the policy or its statutory violations, calculated as "the difference, if any, between the amount USAA should have paid Gail Menchaca for her Hurricane Ike damages and the amount that was actually paid."[5] The jury answered "$11,350."[6]

4 Question 2 also separately asked whether USAA engaged in an unfair or deceptive act or practice by: "Failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim when the liability under the insurance policy issued to Gail Menchaca had become reasonably clear;" "Failing to promptly provide to Gail Menchaca a reasonable explanation of the factual and legal basis in the policy for the denial of a claim(s);" "Failing to affirm or deny coverage within a reasonable time;" or "Misrepresenting to Gail Menchaca a material fact or policy provision relating to the coverage at issue." As to each of these specific practices, the jury answered "No."

5 Specifically, Question 3 asked: "What sum of money . . . would fairly and reasonably compensate Gail Menchaca for her damages, if any, that resulted from the failure to comply you found in response to Question number 1 and/or that were caused by an unfair or deceptive act that you found in response to Question number 2[?]" The question thus required the jury to determine damages resulting from either a contract breach or a statutory violation or both. The charge instructed the jury to answer Question 3 only if it "answered 'Yes' to Question No. 1 *or* any part of Question No. 2 *or* both questions." The charge then instructed the jury that the "sum of money to be awarded is the difference, if any, between the amount USAA should have paid Gail Menchaca for her Hurricane Ike damages and the amount that was actually paid."

6 The jury also found that Menchaca's reasonable and necessary attorney's fees "for representation in the trial court" totaled $130,000, and did not find that Menchaca failed to mitigate her damages or that USAA "knowingly" violated the Insurance Code.

Both parties moved [*5] for judgment in their favor based on the jury's verdict. USAA argued that because the jury failed to find in its answer to Question 1 that USAA failed to comply with the policy's terms, Menchaca could not recover for "bad faith or extra-contractual liability as a matter of law." Menchaca argued that the court should enter judgment in her favor based on the jury's answers to Questions 2 and 3, neither of which was conditioned on a "Yes" answer to Question 1. The trial court disregarded Question 1 and entered final judgment in Menchaca's favor based on the jury's answers to Questions 2 and 3. The court of appeals affirmed, S.W.3d ,[7] and we granted USAA's petition for review.

7 The court of appeals modified the judgment to delete an award of penalty interest and affirmed as modified. S.W.3d . Menchaca does not complain here about that aspect of the court's judgment.

II.

RECOVERING POLICY BENEFITS FOR STATUTORY VIOLATIONS

The parties agree that the damages the jury found in response to Question 3 represent the amount of insurance policy benefits the jury concluded USAA "should have paid" to Menchaca. USAA contends that Menchaca cannot recover any amount of policy benefits because the jury failed to find that USAA breached its obligations under the policy. Although the jury did find that USAA violated the Insurance Code, USAA contends that Menchaca cannot recover policy benefits based on [*6] that finding alone.[8] USAA primarily relies on *Provident American Insurance Co. v. Castañeda*, in which we stated that an insurance company's "failure to properly investigate a claim is not a basis for obtaining policy

benefits." 988 S.W.2d 189, 198 (Tex. 1998). Menchaca argues that the jury's findings that USAA violated the Code and that USAA "should have paid" Menchaca $11,350 sufficiently support the award of policy benefits. Menchaca primarily relies on *Vail v. Texas Farm Bureau Mutual Insurance Co.*, in which we stated that an insurer's "unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld." 754 S.W.2d 129, 136 (Tex. 1988).

8 Menchaca argues that USAA waived this argument because it (1) did not object that Question 2 was not predicated on a "yes" answer to Question 1; (2) did not request an instruction that the jury should answer "no" to Question 2 if they answered "no" to Question 1; (3) did not object to Question 2 on the ground that it imposed liability without a finding that Menchaca was entitled to benefits under the policy; and, (4) did not object to Question 3 on the ground that it permitted a recovery of policy benefits without a finding that Menchaca was entitled to benefits under the policy. USAA did object to Question 3, however, on the ground that the question impermissibly combined "contractual damages from Question 1 and statutory damages from Question 2, [because] Texas courts have held that extra[-]contractual damages need to be independent from policy damages." USAA complained that submitting just one damages question for all damages arising either under the policy or under the statute or both would make it "unclear potentially if we get 'yes' answers to [Questions] 1 and 2 what the damages are based on." We conclude that USAA's objections were sufficient to make clear its position that contractual damages are independent from statutory damages and must be based on a finding that USAA breached the policy. *See State Dep't of Highways & Public Transp. v. Payne*, 838 S.W.2d 235, 241 (Tex. 1992) (holding that an objection should make "the trial court aware of the complaint, timely and plainly"). We also conclude that USAA's argument raises a purely legal issue that does not affect the jury's role as fact-finder, and that USAA thus preserved the argument by asserting it as a ground for its motion for judgment based on the jury's verdict. *Hoffmann--La Roche Inc. v. Zeltwanger*, 144 S.W.3d 438, 450 (Tex. 2004) (holding that when "the issue presented a pure legal question which did not affect the jury's role as fact finder, the post-verdict motion [can be] sufficient to preserve error"); *see also Felton v. Lovett*, 388 S.W.3d 656, 660 n.9 (Tex. 2012) (citing *Waffle House, Inc. v. Williams*, 313 S.W.3d 796, 802 (Tex. 2010); *Hoffmann--La Roche*, 144 S.W.3d at 450; *Holland v. Wal--Mart Stores, Inc.*, 1 S.W.3d 91, 94 (Tex. 1999)) (holding that "a purely legal issue which does not affect the jury's role as fact-finder" may preserve error when "raised for the first time post-verdict"). Because USAA raises a purely legal argument that the jury's failure to find a contractual breach precludes Menchaca from recovering policy benefits as a matter of law, USAA preserved error by raising the argument in its motion for judgment.

Courts and commentators have expressed confusion over our decisions in this area, and over our statements in *Castañeda* and *Vail* in particular.[9] The United States Court of Appeals for the Fifth Circuit, for example, recently concluded that *Castañeda* and other "decisions from the Supreme Court of Texas and Texas's intermediate appellate courts arguably cast doubt on *Vail*'s continued vitality." *In re Deepwater Horizon*, 807 F.3d 689, 698 (5th Cir. 2015). In the *Deepwater Horizon* panel's view, the Fifth Circuit interpreted *Castañeda* "as setting [*7] out the opposite rule from that in *Vail*." *Id.* (citing *Great Am. Ins. Co. v. AFS/IBEX Fin. Servs.*, 612 F.3d 800, 808 & n.1 (5th Cir. 2010)).[10] Today's case presents an opportunity to provide clarity regarding the relationship between claims for an insurance policy breach and Insurance Code violations. In light of the confusing nature of our precedent in this area, we begin by returning to the underlying governing principles. *See, e.g., U.S. v. New Mexico*, 455 U.S. 720, 733, 102 S. Ct. 1373, 71 L. Ed. 2d 580 (1982) (concluding that "the confusing nature of our precedents counsels a return to the underlying constitutional principle").

9 *See, e.g.*, Richard G. Wilson, *Policy Benefits--Are They Recoverable Under Extra-Contractual Theories When a Covered Claim is Denied?*, 12 J. TEX. INS. L. 17, 23 (2014) ("In some circumstances, it appears that courts have simply failed to follow the Texas Supreme Court precedent that is *Vail*."); Robert M. Hoffman & Jaclyn M. O'Sullivan, *What the*

Insurance Code Giveth, the Courts Cannot Taketh Away: Judicial Confusion Over Whether Insurance Proceeds Can be Trebled, 11 J. TEX. INS. L. 23, 24 (2011) ("Unfortunately, it is easy to confuse the independent injury issue due to a line of cases that misapplied the 1998 Texas Supreme Court decision in . . . *Castañeda*.").

10 In *Deepwater Horizon*, the Fifth Circuit certified to us the question of whether, "to maintain a cause of action under Chapter 541 of the Texas Insurance Code against an insurer that wrongfully withheld policy benefits, an insured must allege and prove an injury independent from the denied policy benefits?" 807 F.3d at 701. We accepted the certified question but later dismissed the cause as moot because the parties settled. *See id., certified question accepted* (Dec. 4, 2015) *and dism'd as moot* (Apr. 8, 2016).

The first of these principles is that an[HN1] "insurance policy is a contract" that sets forth the respective rights and obligations to which an insurer and its insured have mutually agreed. *RSUI Indem. Co. v. The Lynd Co.*, 466 S.W.3d 113, 118 (Tex. 2015); *see also Tex. Ass'n of Ctys. Cty. Gov't Risk Mgmt. Pool v. Matagorda Cty.*, 52 S.W.3d 128, 131 (Tex. 2000) (noting that an "insurance policy . . . defines the parties' rights and obligations"). Generally, we construe a policy using the same rules that govern the construction of any other [*8] contract. *See Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773, 778 (Tex. 2008) (citing *Forbau v. Aetna Life Ins. Co.*, 876 S.W.2d 132, 133 (Tex. 1994)). An insurance policy, however, is a unique type of contract because an insurer generally "has exclusive control over the evaluation, processing[,] and denial of claims," and it can easily use that control to take advantage of its insured. *Arnold v. Nat'l Cty. Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987). Because of this inherent "unequal bargaining power," we concluded in *Arnold* that the "special relationship" between an insurer and insured justifies the imposition of a common-law duty on insurers to "deal fairly and in good faith with their insureds." *Id.*

Similar to that common-law duty, [HN2] the Insurance Code supplements the parties' contractual rights and obligations by imposing procedural requirements that govern the manner in which insurers review and resolve an insured's claim for policy benefits. *See, e.g.*, TEX. INS. CODE § 541.060(a) (prohibiting insurers from engaging in a variety of "unfair settlement practices"). The Code grants insureds a private action against insurers that engage in certain discriminatory, unfair, deceptive, or bad-faith practices, and it permits insureds to recover "actual damages . . . caused by" those practices, court costs, and attorney's fees, plus treble damages if the insurer "knowingly" commits the prohibited act. [*9] *Id.* §§ 541.151, .152; *Tex. Mut. Ins. Co. v. Ruttiger*, 381 S.W.3d 430, 441 (Tex. 2012).[11] "Actual damages" under the Insurance Code "are those damages recoverable at common law," *State Farm Life Ins. Co. v. Beaston*, 907 S.W.2d 430, 435 (Tex. 1995) (citing *Brown v. Am. Transfer & Storage Co.*, 601 S.W.2d 931, 939 (Tex. 1980)), which include "benefit-of-the-bargain" damages representing "the difference between the value as represented and the value received," *Arthur Andersen & Co. v. Perry Equip. Corp.*, 945 S.W.2d 812, 817 (Tex. 1997) (citing *Leyendecker & Assocs., Inc. v. Wechter*, 683 S.W.2d 369, 373 (Tex. 1984)). But the Code does not create insurance coverage or a right to payment of benefits that does not otherwise exist under the policy. *See Lyons v. Millers Cas. Ins. Co. of Tex.*, 866 S.W.2d 597, 600 (Tex. 1993) (discussing the necessity of distinguishing bad-faith issues from "the contract issue of coverage").

11 Similarly,[HN3] a claim for bad-faith conduct that breaches the common-law duty "can potentially result in three types of damages: (1) benefit of the bargain damages for an accompanying breach of contract claim, (2) compensatory damages for the tort of bad faith, and (3) punitive damages for intentional, malicious, fraudulent, or grossly negligent conduct." *Transp. Ins. Co. v. Moriel*, 879 S.W.2d 10, 17 (Tex. 1994), *abrogated on other grounds by U-Haul Int'l, Inc. v. Waldrip*, 380 S.W.3d 118, 140 (Tex. 2012).

[HN4] An insured's claim for breach of an insurance contract is "distinct" and "independent" from claims that the insurer violated its extra-contractual common-law and statutory duties. *See Liberty Nat'l Fire Ins. Co. v. Akin*, 927 S.W.2d 627, 629 (Tex. 1996) ("Insurance coverage claims and bad faith claims are by their nature independent."); *Twin City Fire Ins. Co. v. Davis*, 904 S.W.2d 663, 666 (Tex. 1995) (noting that a bad-faith claim is "distinct" from a suit for breach of the policy); *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995) ("[A] policy claim is independent of a bad faith claim."). A claim for breach of the policy is a "contract

cause of action," while a common-law or statutory bad-faith claim "is a cause of action that sounds in tort." *Twin City*, 904 S.W.2d at 666; *see also Viles v. Sec. Nat'l Ins. Co.*, 788 S.W.2d 566, 567 (Tex. 1990) ("[A] breach of the duty of good faith and fair dealing will give rise to a cause of action in [*10] tort that is separate from any cause of action for breach of the underlying insurance contract."). But the claims are often "largely interwoven," and the same evidence is often "admissible on both claims." *Akin*, 927 S.W.2d at 630.

The primary question in this case is whether an insured can recover policy benefits as actual damages caused by an insurer's statutory violation absent a finding that the insured had a contractual right to the benefits under the insurance policy. Generally, the answer to this question is "no," but the issue is complicated and involves several related questions. In an effort to clarify these issues, we distill from our decisions [HN5] five distinct but interrelated rules that govern the relationship between contractual and extra-contractual claims in the insurance context. First, as a general rule, an insured cannot recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits. Second, an insured who establishes a right to receive benefits under the insurance policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits. [*11] Third, even if the insured cannot establish a present contractual right to policy benefits, the insured can recover benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right. Fourth, if an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits. And fifth, an insured cannot recover *any* damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

A. The General Rule

[HN6] The general rule is that an insured cannot recover policy benefits for an insurer's statutory violation if the insured does not have a right to those benefits under the policy. This rule derives from the fact that the Insurance Code only allows an insured to recover actual damages "caused by" the insurer's statutory violation. *See* TEX. INS. CODE § 541.151; *Minn. Life Ins. Co. v. Vasquez*, 192 S.W.3d 774, 780 (Tex. 2006). We first announced this rule in *Stoker*, 903 S.W.2d at 341. The insurer in *Stoker* relied on an invalid reason to deny the insureds' claim for benefits but later asserted a valid basis [*12] for denying the claim. *See id.* at 339. The insureds sued the insurer for breach of contract and for bad-faith denial of the claim, seeking only policy benefits as damages. *Id.* at 339-40. The trial court granted summary judgment for the insurer on the breach-of-contract claim because the policy did not cover the claim. *Id.*at 339. The jury, however, found the insurer liable on the extra-contractual claims, and based on that finding, the trial court awarded policy benefits as "extra-contractual damages." *Id.* at 339-40. The court of appeals affirmed, but we reversed and rendered judgment for the insurer. We explained that as "a general rule there can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered." *Id.* at 341.[12]

12 We cited the following non-Texas authorities in support of this general rule:

> *O'Malley v. United States Fidelity & Guar. Co.*, 776 F.2d 494, 500 (5th Cir. 1985) (noting that no Mississippi case has ever allowed bad faith recovery for the insured without first establishing liability under the policy); *Gilbert v. Cong. Life Ins. Co.*, 646 So. 2d 592, 593 (Ala. 1994) (plaintiff bears the burden of proving a breach of contract by the defendant); *Reuter v. State Farm Mut. Auto. Ins. Co., Inc.*, 469 N.W.2d 250, 253 (Iowa 1991) ("[A] bad faith failure to pay the insured when the insured event occurs . . . may subject the insurer to tort liability"); *Wittmer v. Jones*, 864 S.W.2d 885, 890 (Ky. 1993) (noting that in order to establish a tort action for bad faith the insured must first prove that the insurer was obligated to pay under the policy); [*13] *Pemberton v. Farmers Ins. Exchange*, 109 Nev. 789, 858 P.2d 380, 382 (1993)

> ("An insurer fails to act in good faith when it refuses 'without proper cause' to compensate the insured for a loss covered by the policy."); *Bartlett v. John Hancock Mut. Life Ins. Co.*, 538 A.2d 997, 1000 (R.I. 1988) ("[T]here can be no cause of action for an insurer's bad faith refusal to pay a claim until the insured first establishes that the insurer breached its duty under the contract of insurance."); *see also* OSTRAGER & NEWMAN, INSURANCE COVERAGE DISPUTES § 12.01 at 503 (7th ed. 1994) ("The determination of whether an insurer acted in bad faith generally requires as a predicate a determination that coverage exists for the loss in question."); 15A RHODES, COUCH ON INSURANCE LAW 2D § 58:1 at 249 (Rev. ed. 1983) ("As a general rule, there may be no extra-contractual recovery where the insured is not entitled to benefits under the contract of insurance which establishes the duties sought to be sued upon.").

Stoker, 903 S.W.2d at 341.

Some courts have read *Stoker* to hold that no claim for *any kind of* bad-faith conduct can exist if the policy does not cover the claim. But *Stoker* involved only a claim for bad-faith denial of the insureds' claim for benefits. We clarified this point the following year in *Akin*: "While *Stoker* held that a judgment for the insurer on the coverage claim prohibits recovery premised [*14] only on bad faith *denial of a claim*, it does not necessarily bar *all claims for bad faith*." 927 S.W.2d at 631 (citing *Stoker*, 903 S.W.2d at 342) (emphases added). Thus, a more accurate statement of the rule we announced in *Stoker* is that "there can be no claim for bad faith [denial of an insured's claim for policy benefits] when an insurer has promptly denied a claim that is in fact not covered." *Stoker*, 903 S.W.2d at 341.

Although *Stoker* involved only a bad-faith-denial claim, we have since applied its general rule to other types of extra-contractual violations. In doing so, we have confirmed that the rule is based on the principle that an insured who sues an insurer for statutory violations can only recover damages "caused by" those violations. In *Progressive County Mutual Insurance Co. v. Boyd*, for example, the insured alleged that the insurer breached the policy and violated the Code and its common-law duty by failing to promptly pay his claim, failing to fairly investigate the claim, and denying the claim in bad faith. 177 S.W.3d 919, 920, 922 (Tex. 2005) (per curiam). Because these extra-contractual claims were "predicated on [the] insurance policy and the accident being covered under the insurance policy," we held that the trial court's take-nothing judgment on the contract claim [*15] "negate[d]" the extra-contractual claims. *Id.* at 920-21. Specifically addressing the statutory prompt-payment claim, we explained that there "can be no liability [under the Code] if the insurance claim is not covered by the policy." *Id.* at 922. Similarly, in *Chrysler Insurance Co. v. Greenspoint Dodge of Houston, Inc.*, we quoted *Stoker*'s general rule and held that, because the insurer "did not breach the insurance contract, no basis supports" the insured's recovery of "punitive and extra-contractual damages." 297 S.W.3d 248, 253-54 (Tex. 2009) (per curiam). And in *State Farm Lloyds v. Page*, we said, "When the issue of coverage is resolved in the insurer's favor, extra-contractual claims do not survive," and there is "no liability under [the Insurance Code] if there is no coverage under the policy." 315 S.W.3d 525, 532 (Tex. 2010) (citing *Boyd*, 177 S.W.3d at 921). Most recently, in *JAW the Pointe, L.L.C. v. Lexington Insurance Co.*, we relied on *Stoker* for the proposition that when an insurance policy does not cover the insured's claim for benefits, "the insured cannot recover for the insurer's bad faith failure to effectuate a prompt and fair settlement of the claim." 460 S.W.3d 597, 599, 602 (Tex. 2015).

In the present case, the jury found that USAA violated the Code by denying the claim without conducting a reasonable investigation. [*16] *See* TEX. INS. CODE § 541.060(a)(7) (providing that an insurer that "refus[es] to pay a claim without conducting a reasonable investigation with respect to the claim" commits an unfair settlement practice). In our early decisions, we mentioned this type of statutory violation but did not specifically address whether the general rule applies to such a claim. In *Stoker*, we expressly stated that the general rule should not "be understood as retreating from the established principles regarding the duty of an insurer to timely investigate its insureds' claims." 903 S.W.2d at 341. But

we did not cite any authority for those "established principles." Instead, we merely noted, "These circumstances are not present in this case." *Id.*[13] That same year, we noted in *Twin City* that "some acts of bad faith, such as a *failure to properly investigate a claim* or an unjustifiable delay in processing a claim, do not *necessarily* relate to the insurer's breach of its contractual duties to pay covered claims, and may give rise to different damages." 904 S.W.2d at 666 n.3 (emphases added). The following year, we noted in *Akin* that the insured alleged that the insurer violated its statutory duties by failing to "properly investigate" the claim, 927 S.W.2d at 629, and we explained that the general rule [*17] "does not necessarily bar all claims for bad faith," *id.* at 631 (citing *Stoker*, 903 S.W.2d at 342), but we did not specifically address whether the general rule applies to an improper-investigation claim.

> 13 At least one court of appeals has held that in *Stoker* we recognized an inadequate-investigation violation as an "exception" to the general rule. *See Toonen v. United Servs. Auto Ass'n*, 935 S.W.2d 937, 941-42 (Tex. App.--San Antonio 1996, no writ) (citing *Stoker*, 903 S.W.2d at 341). That holding misconstrues *Stoker*, as our subsequent decisions demonstrate.

We did address something akin to an improper-investigation claim, however, in *Castañeda*. The insured in that case sued her insurer alleging statutory violations "arising out of the denial of her claim for benefits under a health insurance policy and the manner in which her claim was handled." 988 S.W.2d at 191. But she did not assert a claim for breach of contract or seek a finding that the policy covered her claim. *Id.* at 196, 201. Instead, she argued that she was entitled to recover damages "*equivalent* to policy benefits" based on the jury's finding that the insurer violated the statute by failing to acknowledge communications about the claim and by failing "to adopt reasonable standards for investigating claims." *Id.* at 198 (emphasis added). We found no evidence that the insurer violated the statute in either manner. *Id.* at 192. We also explained that, even if there had been evidence of a violation, a "failure to properly investigate a claim is not a basis for obtaining policy benefits." *Id.* at 198 (citing *Stoker*, 903 S.W.2d at 341). We ultimately rendered judgment for the insurer because [*18] "no support in the evidence for any of the extra-contractual claims" existed and because the insured "did not plead and did not obtain a determination [that the insurer] was liable for breach of the insurance contract." *Id.* at 201. We held similarly in *Boyd*, 177 S.W.3d at 922. Because the claim there was predicated on the accident being covered under the insurance policy, when the trial court granted a take-nothing judgment on the insured's breach-of-contract claim, the insured's failure-to-fairly-investigate claim failed as well. *Id.* at 920-21; *see also In re Allstate Cnty. Mut. Ins. Co.*, 447 S.W.3d 497, 501 (Tex. App.--Houston [1st Dist.] 2014, orig. proceeding) (citing *Boyd* for the proposition that an "insurer generally cannot be liable for failing to settle or investigate a claim that it has no contractual duty to pay").

Here, Menchaca contends that she can recover policy benefits as damages resulting from USAA's statutory violation because that claim is independent from her claim for policy breach. The court of appeals agreed, reasoning that the statute "imposes a duty on an insurer, above and beyond the duties established by the insurance policy itself, to conduct a reasonable investigation prior to denying a claim," and thus "USAA could have fully complied with the contract even if it failed to reasonably investigate Menchaca's claim." [*19] S.W.3d . While we agree with the court's premise that USAA could have complied with the policy even if it failed to reasonably investigate the claim, we reject its conclusion just as we expressly rejected it in *Stoker*. Although we accepted the argument's premise that "a policy claim is independent of a bad faith claim," we found that the "asserted conclusion . . . does not necessarily follow," at least when the claim seeks benefits "not covered by the policy." *Id.* at 340-41.

The reason we reject Menchaca's independent-claims argument--indeed, the very reason for the general rule--derives from the fact that the Insurance Code only allows an insured to recover actual damages "caused by" the insurer's statutory violation. TEX. INS. CODE § 541.151. "Actual damages" are the common-law damages the insured sustains "as a result of" the statutory violation. *Kish v. Van Note*, 692 S.W.2d 463, 466 (Tex. 1985) (citing *Smith v. Baldwin*, 611 S.W.2d 611, 617 (Tex. 1980)). If the insurer violates a statutory provision, that violation--at least generally[14]--cannot cause damages in the form of policy benefits that the insured has no right to receive under the policy. We acknowledged this reasoning in *Castañeda*, noting that the "concurring Justices in *Stoker* agreed that [HN7] the manner in which a claim is investigated must be the proximate cause of

damages [*20] before there could be a recovery." 988 S.W.2d at 198 (citing *Stoker*, 903 S.W.2d at 345 (Spector, J., concurring)).[15] We held that, in the absence of a finding that the insurer had breached the policy, the insured could not recover any damages because none of the insurer's alleged statutory violations "was the producing cause of any damage separate and apart from those that would have resulted from a wrongful denial of the claim." *Id.* Because the insured only sought damages that "flow[ed]" and "stemmed from the denial of benefits," *id.* at 198, 199, she could not recover anything because she "did not plead and did not obtain a determination [that the insurer] was liable for breach of the insurance contract." *Id.* at 201.[16]

14 We say "generally" here because in some cases the insurer's statutory violation may cause the policy to not cover the claim when, but for the statutory violation, the policy would cover the claim. *See, e.g., JAW the Pointe*, 460 S.W.3d at 602. We discuss this situation further below.

15 Justice Spector authored the concurrence in *Stoker*, joining the Court's judgment because she agreed that no evidence supported the claim that the insurer's "bad faith caused damages to the Stokers." *Stoker*, 903 S.W.2d at 342 (Spector, J., concurring). Notably, Justice Spector joined Justice Gonzalez's dissent in *Castañeda* in which Justice Gonzalez argued that *Stoker* does not apply when the policy covers the claim. *See Castañeda*, 988 S.W.2d at 203, 208 (Gonzalez, J., dissenting).

16 Although we did not explain the reason for the general rule in *Stoker*, we alluded to it by acknowledging "the possibility that in denying the claim, the insurer may commit some act, so extreme, that would *cause* injury independent of the policy claim." *Stoker*, 903 S.W.2d at 341 (emphasis added). We made similar allusions to the causation requirement in *Boyd*, 177 S.W.3d at 920-21 (holding that insured could not recover benefits based on the insurer's improper investigation when the policy did not cover the claim for benefits because the improper-investigation claim was "predicated" on policy coverage), and in *Twin City*, 904 S.W.2d at 667 n.3 (noting that some bad-faith acts may "give rise" to damages other than policy benefits).

Relying on these decisions, USAA contends that the general rule applies here and Menchaca cannot recover policy benefits based on a statutory violation because the jury failed to find that USAA "breached" the insurance contract. In response, Menchaca argues that she can avoid the general rule by obtaining a finding that the policy "covers" her losses, and she did not have to obtain a finding that USAA "breached" the policy to recover under the statute. Our precedent is confusing on this point because [*21] we have actually used both phrases to describe the general rule. *See, e.g., JAW the Pointe*, 460 S.W.3d at 599 (holding that insured could not recover benefits as statutory damages because "the policy *did not cover* the insured's losses") (emphasis added); *Page*, 315 S.W.3d at 532 ("There can be no liability under [the Insurance Code] if there is *no coverage* under the policy.") (emphasis added); *Chrysler*, 297 S.W.3d at 254 (holding that insured could not recover extra-contractual damages because the insurer "*did not breach* the insurance contract") (emphasis added); *Boyd*, 177 S.W.3d at 920-21 (concluding that a take-nothing judgment on a breach-of-contract claim negated recovery of benefits as statutory damages); *Castañeda*, 988 S.W.2d at 201 (holding that insured could not recover statutory damages "equivalent to policy benefits" because she did not plead or establish that the insurer "was *liable for breach* of the insurance contract") (emphasis added); *Stoker*, 903 S.W.2d at 341 ("[T]here can be no claim for bad faith when an insurer has promptly denied a claim that is in fact *not covered*.") (emphasis added).

In one sense, no relevant distinction exists between "breach" and "coverage" in this context because no breach can occur unless coverage exists, and if there is coverage, there is necessarily a breach if the insurer fails to pay the amount covered. [*22] If the policy does not cover the insured's loss, the insurer does not breach the policy by failing to pay benefits for that loss, because the insured is not entitled to those benefits. Conversely, if the policy does cover the loss, the insurer necessarily breaches the policy if it fails to pay benefits for the loss because the insured is entitled to those benefits. In another sense, however, an important distinction does exist because USAA contends that Menchaca could not recover policy benefits unless she prevailed on her breach-of-contract claim. According to USAA, in other words, an insured can never recover policy benefits as damages for a statutory violation.

We disagree. Although our prior decisions refer interchangeably to both "breach" and "coverage," our

focus in those cases was on whether the insured was entitled to benefits under the policy, because an insurer's statutory violation cannot "cause" the insured to suffer the loss of benefits unless the insured was entitled to those benefits. Thus, although we have referred to both "breach" and "coverage," what matters for purposes of causation under the statute is whether the insured was entitled to receive benefits under the [*23] policy. [HN8] While an insured cannot recover policy benefits for a statutory violation unless the jury finds that the insured had a right to the benefits under the policy, the insured does not *also* have to establish that the insurer breached the policy by refusing to pay those benefits. As we explain further in the following section, if the jury finds that the policy entitles the insured to receive the benefits and that the insurer's statutory violation caused the insured to not receive those benefits, the insured can recover the benefits as "actual damages . . . caused by" the statutory violation. *See* TEX. INS. CODE § 541.151.

Nevertheless, [HN9] an insurer's obligation to pay policy benefits and the insured's right to receive them derive solely from the insurance policy's terms: "If the loss is covered, then the insurer is obligated to pay the claim according to the terms of the insurance contract." *Moriel*, 879 S.W.2d at 17. Because an insurer's statutory violation permits an insured to receive only those "actual damages" that are "caused by" the violation, we clarify and affirm the general rule that an insured cannot recover policy benefits as actual damages for an insurer's statutory violation if the insured has no right to those benefits [*24] under the policy.

B. The Entitled-to-Benefits Rule

The second rule from our precedent is that [HN10] an insured who establishes a right to receive benefits under an insurance policy can recover those benefits as "actual damages" under the statute if the insurer's statutory violation causes the loss of the benefits. This rule, a logical corollary to the general rule, is what we recognized in *Vail*. The insureds in *Vail* sued their insurer for common-law bad faith and statutory violations (but not for breach of contract), alleging a "bad faith failure to pay the claim" and seeking "the full amount" of policy benefits plus statutory damages. 754 S.W.2d at 130. The jury found that the insurer violated the statute by failing to "attempt[ ] in good faith to effectuate a prompt, fair, and equitable settlement" when "liability had become reasonably clear," and breached its common-law duty of good faith and fair dealing by failing "to exercise good faith in the investigation and processing of the claim." *Id.* at 134. Based on these findings, the trial court awarded benefits in the amount of the "full policy limit" plus treble that amount, attorney's fees, and prejudgment interest. *Id.* at 131.

The insurer argued that the insureds could not [*25] recover policy benefits as damages for statutory violations because "the amount due under the policy solely represents damages for breach of contract and does not constitute actual damages in relation to a claim of unfair claims settlement practices." *Id.* at 136. We rejected that argument and held that "an insurer's unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld." *Id.* We explained that the insureds "suffered a *loss* . . . for which they were entitled to make a claim under the insurance policy," and that loss was "transformed into a legal *damage*" when the insurer "wrongfully denied the claim." *Id.* "That damage," we held, "is, at minimum, the amount of policy proceeds wrongfully withheld by" the insurer. *Id.*[HN11] Because the Insurance Code provides that the statutory remedies are cumulative of other remedies, we concluded that the insureds could elect to recover the benefits under the statute even though they also could have asserted a breach-of-contract claim. *Id.*

USAA contends, and some Texas courts have concluded, that we later rejected the *Vail* rule in *Castañeda* and *Stoker*, and thus an insured can never [*26] recover policy benefits as actual damages for statutory or common-law bad-faith violations. *See, e.g.*, *Mai v. Farmers Tex. Cnty. Mut. Ins. Co.*, 2009 Tex. App. LEXIS 3220, 2009 WL 1311848, at *6 (Tex. App.--Houston [14th Dist.] May 7, 2009, pet. denied) (mem. op.) ("This position, that expected policy benefits can equate to bad faith damages, has been firmly rejected by the Texas Supreme Court."). The United States Court of Appeals for the Fifth Circuit reached the same conclusion in *Parkans International, LLC v. Zurich Insurance Co.*, holding that, in light of *Castañeda*, there "can be no recovery for extra-contractual damages for mishandling claims unless the complained of actions or omissions caused injury independent of those that would have resulted from a wrongful denial of policy benefits." 299 F.3d 514, 519 (5th Cir. 2002). The Fifth Circuit later relied on *Parkans* to reject an insured's argument that "it did not need to prove a separate injury in order to

maintain its extra-contractual claims" because the insurer's "denial of insurance proceeds, standing alone, entitled it to recover on its extra-contractual claims." *Great Am. Ins. Co. v. AFS/IBEX Fin. Servs., Inc.*, 612 F.3d 800, 808 n.1 (5th Cir. 2010).[17]

17 At least one federal district court expressly disagreed with *Great American*'s reading of *Castañeda*, but it ultimately concluded that it was compelled to follow the Fifth Circuit's precedent. *See In re Oil Spill by the Oil Rig Deepwater Horizon*, 2014 U.S. Dist. LEXIS 155043, 2014 WL 5524268, at *15 (E.D. La. Oct. 31, 2014) (disagreeing with insurer's argument that the insured could not recover policy benefits as actual damages under the statute because we "considered and rejected" that argument in *Vail*, but nevertheless concluding that it was required to follow *Great American*), *aff'd in part, question certified sub nom, Deepwater Horizon*, 807 F.3d at 689.

We did not reject the *Vail* rule in *Stoker* or in *Castañeda*. While we could have made the point more clearly, the distinction between the cases is that the [*27] parties in *Vail* did not dispute the insured's entitlement to the policy benefits, and the only issue was whether the insured could recover those benefits as statutory damages. *Vail*, 754 S.W.2d at 136. The rule we announced in *Vail* was premised on the fact that the policy undisputedly covered the loss in that case, and the insurer therefore "*wrongfully* denied" a "*valid* claim." *Id.* at 136-37 (emphases added).[18] If an insurer's "wrongful" denial of a "valid" claim for benefits results from or constitutes a statutory violation, the resulting damages will necessarily include "at least the amount of the policy benefits wrongfully withheld." *Id.* at 136. We confirmed this reading of *Vail* and reaffirmed the general rule in *Twin City*, 904 S.W.2d at 666. There, we explained that "*Vail* was only concerned with the insurer's argument that policy benefits *improperly withheld* were not 'actual damages in relation to a claim of unfair claims settlement practices.'" *Id.* (emphasis added) (quoting *Vail*, 754 S.W.2d at 136). We further explained that the Court rejected the insurer's argument in *Vail* because "policy benefits *wrongfully withheld* were indeed actual damages" under the statute. *Id.* (emphasis added).

By contrast, in *Castañeda*, the insured did not establish and the insurer did not concede that [*28] the insured had a right to benefits under the policy. To the contrary, the insured "never sought and did not receive any contractual relief," *Castañeda*, 988 S.W.2d at 196, and never even alleged that the insurer "was liable for breach of the insurance contract," *id.* at 201. Instead, she sought only to recover damages "*equivalent* to policy benefits" based solely on her statutory claims that the insurer failed to acknowledge communications about her claim and failed to "adopt reasonable standards for investigating claims." *Id.* at 198 (emphasis added). We expressly refused to provide any opinion on "whether there was contractual coverage." *Id.* at 196. We first addressed whether any evidence existed that the insurer violated the statute or its common-law duties, and in deciding that issue we concluded that, even *assuming* that there was coverage, the mere existence of coverage would not prove that the insurer violated the statute or its common-law duties by denying the claim. *Id.* at 196-97. We made no such assumption, however, when we later addressed the insured's separate argument regarding "the damages that might be recoverable if an insurer failed to adequately investigate a claim." *Id.* at 198. On that issue, we held that[HN12] an insurer's "failure to properly investigate [*29] a claim is not a basis for obtaining policy benefits," but we did not assume that coverage existed when deciding that separate issue. *Id.* Instead, we relied on the fact that the insured "did not plead and did not obtain a determination [that the insurer] was liable for breach of the insurance contract." *Id.* at 198, 201.

18 Although four justices dissented in *Vail* in two separate opinions, none of them objected to the Court's opinion or judgment on the basis that the insureds failed to plead or obtain a finding that the insureds were entitled to receive benefits under the policy. Although the Court's majority opinion did not expressly explain the circumstances, it noted that the insureds "pleaded and proved" the amount of the policy's coverage and "offered evidence that [the insurer] had wrongfully denied the claim, resulting in a failure to pay [the policy benefits] when due." *Vail*, 754 S.W.2d at 137. The majority thus concluded that the insureds sustained the policy limits "as actual damages as a result of [the insurer's] unfair claims settlement practices." *Id.* JUSTICE GONZALEZ provided more clarity in his dissent, noting that the insurer "*admits* that it owes [the insured] the full amount of the policy" and thus "the sole issue on appeal is whether [the insured] is entitled to

> treble damages under the [statute]." *Id.* at 138 n.1 (GONZALEZ, J., dissenting) (emphasis added). Apparently, the Court's majority did not insist upon a jury finding of coverage or breach because the insurer admitted that the insured was entitled to the benefits. *Vail* should not be read, however, as suggesting that an insured can recover benefits for a statutory violation when the insured fails to establish and the insurer does not concede that the insured has a contractual right to the benefits.

In short, *Stoker* and *Castañeda* stand for the general rule that an insured cannot recover policy benefits as damages for an insurer's extra-contractual violation if the policy does not provide the insured a right to those benefits. *Vail* announced a corollary rule: [HN13] an insured who establishes a right to benefits under the policy can recover those benefits as actual damages resulting from a statutory violation. We clarify and affirm both of these rules today.

C. The Benefits-Lost Rule

A third rule that our precedent recognizes is the rule that [HN14] an insured can recover benefits as actual damages under the Insurance Code even if the insured has no right to those benefits under the policy, *if the insurer's conduct caused the insured to lose that contractual right*. We have recognized this principle in the context of claims alleging that an insurer misrepresented a policy's coverage, [*30] waived its right to deny coverage or is estopped from doing so, or committed a violation that caused the insured to lose a contractual right to benefits that it otherwise would have had. In each of these contexts, the insured can recover the benefits even though it has no contractual right to recover them because the benefits are actual damages "caused by" the insurer's statutory violation.

In the first context, we have recognized that[HN15] an insurer that violates the statute by misrepresenting that its policy provides coverage that it does not in fact provide can be liable under the statute for such benefits if the insured is "adversely affected" or injured by its reliance on the misrepresentation. *See Royal Globe Ins. Co. v. Bar Consultants, Inc.*, 577 S.W.2d 688, 694 (Tex. 1979).[19] Although the policy does not give the insured a contractual right to receive the benefits, the insurer's misrepresentation of the policy's coverage constitutes a statutory violation that causes actual damages in the amount of the benefits that the insured reasonably believed she was entitled to receive. *Id.* When, for example, a health insurer's agent represented that a policy "offered full coverage without qualification" for preexisting medical conditions, and the insured reasonably relied [*31] on that representation, the insured could recover the full coverage even though the policy actually limited such coverage to a specific maximum amount. *Kennedy v. Sale*, 689 S.W.2d 890, 891-92 (Tex. 1985); *see also Tapatio Springs Builders Inc. v. Md. Cas. Ins. Co.*, 82 F. Supp. 2d 633, 647 (W.D. Tex. 1999) ("A misrepresentation claim is independent, and may exist in the absence of coverage. To allege a misrepresentation claim under the DTPA, a plaintiff must plead a misrepresentation that caused actual damages.") (citing TEX. BUS. & COM. CODE § 17.50(a); *Castañeda*, 988 S.W.2d at 199-200); *In re Allstate Cnty. Mut. Ins. Co.*, 447 S.W.3d 497, 502 (Tex. App.--Houston [1st Dist.] 2014, orig. proceeding) ("[M]isrepresentation claims . . . are not dependent upon a determination that [the insurer] has a contractual duty to pay . . . benefits to the [insureds], and will not be rendered moot if [the insurer] prevails on the breach of contract claim.") (citing TEX. BUS. & COM. CODE § 17.46(b)(5), (b)(12); TEX. INS. CODE § 541.061(3)-(5)).

> 19 *Royal Globe*, which was also a DTPA case, preceded the 1979 amendments to the DTPA that changed the causation standard from "adversely affected" to "producing cause." *See Metro Allied Ins. Agency, Inc. v. Lin*, 304 S.W.3d 830, 835 (Tex. 2009) (explaining effect of the 1979 amendments).

The second context in which the benefits-lost rule might apply involves claims based on waiver and estoppel. We have explained that waiver and estoppel cannot be used to re-write a policy so that it provides coverage it did not originally provide. *Ulico*, 262 S.W.3d at 775. But if the insurer's statutory violations prejudice the insured, the insurer may be estopped "from denying benefits that would be payable under its policy as if the risk had been covered." *Id.* Under such circumstances, the insured may recover "any damages it sustains because of the insurer's actions," [*32] even though the policy does not cover the loss. *Id.* at 787.

Finally, the benefits-lost rule may apply when the insurer's statutory violation actually caused the policy not to cover losses that it otherwise would have covered. *See, e.g., JAW the Pointe*, 460 S.W.3d at 602. The insured in

JAW the Pointe sought policy benefits to cover its costs to demolish and rebuild an apartment complex that sustained significant damage from Hurricane Ike. *See id.* at 599. The primary insurance policy covered three hundred otherwise unrelated apartment complexes but limited the total coverage to $25 million per occurrence. *Id.* When the insurer denied the insured's claim for some of the losses, the insured filed suit asserting claims for both breach of contract and statutory violations. *Id.* at 601. As the parties continued efforts to resolve their dispute, the insurer continued paying claims filed by the other covered apartment complexes until the insurer reached the policy's $25 million limit. *Id.* The insurer then filed for summary judgment on the insured's contract claim, arguing that it no longer had a contractual duty to cover the losses because it had paid the policy limits. *Id.* at 600. The insured did not oppose the motion and the trial court granted it, leaving only [*33] the statutory claims for trial. *Id.* A jury found that the insurer had violated the statute, and based on the statutory violations the trial court awarded the insured both actual damages in the form of the policy benefits and additional statutory damages based on the insurer's "bad faith" statutory violations. *Id.* at 601-02.

The insurer appealed, arguing that the insured could not recover policy benefits or statutory damages because the policy did not cover the insured's losses. *See id.* at 602. But instead of relying on the policy limits to defeat coverage, the insurer argued that the policy never covered the losses even before the insurer paid out the limits because a policy exclusion applied and negated any coverage. *See id.* We acknowledged that as "a general rule there can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered." *Id.* (quoting *Stoker*, 903 S.W.2d at 341) (internal quotation marks omitted). But we also noted that the insured argued that "the policy covered [the insured's losses] and [the insurer] should have paid those costs before it made other payments that exhausted the policy limits." *Id.* In other words, the insured argued that, although it could no longer prevail on its [*34] breach-of-contract claim because the insurer had paid out its policy limits, the insurer's statutory violations caused the insured to lose its contractual right to the policy benefits by delaying the payments until after the limits had been reached. We accepted this argument, but ultimately concluded that the insured was never entitled to the policy benefits because the exclusion negated any coverage under the policy. Because the policy "excluded coverage for [the insured's] losses, [the insured] cannot recover against [the insurer] on its statutory bad-faith claims." *Id.* at 610. Put simply, an insurer that commits a statutory violation that eliminates or reduces its contractual obligations cannot then avail itself of the general rule.

D. The Independent-Injury Rule

The fourth rule from our precedent derives from the fact that an insurer's extra-contractual liability is "distinct" from its liability for benefits under the insurance policy. *See Aranda v. Ins. Co. of N. Am.*, 748 S.W.2d 210, 214 (Tex. 1988), *overruled on other grounds by Ruttiger*, 381 S.W.3d at 441. In *Stoker*, after we announced the general rule that "there can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered," we explained that we were not excluding "the possibility [*35] that in denying the claim, the insurer may commit some act, so extreme, that would cause injury independent of the policy claim." 903 S.W.2d at 341 (citing *Aranda*, 748 S.W.2d at 214).

There are two aspects to this independent-injury rule. The first is that,[HN16] if an insurer's statutory violation causes an injury independent of the insured's right to recover policy benefits, the insured may recover damages for that injury even if the policy does not entitle the insured to receive benefits. *Id.* We recognized this in *Twin City*, explaining that some extra-contractual claims may not "relate to the insurer's breach of contractual duties to pay covered claims" and may thus "give rise to different damages." 904 S.W.2d at 666 n.3. If such damages result from an independent injury "caused by" the insurer's statutory violation, the insured can recover those damages, just as insureds have always been able to recover "compensatory damages for the tort of bad faith" under the common law. *Moriel*, 879 S.W.2d at 17. Thus, an insured can recover actual damages caused by the insurer's bad-faith conduct if the damages "are separate from and . . . differ from benefits under the contract." *Twin City*, 904 S.W.2d at 666 (identifying mental anguish damages as an example). We reaffirmed this aspect of the independent-injury [*36] rule in *Castañeda*, recognizing that "there might be liability for damage to the insured other than policy benefits or damages flowing from the denial of the claim if the insured mishandled a claim." 988 S.W.2d at 198. We concluded that the insured could not recover anything in that case, however, because "none of the [insurer's] actions or inactions . . . was the

producing cause of any damage separate and apart from those that would have resulted from a wrongful denial of the claim." *Id.*

This aspect of [HN17] the independent-injury rule applies, however, only if the damages are truly independent of the insured's right to receive policy benefits. It does not apply if the insured's statutory or extra-contractual claims "are predicated on [the loss] being covered under the insurance policy," *Boyd*, 177 S.W.3d at 920, or if the damages "flow" or "stem" from the denial of the claim for policy benefits, *see Castañeda*, 988 S.W.2d at 198-99. When an insured seeks to recover damages that "are predicated on," "flow from," or "stem from" policy benefits, the general rule applies and precludes recovery unless the policy entitles the insured to those benefits. *See Boyd*, 177 S.W.3d at 920-22 (concluding that insured's common-law conversion claim, common-law bad-faith claim, and statutory claims were [*37] all "negated" because policy did not cover underlying losses and insured did "not allege that he suffered any damages unrelated to and independent of the policy claim"); *Castañeda*, 988 S.W.2d at 199 (holding that insured could not recover damages for loss of credit reputation because any such loss "stemmed from the denial of benefits" that were not owed under the policy).

The second aspect of the independent-injury rule is that[HN18] an insurer's statutory violation does not permit the insured to recover *any* damages beyond policy benefits unless the violation causes an injury that is independent from the loss of the benefits. Thus, we held in *Twin City* that an insured who prevails on a statutory claim cannot recover punitive damages for bad-faith conduct in the absence of independent actual damages arising from that conduct. 904 S.W.2d at 666; *see also Powell Elec. Sys., Inc. v. Nat'l Union Fire Ins. Co.*, 2011 U.S. Dist. LEXIS 96848, 2011 WL 3813278, at *9 (S.D. Tex. Aug. 29, 2011) (granting summary judgment for the insured on its breach-of-contract claim but for the insurer on common-law and statutory bad-faith claims because the insured "failed to allege damage independent of the damages arising from the underlying breach of the insurance contract").

Our reference in *Stoker* to "the possibility" that a statutory violation could cause an independent injury suggested [*38] that a successful independent-injury claim would be rare, and we in fact have yet to encounter one. *See, e.g., Mid-Continent Cas. Co. v. Eland Energy, Inc.*, 709 F.3d 515, 521-22 (5th Cir. 2013) ("The *Stoker* language has frequently been discussed, but in seventeen years since the decision appeared, no Texas court has yet held that recovery is available for an insurer's extreme act, causing injury independent of the policy claim . . . ."). This is likely because the Insurance Code offers procedural protections against misconduct likely to lead to an improper denial of benefits and little else. *See, e.g.*, TEX. INS. CODE § 541.060 (prohibiting an insurer from "requiring a claimant as a condition of settling a claim to produce the claimant's federal income tax returns"). We have further limited the natural range of injury by insisting that an "independent injury" may not "flow" or "stem" from denial of policy benefits. *See Castañeda*, 988 S.W.2d at 198. Today, although we reiterate our statement in *Stoker* that such a claim could exist, we have no occasion to speculate what would constitute a recoverable independent injury.

E. The No-Recovery Rule

The fifth and final rule is simply the natural corollary to the first four rules: An insured cannot recover *any* damages based on an insurer's statutory violation unless the insured [*39] establishes a right to receive benefits under the policy or an injury independent of a right to benefits. *Castañeda*, 988 S.W.2d at 198; *see also Lundstrom v. United Servs. Auto. Ass'n--CIC*, 192 S.W.3d 78, 96 (Tex. App.--Houston [14th Dist.] 2006, pet. denied) (rendering judgment for insurer because policy did not cover claim and insureds "have not alleged any act so extreme as to cause an injury independent of [the insurer's] denial of their policy claim"); *Bailey v. Progressive Cnty. Mut. Ins. Co.*, 2004 Tex. App. LEXIS 4880, 2004 WL 1193917, at *1 (Tex. App.--Dallas June 1, 2004, no pet.) (mem. op., not designated for publication) (rendering judgment against insureds because policy did not cover claim and insureds demonstrated no "independent injury arising from" statutory violations); *see also Alaniz v. Sirius Int'l Ins. Corp.*, 626 F. App'x 73, 79 (5th Cir. 2015) (per curiam) (citing *Boyd*, 177 S.W.3d at 922) (affirming summary judgment for insurer on all claims because no coverage or breach and insured put forth no evidence of "extreme conduct or of damages suffered independent of those that would have resulted from an alleged wrongful denial of his claim").

F. Summary

We clarify today that an insured cannot recover

policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits. An insured who establishes a right to receive benefits under the policy can recover those benefits as actual damages [*40] under the Insurance Code if the insurer's statutory violation causes the loss of the benefits. And an insured can recover benefits as actual damages under the Insurance Code even if the insured has no contractual right to those benefits if the insurer's conduct caused the insured to lose that right. If an insurer's statutory violation causes an injury independent of the insured's right to recover policy benefits, the insured may recover damages for that injury even if the insured is not entitled to receive benefits under the policy. But if the policy does entitle the insured to benefits, the insurer's statutory violation does not permit the insured to recover any actual damages beyond those policy benefits unless the violation causes an injury that is independent from the loss of the benefits. Finally, an insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

III.

MENCHACA'S CLAIMS AGAINST USAA

Having clarified the governing rules, we now turn to the case before us. As explained above, the jury in this case (1) failed to find that USAA failed [*41] to comply with its obligations under the insurance policy; (2) found that USAA violated the Insurance Code by failing to reasonably investigate Menchaca's claim for policy benefits; and (3) found that USAA's statutory violation resulted in damages of $11,350, representing the amount of policy benefits USAA "should have paid" Menchaca. Ever since the jury returned its verdict, the parties have disputed the effect of these findings. Relying on the jury's answer to Question 1 and on its misunderstanding of the general rule, USAA contends that Menchaca cannot recover any policy benefits because the jury failed to find that USAA "breached" its obligations under the policy. Relying on the jury's answers to Questions 2 and 3 and on her misunderstanding of *Vail*'s holding that damages under the Insurance Code were "at minimum, the amount of policy proceeds wrongfully withheld," 754 S.W.2d at 136, Menchaca contends that she can recover the policy benefits because the jury found that USAA violated the statute and the violation caused damages in the form of policy benefits USAA "should have paid" to Menchaca.

The trial court resolved the parties' dispute by disregarding the jury's answer to Question 1, and USAA [*42] argues that the court erred by doing so. We agree. As a result, we are left to decide the effect of the jury's answers based on arguments the parties have made without the benefit of the clarifications we have provided today. Under these circumstances, and because we have found it necessary to clarify the confusion resulting from our decisions, we conclude that it is proper to remand the case for a new trial in the interest of justice.

A. Disregarding Question 1

After the jury returned its verdict, both parties accepted it without objection, and the trial court dismissed the jury. Both parties then filed motions for judgment in their favor based on the jury's verdict. Relying primarily on *Stoker* and *Castañeda*, USAA argued that Menchaca could not recover any damages based on the jury's finding of a statutory violation because the jury failed to find that USAA had "breached" the policy in answer to Question 1. Relying primarily on *Vail* and on the jury's answers to Questions 2 and 3, Menchaca argued that she could recover the amount of policy benefits the jury found because "the jury found there was coverage," even if she failed to find that USAA breached the contract. Although neither [*43] party argued that the jury's answers created a conflict, the trial court believed they did. Instead of considering how to address and resolve the conflict, however, the court decided to disregard Question 1 because it found the question to be "poorly worded" and "incomprehensible." Specifically, the court explained that Question 1:

> says, "Breach of contract," but it doesn't say what kind of breach.[20] It doesn't even explain breach of contract. It doesn't even give a definition for breach of contract. There's all kinds of other things that should have been put in there about what's material breach, definition of material breach. The question fails altogether. It shouldn't have been submitted in the first place. If you remember correctly, I didn't want that question submitted. But it was insisted upon by the plaintiffs, so they've got to reap what they sow. But I think that I can easily ignore question number one as

> being incomprehensible to a layman and that it has no effect. I can go with what I wanted to go with in the first place which was question number two, damage question, then attorney's fees. That's what I'm going to do. I'm going to ignore question number one entirely because [*44] I think it was poorly worded.

> 20 We note that in fact Question 1 did not say "breach of contract" or ask whether there was a "breach of contract," and neither did any other question. Instead, Question 1 asked whether USAA "failed to comply" with the policy.

The court of appeals affirmed the trial court's decision to disregard Question 1, but for different reasons. First, the court concluded that it was impossible to know why the jury answered "No" to the question. *See* S.W.3d at . In the court's view, the jury could have answered "No" because it mistakenly believed that USAA could only "fail to comply with the terms of the insurance policy" if it failed to pay the amount that USAA *subjectively* believed it had to pay. *See id.* Second, it concluded that the jury's "No" answer to Question 1 did not "definitively establish that there was no coverage," because USAA agreed that the policy provided coverage for Menchaca's losses and instead only contended that the amount of the losses did not exceed the policy's deductible. *See id.* Finally, the court concluded that the jury's finding in answer to Question 2 that USAA violated the statute rendered its answer to Question 1 immaterial because Question 3 "instructed the jury to award the same damages regardless of which theory of liability was adopted." *See id.*

We conclude that the trial court erred by disregarding the jury's answer to Question 1. "A trial court may disregard a jury [*45] finding only if it is unsupported by evidence . . . or if the issue is immaterial." *Spencer v. Eagle Star Ins. Co. of Am.*, 876 S.W.2d 154, 157 (Tex. 1994) (citing *C. & R. Transp., Inc. v. Campbell*, 406 S.W.2d 191, 194 (Tex. 1966)). Contrary to the court of appeals' conclusion, the fact that the court cannot determine the reasons for a jury's answer does not permit the court to disregard that answer. Here, the jury's answer to Question 1 was neither unsupported by the evidence nor immaterial.

First, in light of USAA's evidence that Menchaca's damages were less than the amount of her deductible, at least some evidence supported the jury's finding that USAA did not fail to comply with its obligations under the policy. Although USAA did not dispute that the policy provided "coverage" for some of Menchaca's damages, it provided evidence that the amount of her loss was less than the policy's deductible, and that evidence supports the jury's failure to find that USAA "failed to comply" with its obligations under the policy.[21]

> 21 We do not agree with the court of appeals' reliance on the fact that USAA conceded that the policy "covered" some of Menchaca's losses. While USAA did in fact concede that point, it contested Menchaca's claim that her covered losses exceeded the amount of her deductible. By contending that Menchaca's covered losses did not exceed the amount of her deductible, USAA disputed that the policy "covered" the benefits for which she sued because the policy expressly provided that USAA would "cover only that part of the loss over the deductible stated."

Second, Question 1 was not immaterial. A jury finding is immaterial when the question "should not have been submitted, or when it was properly submitted but has been rendered immaterial by other findings." *Spencer*, 876 S.W.2d at 157 (citing *C. & R. Transp.*, 406 S.W.2d at 194). Contrary to the trial court's conclusion, the fact that a question is defective does not [*46] render the jury's answer immaterial. *See id.* (concluding that, "while [a question] was defective, it was not immaterial."). Question 1 was material because Menchaca sued USAA for breach of the insurance policy as well as for statutory violations, and she sought to recover on either claim. The jury's answers to Questions 2 and 3 did not render its "No" answer to Question 1 immaterial because that answer was necessary to resolve Menchaca's breach-of-contract claim. We therefore conclude that the court of appeals erred by affirming the trial court's decision to disregard the jury's answer to Question 1.

B. Reversal and Remand in the Interest of Justice

Having concluded that the trial court and court of appeals erred in disregarding the jury's answer to Question 1, we will reverse the judgment in Menchaca's favor. In the interest of justice, however, we may "remand the case to the trial court even if a rendition of

judgment is otherwise appropriate." TEX. R. APP. P. 60.3. Such a remand is particularly appropriate when it appears that one or more parties "proceeded under the wrong legal theory," *Boyles v. Kerr*, 855 S.W.2d 593, 603 (Tex. 1993), especially when "the applicable law has . . . evolved between the time of trial and the disposition of the appeal." [*47] *Natural Gas Pipeline Co. of Am. v. Justiss*, 397 S.W.3d 150, 162 (Tex. 2012); *see also Hamrick v. Ward*, 446 S.W.3d 377, 385 (Tex. 2014) (remanding in the interest of justice "in light of our clarification of the law"); *Moriel*, 879 S.W.2d at 26 (same, in light of our "substantial clarification"). In light of the parties' obvious and understandable confusion over our relevant precedent and the effect of that confusion on their arguments in this case, we conclude that a remand is necessary here in the interest of justice.

Specifically, USAA has steadfastly maintained that Menchaca cannot recover policy benefits for a statutory violation unless she also obtains a finding that USAA "breached" the insurance policy or that USAA's statutory violation caused an injury independent of her right to benefits. At trial, USAA objected to the charge's failure to condition Question 2 on a "Yes" finding to Question 1 and objected to the submission of Question 3 on the ground that "Texas courts have held that extra[-]contractual damages need to be independent from policy damages." After the jury returned its verdict, USAA argued that it should prevail because "the jury found 'NO' breach of contract" and awarded only policy benefits "for repairs to the property which Plaintiff and her experts testified were proximately caused by Hurricane Ike." After [*48] the trial court entered its judgment, USAA argued in its motion for new trial that Menchaca cannot recover in the absence of a finding of breach because she did not seek damages "separate and apart from those sought under the breach of contract theory." Although we have clarified today that Menchaca did not have to prevail on her breach-of-contract claim to recover policy benefits for a statutory violation, the confusing nature of our precedent precludes us from faulting USAA for the position it has maintained throughout this litigation.

Meanwhile, Menchaca has consistently argued that she can recover, even in the absence of a finding of "breach," based on the jury's findings in answer to Questions 2 and 3 that USAA violated the statute and that the violation "caused" Menchaca to incur damages in the form of policy benefits that USAA "should have paid." In support of its motion for judgment on the verdict, Menchaca argued that through these answers "the jury found there was coverage," and that finding supported the judgment even though the jury failed to find a "material breach." Before us, Menchaca argues that the jury "did not find that [she] suffered no covered losses or that USAA [*49] paid for all Menchaca's covered losses," but in fact "found the contrary" in response to Question 3, "finding that USAA failed to pay $11,350 it should have paid (and would have paid but for its unreasonable investigation) in accordance with the policy." As with USAA's arguments, we conclude that the confusing nature of our precedent precludes us from faulting Menchaca for asserting throughout this litigation that she did not have to prove breach.

In their briefing to this Court, the parties make additional arguments regarding such issues as whether USAA adequately objected to the jury charge; whether the jury's answer to Question 1 established that Menchaca was not entitled to any benefits under the policy; whether the answer to Question 2 established that USAA breached the policy; whether the answer to Question 3 established that the policy entitled Menchaca to receive $11,350 in benefits; whether the jury's answers irreconcilably conflict; and if so, whether and how we can resolve that conflict. We conclude that the parties' confusion about our precedent has affected these arguments as well, to such an extent that justice requires that we remand the case for a new trial without addressing [*50] them.

IV.

CONCLUSION

The trial court erred by disregarding the jury's answer to Question 1, and the court of appeals erred by affirming the trial court's judgment. In light of the confusion that our precedent caused in the litigation and appeal of this case, we reverse the court of appeals' judgment and remand this case in the interest of justice for a new trial consistent with the rules we have clarified today.

Jeffrey S. Boyd

Justice

Opinion delivered: April 7, 2017

APPENDIX 3

12 No. 26 Westlaw Journal Insurance Bad Faith 1

Westlaw Journal Insurance Bad Faith

***1**

April 26, 2017

Storm Damage
By Rae Theodore

NO BAD-FAITH CLAIM WITHOUT BREACH OF CONTRACT, TEXAS HIGH COURT RULES

USAA Texas Lloyds Co. v. Menchaca

An insured cannot proceed with a statutory bad-faith claim if the insurer never breached the terms of the insurance contract, Texas' highest court has ruled.

USAA Texas Lloyds Co. v. Menchaca, No. 14-0721, 2017 WL 1311752 (Tex. Apr. 7, 2017).
The Texas Supreme Court said a trial court and intermediate appeals court both erred in allowing an insured to win a judgment for statutory bad-faith damages while disregarding a jury's finding that there was no insurer breach of contract.

The high court remanded the case, directing the trial court to follow five rules "distilled" from previous decisions governing the relationship between contractual and extracontractual claims in the area of insurance.

USAA denies coverage

The case involves Gail Menchaca, who reported damage to her house to insurer USAA Texas Lloyds Co. after Hurricane Ike struck Galveston Island in September 2008.

USAA sent out an adjuster, who reported minimal damage to the property. The insurer determined that some of the damage was eligible for coverage but declined to pay benefits because the estimated repair costs did not exceed the policy's deductible, the high court's opinion said.

About five months later, USAA conducted a second inspection at Menchaca's request. The second adjuster confirmed the previous adjuster's findings, and USAA again declined to pay benefits, the opinion said.

Menchaca sued USAA for breach of contract and unfair settlement practices in violation of the Texas Insurance Code. She sought insurance benefits under the policy, court costs and attorney fees.

Jury awards damages

A jury for the 9th District Court of Montgomery County found that USAA had not breached the terms of the policy. However, the jury said the insurer had engaged in unfair or deceptive practices by failing to conduct a proper investigation and determined Menchaca was owed $11,350 in policy benefits, the opinion said.

The trial court entered final judgment in Menchaca's favor, and the Court of Appeals affirmed.

The state Supreme Court granted USAA's petition for review.

Supreme Court establishes 5 rules

The high court defined the primary issue as whether an insured can recover policy benefits as actual damages caused by a carrier's statutory violation without a finding that the insurer breached the terms of the policy.

In answering the question, the court looked at its previous related decisions and offered five rules governing the relationship between contractual and extracontractual claims in the area of insurance.

***2** As a "general rule," the high court said, an insured cannot recover policy benefits for an insurer's statutory violation if the insured does not have a right to those benefits under the policy.

Menchaca had argued she can recover policy benefits as damages stemming from USAA's statutory breach because that claim is independent from her claim for breach of contract.

"The reason we reject Menchaca's independent-claims argument -- indeed, the very reason for the general rule -- derives from the fact that the insurance code only allows an insured to recover actual damages 'caused by' the insurer's statutory violation," the opinion said.

The second rule, which the justices called the "entitled-to-benefits rule," says an insured who establishes a right to receive policy benefits can recover them as "actual damages" under Texas insurance law if the insurer's statutory violation causes the benefit loss.

The "benefits-lost rule" allows an insured to recover benefits as actual damages under Texas' insurance law-- even if the insured has no right to them under the policy -- if the insurer caused the policyholder to lose that contractual right.

"[T]he insured can recover the benefits even though it has no contractual right to recover them because the benefits are actual damages 'caused by' the insured's statutory violation," the high court said of the third rule.

"Put simply, an insurer that commits a statutory violation that eliminates or reduces its contractual obligations cannot then avail itself of the general rule," the opinion explained.

As a fourth rule, called the "independent-injury rule," the court held that an insurer's extracontractual liability is "distinct" from its liability for policy benefits.

The fifth rule --the "no-recovery rule" -- is a prohibition on an insured's right to recover damages based on an insurer's statutory violation unless the insured demonstrates a right to receive benefits under the policy or an injury independent of that right.

Case remanded

Applying the governing rules to Menchaca's case, the Supreme Court said the trial court erred when it disregarded the jury's finding that USAA had not breached the terms of the policy.

The court reversed and remanded the case for a new trial consistent with the five rules.

Attorneys:

Petitioner (USAA): Bruce E. Ramage and Christopher W. Martin, Martin Disiere Jefferson & Wisdom, Houston, TX

Respondent (Menchaca): Gilberto Hinojosa, Brownsville, TX
Company: USAA Texas Lloyds Co.
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APPENDIX 4

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Texas Ruling Could Mean Bigger Paydays For Policyholders

By Jess Krochtengel

Law360, Dallas (April 11, 2017, 10:54 PM EDT) -- The Texas Supreme Court on Friday restored protections for policyholders by putting teeth back into statutory provisions that penalize carriers for deceptive practices in an opinion insurance lawyers say is one of the most important in recent history.

In USAA Texas Lloyd's v. Menchaca, the court set out five rules governing the intersection between claims for a breach of an insurance policy and claims of wrongdoing under the Texas Insurance Code, in what it said was intended to clarify decades of confusing precedent. Insurance lawyers say the decision will likely revive claims for treble damages under the code, an important tool that could lead to bigger payouts but also mean more early resolutions of claims disputes before they ever hit the courtroom.

Lawyers representing policyholders have praised the decision for clarifying important principles using a common sense approach. On the carrier side, reaction to the ruling is mixed, with lawyers saying they think the court actually muddied the waters and the ruling will stir up significant amounts of follow-on litigation.

"I think it does revive some old bad-faith concepts that people had more or less thought had fallen by the wayside," Stephen Pate of Cozen O'Connor said. "I often tell my clients that while the Texas Supreme Court is a pro-business court, that does not always translate into being a pro-insurance carrier court."

The case arose from Gail Menchaca's claim USAA acted in bad faith under the Texas Insurance Code by failing to conduct a reasonable investigation into her claim her home was damaged by a hurricane. A jury had found USAA did not fail to comply with the terms of Menchaca's policy. But it also found USAA had engaged in unfair or deceptive practices in violation of the code by refusing her claim without performing a reasonable investigation.

USAA appealed, arguing the jury's finding it didn't breach the policy precludes Menchaca from recovering policy benefits as damages for the statutory violation. The court disagreed, saying the focus should be on whether the insured was entitled to receive benefits under the policy, not whether the policy was breached.

The court's five rules for evaluating similar cases are:

The General Rule: An insured can't recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits.

The Entitled-To-Benefits Rule: An insured who establishes a right to receive benefits under the policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits.

The Benefits-Lost Rule: Even if the insured cannot establish a present contractual right to policy benefits, the insured can recover benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right.

The Independent Injury Rule: If an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits.

And lastly, the No-Recovery Rule: An insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

"It sets the record straight on the scope of recovery under the Insurance Code, and it puts an end to the notion that the Insurance Code was narrowly intended to only address a situation where the insured has some injury that's different from being deprived of its rights under the policy," Amy Elizabeth Stewart of Amy Stewart PC said.

Stewart said policyholders often run up against the argument from insurers that without an injury independent of the failure to pay benefits, policyholders can't recover benefits as damages for a violation of the Insurance Code.

She said that argument was rooted in the Texas Supreme Court's 1998 decision in Provident American Insurance Co. v. Castañeda — in which the court determined that in order for a policyholder to get extracontractual damages, the insurer must have caused an injury other than denial of policy benefits — but that it did not take into account the court's 1988 holding in Vail v. Texas Farm Bureau Mutual Insurance Co., where the court upheld a finding coverage was wrongly denied and said the policyholder could recover damages based on both the policy breach and for violations of the Insurance Code.

Laywers and courts have long wrestled with the distinctions between Castañeda and Vail, and the Fifth Circuit had said as recently as its 2015 decision in In re Deepwater Horizon that Castañeda and other Texas appellate decisions "cast doubt on Vail's continued vitality," and said in 2010 Castañeda set out the opposite rule from that in Vail.

But the Menchaca decision reaffirms Vail, with the court saying the Vail decision recognized what it's now calling the entitled-to-benefits rule.

Stewart said by making it clear policy benefits can be recovered as damages for statutory violations, the court also opened the door to the potential to triple damages for knowing acts of unfair competition or deceptive trade practices by insurers.

"That's really the big issue," Stewart said.

Bobby Rubarts of Koning Rubarts agreed, saying for insured parties with smaller damages claims that might not be economical to pursue based on their policy benefits, an opportunity to seek treble damages could open new avenues for compensation.

"It's putting the teeth back in the Insurance Code," he said. "It gives the policyholder an opportunity to recover treble damages. That's a big deal."

Rubarts said the threat of treble damages should also be an incentive for insurance carriers "to go ahead and pay the claim timely rather than delay or not pay it," he said. That was part of the original intent of the code when it was written, he said.

Tamara Bruno of Pillsbury Winthrop Shaw Pittman LLP said the court's five rules will have impacts for policyholders long before a dispute reaches court.

When insurers operated with the idea in mind that as long as they pay policy benefits at some point they won't be exposed to Insurance Code claims, they had no incentive to "handle claims as they should in the beginning of the claims process," she said.

"The insurance company now has more incentive to handle claims as required by the Insurance Code and not to think that if they pay benefits at some point, it will be OK, whether that's now or a year from now — which can make a big difference in a policyholder's life," she said.

Pate, who represents insurance carriers, said he does expect the decision to embolden policyholder counsel to pursue treble damages awards — but said carriers "are going to fight this." There may be more settlements early in the claims process, but there will also be more litigation on these issues, he said.

"Carriers are not going to sit idly by with this decision," Pate said. "They think this decision muddies the waters and needs some clarity on it. They're going to be looking to get a motion for rehearing, looking for things that will go up to the appellate courts on damages, things like that."

He said the decision is especially confusing when it comes to damages, as it's unclear how to calculate damages for a violation of the code that happens without a breach of the underlying policy. Practically speaking, trial lawyers and judges are likely to struggle with how to submit questions to a jury on breach of a policy and on damages, he said.

"This issue's going to be headed right back to the Texas Supreme Court in a couple of years," Pate said.

Another potential hurdle at trials will likely be in establishing causation under the court's five rules, Jay Thompson of Thompson Coe Cousins & Irons LLP, another carrier-side attorney, said. The court has said damages are recoverable under the Insurance Code if the insurer caused a loss of benefits or a contractual right, but Thompson said he's unsure in what kind of situations an insurer could be held liable.

He thinks causation is likely to be a big battleground for years to come, as the ruling doesn't clarify what kind of conduct by an insurer could be deemed to cause a loss of policy benefits.

And when causation is the focus in the courtroom, it may be harder for insurance companies to win dismissal of cases at the summary judgment stage because causation is a fact issue, not a legal issue, Thompson said. That would be unless a company can prove there's no evidence at all supporting the plaintiff's causation theory, he said.

"Most of the lawyers I've talked to, on both sides of the docket, are not sure if the law was clarified or further muddled a little bit with that decision," Thompson said. "I think everybody's kind of still studying it."

USAA is represented by Wallace B. Jefferson, Rachel A. Ekery and Charles T. Frazier Jr. of Alexander Dubose Jefferson & Townsend LLP.

Menchaca is represented by Jennifer Bruch Hogan, Richard P. Hogan Jr. and James C. Marrow of Hogan & Hogan.

The case is USAA Texas Lloyd's Co. v. Gail Menchaca, case number 14-0721, in the Supreme Court of the State of Texas.

--Editing by Pamela Wilkinson and Aaron Pelc.

APPENDIX 5

alert Insurance Practice

Saul Ewing LLP

APRIL 2017

New Bad Faith Guidance in Texas

Author:
Matthew M. Haar

SUMMARY

The Texas Supreme Court has announced five rules which the Court believes will "provide clarity regarding the relationship between claims for an insurance policy breach and Insurance Code violations." *USAA Texas Lloyds Co. v. Menchaca*, No. 14-0721, slip op. at 6 (Tex. April 7, 2017).

The new rules are:

1. an insured cannot recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits;
2. an insured who establishes a right to receive benefits under the insurance policy can recover those benefits as actual damages under the Insurance Code if the insurer's violation causes the loss of benefits;
3. even if the insured cannot establish a present contractual right to policy benefits, the insured can recover benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right;
4. if an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits; and
5. an insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

In the *Menchaca* case, Menchaca submitted a homeowners claim to USAA following Hurricane Ike, and USAA concluded that her damages were minimal and below the amount of her deductible. Menchaca pursued claims of breach of contract and unfair and deceptive practices against USAA, which were all submitted to a jury. The jury found that USAA did not breach the contract with Menchaca, but found that USAA engaged in unfair practices, and it awarded Menchaca damages equal to those sought for breach of contract. The trial court entered judgment in Menchaca's favor, and the court of appeals affirmed. In announcing its five rules, the Texas Supreme Court concluded that its earlier decisions on the interplay between breach of contract and violations of the Insurance Code were not sufficiently clear, and remanded the matter to the trial court for a new trial.

In many jurisdictions, insureds have been barred from recovering extracontractual damages where an insurer correctly paid or denied benefits, even if there were questions as to how the insurer got to that result. The Texas Supreme Court's decision clarifies only that the analysis in such situations is not nearly that simple, nor the result so straightforward. Insurers can now expect attacks on the distinction between and overlap of policy benefits compared to damages attributable to allegedly unfair

practices. Similarly, policyholders are likely to focus on insurer conduct that they may claim causes a loss of benefits, and what constitutes independent injury attributable to allegedly unfair conduct by an insurer.

The *Menchaca* decision is likely to open new paths to potential recovery for creative plaintiff's counsel, further complicate coverage and damages analysis, and result in significant follow up litigation seeking to clarify the five rules articulated by the court and expand that jurisprudence to other jurisdictions.

Saul Ewing has a deep bench of seasoned insurance attorneys with decades of experience in handling bad faith and other high stakes litigation. Our team is ready to help you navigate the increasing complexities of developments in insurance bad faith law around the country.

This Alert was written by Matthew M. Haar, a member of the firm's Insurance Practice. Matthew can be reached at 717.257.7508 or mhaar@saul.com. This publication has been prepared by the Insurance Practice for information purposes only.

APPENDIX 6

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TEXAS SUPREME COURT ATTEMPTS TO CLARIFY STATUTORY BAD FAITH LIABILITY

04.07.17

On April 7, 2017, the Texas Supreme Court issued its opinion in USAA Texas Lloyds Co. v. Menchaca. The Supreme Court was called upon to decide whether the insured can recover policy benefits based on jury findings that the insurer violated the Insurance Code and the violation resulted in a loss of benefits that the insurer should have paid, even though the jury declined to find that the insurer failed to comply with the policy.

In Menchaca, the insured made a homeowner's property claim to USAA following Hurricane Ike. USAA sent an adjuster to investigate the claim. Based upon the adjuster's finding of minimal "covered" damage that did not exceed the policy's deductible, USAA paid no benefits. Approximately five months later, the insured requested a re-inspection. USAA sent a different adjuster, who generally confirmed the initial findings, and USAA again refused to pay benefits. The insured sued USAA for breach of the insurance policy and for unfair settlement practices under the Insurance Code. The case was tried to a jury. The first question on the breach of contract claim asked whether USAA "failed to comply with the terms of the insurance policy with respect to the claim for damages filed by [the insured] resulting from Hurricane Ike." The jury answered "No." Question 2 asked whether USAA engaged in various unfair or deceptive trade practices, including whether USAA refused "to pay a claim without conducting a reasonable investigation" with respect to the claim. The jury answered "Yes." Question 3 asked the jury to determine the insured's damages resulting from either USAA's failure to comply with the policy or its statutory violations, calculated as "the difference, if any, between the amount USAA should have paid [the insured] for her Hurricane Ike damages and the amount that was actually paid." The jury answered "$11,350."

Both parties moved for judgment in their favor. USAA argued that the insured was not entitled to statutory damages because the jury did not find that it failed to comply with the policy. The insured argued that she was entitled to judgment because the answers to Questions 2 and 3 were not conditioned on a "Yes" answer to Question 1. The trial court ultimately disregarded Question 1 and entered judgment in the insured's favor based upon the answers to Questions 2 and 3. The court of appeals affirmed.

The Supreme Court admitted that its prior cases on this issue had led to "substantial confusion" among the lower courts and that it hoped to "clarify our precedent" by

announcing five rules addressing the relationship between contract claims under an insurance policy and tort claims under the Insurance Code. The five rules are:

1. The General Rule: An insured cannot recover policy benefits as damages for an insurer's statutory violation if the insured does not have a right to those benefits under the policy.

2. The Entitled-to-Benefits Rule: An insured who establishes a right to receive benefits under an insurance policy can recover those benefits as "actual damages" under Chapter 541 if the insurer's statutory violation causes the loss of policy benefits.

3. The Benefits-Lost Rule: An insured can recover benefits as actual damages under the Insurance Code - even if the insured has no right to those benefits under the policy - if the insurer's conduct caused the insured to lose that contractual right.

4. The Independent-Injury Rule: If an insurer's statutory violation causes an injury "truly" independent of the insured's right to recover policy benefits, the insured can recover those damages under the statute. In other words, the damages are separate from and differ from the benefits under the contract. The independent injury must be "caused" by a statutory violation and not be "predicated on" or "stem or flow from" denial of policy benefits. Although the Supreme Court recognizes this possibility, the opinion clearly suggests that this will be a rare occurrence-admitting that "[they] in fact have yet to encounter one."

5. The No-Recovery Rule: An insured cannot recover any damages based on an insurer's statutory violation unless the insured establishes a right to receive benefits under the policy or an injury independent of a right to benefits.

As often happens, the Menchaca decision raises many more questions than it answers. The Court did not give any guidance on when an act of statutory bad faith will be the "cause" of the loss of policy benefits. Causation is often the province of the jury, potentially resulting in more cases with the possibility of policy benefits as statutory violation damages. The Court did not discuss the proper jury submission to entitle an insured to recover policy benefits under the entitled-to-benefits rule.

The decision is 37 pages long. It can be accessed here.

APPENDIX 7

April 19, 2017

THE TEXAS SUPREME COURT "CLARIFIES" THE LAW REGARDING RECOVERY OF DAMAGES IN FIRST PARTY BAD FAITH CLAIMS

Prior to last Friday, courts in Texas, both at the state and federal level, had been struggling with the apparent discrepancy between the Texas Supreme Court's holding in *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129 (Tex. 1988), wherein the court held that an insurer's unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld, and the holding in *Provident Am. Ins. Co. v. Castaneda*, 988 S.W.2d 189 (Tex. 1998), wherein the court held than an insurance company's failure to properly investigate a claim is not a basis for obtaining policy benefits. Many courts had taken the position that *Castaneda* effectively overruled *Vail*.

The Texas Supreme Court now believes that it has "clarified" the issues in *USAA Tex. Lloyds Co. v. Menchaca*, 2017 WL 1311752 (Tex. Apr. 7, 2017), a case in which the court, while recognizing that its prior language could have been clearer, recognized no concern with the rules stated in *Vail* and *Castaneda* standing side by side. In this case, an insured's home suffered damage when Hurricane Ike struck Galveston. She contacted her carrier and reported the damage. An adjuster investigated the claim and determined that the damage did not exceed her policy's deductible so the claim was denied. Five months later, another adjuster re-inspected the property and confirmed the first adjuster's findings. The insured then sued the carrier for breach of contract and for unfair claim settlement practices. As damages for both claims, she sought only the insurance benefits under the policy. The jury held that the carrier did not breach the insurance contract, but did find that the carrier failed to conduct a reasonable investigation. The damages question asked the jury to determine insured's damages that resulted from either the carrier's failure to comply with the policy or its statutory violations, calculated as the difference, if any, between the amount the carrier should have paid for the damages and the amount that was actually paid. The jury answered in favor of the insured in the amount of $11,350.

The question presented to the Texas Supreme Court was whether an insured can recover policy benefits as actual damages for insurance code violations absent a finding that the insured had a contractual right to the benefits under the policy? In responding to this question, the court noted that the case "presents an opportunity to provide clarity regarding the relationship between claims for an insurance policy breach and Insurance Code violations." The court went on to outline five rules interrelated rules that govern the relationship between contractual and extra-contractual claims in the insurance context.

1. As a general rule, an insured cannot recover policy benefits as damages for an insurer's statutory violation if the policy does not provide a right to receive those benefits;
2. An insured who establishes a right to receive benefits under the insurance policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits;
3. Even if the insured cannot establish a present contractual right to policy benefits, the insured can recover benefits as actual damages under the Insurance Code if the statutory violation caused the insured to lose that contractual right;
4. If an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits; and
5. An insured cannot recover any damages based on a statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

While these rules seems relatively straightforward, it is not necessarily clear that the court has once and for all clarified anything. In order to try and understand these rules, a brief analysis of each is necessary.

The general rule derives from the fact that the Insurance Code only allows an insured to recover actual damages caused by the insurer's statutory violation. If an insurer violates a statutory provision, that violation, at least generally, cannot cause damage in the form of policy benefits that the insured has no right to receive under the policy.

The second rule, "the entitled to benefits rule," is, according to the court, a logical corollary to the general rule. In discussing this rule, the court found that it did not reject *Vail* in *Castaneda*. Recognizing that it could have made the point clearer, the court noted that the distinction between the two cases is that the parties in *Vail* did not dispute the insured's entitlement to the policy benefits and the only issue was whether the insured could recover those benefits as statutory damages. By contrast, in *Castaneda*, the insured did not establish and the insurer did not concede (once again proof that a carrier should never concede an argument) that the insured had a right to benefits under the policy. In fact, the insured never sought and did not receive any contractual relief and never alleged that the carrier was liable for breach of the insurance contract. Instead, the insured sought only to recover damages equivalent to policy benefits based on her statutory claims. The court ultimately concluded that it clarified and affirmed both of the rules stated in *Vail* and *Castaneda*.

Examples of the third rule, the "benefits lost rule," can be found in claims alleging that an insurer misrepresented a policy's coverage and the insured is adversely affected or injured by its reliance on the misrepresentation, waived its right to deny coverage or is estopped from doing so, or committed a violation that caused the insured to lose a contractual right to benefits it otherwise would have had. In each of these contexts, the insured can recover the policy benefits as damages because the benefits are actual damages caused by the statutory violation.

The fourth rule, entitled the "independent injury rule," is the most problematic for the court. The court noted that there are two aspects to this rule. First, if an insurer's statutory violation causes an injury independent of the right to recovery policy benefits, the insured may recover damage for that injury even if the claim is not covered. This aspect of the rule applies only if the damages are truly independent of the right to recover policy benefits. The second aspect of the rule is that the statutory violation does not permit the insured to recover any damages beyond policy benefits unless the violation causes an injury independent from the loss of benefits. The court noted that the possibility that a statutory violation could cause an independent injury is a rare one, and that it had yet to encounter such an injury. The court refused to even speculate what would constitute a recoverable independent injury.

The final rule, the "no recover rule," is, according to the court, the natural corollary to the first four rules.

Interestingly, the court remanded the case for a new trial given the newly minted rules.

We do not yet know what the result of this case will be. However, what is clear is that carriers can no longer simply argue that the mere fact that no coverage exists under the policy necessarily precludes a claim for statutory damages. Those damages may be the equivalent of policy benefits, depending upon which rule the insured can fight his or her facts under. We are sure that this case will result in more claims for first party bad faith.

We apologize for the lengthy e-mail. It could have been much longer. This was a long opinion. If you have any questions, please do not hesitate to reach out to the firm's appellate and coverage section for additional clarity.

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Craig Reese leads the Firm's appellate and coverage practice group. He has 23 years practice experience including appeals at the federal and state level, insurance coverage/defense, and commercial litigation. He has represented clients in a wide variety of litigation including insurance coverage, general insurance defense, bad faith litigation, and commercial matters. His appellate experience includes cases before every level of the state courts of appeals and appeals to the Fifth Circuit Court of Appeals. In addition, he is a former briefing attorney to the Honorable H.M. Lattimore for the Second Court of Appeals in Fort Worth.

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APPENDIX 8

Bad Faith—Alive and Well in Texas! Who knew?

April 14, 2017

Dear Colleague,

The Supreme Court of Texas issued a significant opinion last week. In USAA Texas Lloyd's Co. v. Menchaca, 14-0721, 2017 WL 1311752 (Tex. Apr. 7, 2017), the Court stated that, "In light of the parties' obvious and understandable confusion over our relevant precedent and the effect of that confusion on their arguments in this case, we conclude that a remand is necessary here in the interest of justice." The Court seemingly recognized a new appellate point—confusion! Practice tip: This new appellate point likely applies only in insurance cases, so proceed with caution.

Oh, and the Court ruled on an important insurance issue as well. If you're like Lee and have been thinking about first-party bad faith claims for the last twenty years (Seriously! See Lee H. Shidlofsky, The Changing Face of First-Party Bad Faith Claims in Texas, 50 S.M.U. L. Rev. 867 (1997)), then you spent last weekend happily curled up with a glass of pinot and a copy of the Menchaca opinion. But you haven't thought about first-party bad faith claims for twenty years and you didn't spend the weekend reading Menchaca because, well, you're sane.

In all seriousness, Menchaca presented the Court with an opportunity to "provide clarity regarding the relationship between claims for an insurance policy breach and Insurance Code violations." A tension had developed in Texas law between the Court's rulings in Vail v. Texas Farm Bureau Mutual Insurance Co., 754 S.W.2d 129, 136 (Tex. 1988), on the one hand, and Provident American Insurance Co. v. Castañeda, 988 S.W.2d 189 (Tex. 1998), on the other.

The Vail court held that an insured who is wrongfully denied policy benefits need not show any injury independent from the denied policy benefits. The Vails purchased fire insurance from Texas Farm Bureau Mutual Insurance Company, and subsequently a fire destroyed their home and its contents. Texas Farm Bureau's agent told the Vails the company would not willingly pay the claim, and Texas Farm Bureau, living up to that prediction, denied the claim. The Vails sued Texas Farm Bureau, and the case proceeded to trial on the Vails' statutory and breach of the common law duty of good faith and fair dealing claims. The Court concluded as follows:

We hold that an insurer's unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld.

Vail established that an insured can recover policy benefits as damages for an unfair settlement practices claim, without any requirement of an independent injury. That holding was uncontroversial until the Supreme Court of Texas' decision in Castañeda ten years later.

In Castañeda, the insured purchased a health insurance policy from Provident American Insurance Company. The policy did not cover expenses resulting from sicknesses manifesting within thirty days of the policy's effective date or disorders of internal organs, including the gallbladder, within six months of the effective date. The insured's two children (also insured under the policy) were diagnosed with hemolytic spherocytosis (HS) thirty-three days after the effective date of the policy; however, they had exhibited symptoms of HS all of their lives. Provident denied coverage for the splenectomy and gallbladder removal for the insured's daughter. She sued Provident, alleging violations of the Texas Deceptive Trade Practices Act and Article 21.21 of the Texas Insurance Code. The jury awarded $50,000 in damages and the trial court trebled those damages. The Supreme Court of Texas reversed the award, holding that "none of the actions or inactions of Provident American was the producing cause of any damage separate and apart from those that would have resulted from a wrongful denial of the claim." In particular, the Court agreed with Provident "that its conduct in handling the claim did not cause any injury independent of the denial of policy benefits." The Court seemed to require an injury independent of the contractual damages for a bad faith claim to exist.

Courts latched on to that language and routinely stated that the Supreme Court of Texas had implicitly overturned Vail. Most notably, the Fifth Circuit, in Parkans International, LLC v. Zurich Insurance Co. 299 F.3d 514 (5th Cir. 2002), and Great American Insurance Co. v. AFS/IBEX Financial Services, 612 F.3d 800 (5th Cir. 2010), limited the damages available to an insured for a first-party bad faith claim to independent injuries, not policy benefits. In Parkans, the insurer had not breached the contract, and the Fifth Circuit held that, there "can be no recovery for extra-contractual damages for mishandling claims unless the complained of actions or omissions caused injury independent of those that would have resulted from a wrongful denial of policy benefits." In AFS/IBEX Financial Services, the claim was covered by the policy, and the Fifth Circuit reaffirmed its holding in Parkans. Countless federal district court opinions did the same. And, Texas intermediate courts of appeals got into that act as well and for nearly twenty years an insured had to establish an independent injury to successfully prosecute an extra-contractual claim in many, if not most, courts in Texas.

The Supreme Court of Texas had an opportunity to right the ship in In re Deepwater Horizon, 807 F.3d 689, 698 (5th Cir. 2015), on certified questions from the Fifth Circuit, but that case settled before the Court could address the question of whether an insured must allege and prove an injury independent from the denied policy benefits to maintain an extra-contractual claim. The issue came up again in Menchaca, and nearly twenty years after Castañeda, the Supreme Court had its opportunity to clarify the law on the issue.

The factual background in Menchaca is relatively straightforward—Gail Menchaca's home was

damaged by Hurricane Ike, she made a claim on her homeowner's policy issued by USAA, and the claims adjuster determined that, although there were damages to the home, the estimated amount of the costs of repair were less than the deductible. Five months later, at Menchaca's request, USAA sent another adjuster to re-inspect the home, that adjuster reached the same conclusion, and USAA again denied the claim. Menchaca sued USAA for breach of the insurance policy and for unfair settlement practices in violation of the Texas Insurance Code. The jury found that USAA had not breached the policy; however, it also found that USAA had engaged in various unfair or deceptive practices resulting in $11,350 in damages—the difference between what should have been paid under the policy and what was actually paid. Thus, the applicability of the independent injury rule was set for review. The Supreme Court of Texas framed the issue before it as follows:

The primary issue is whether the insured can recover policy benefits based on jury findings that the insurer violated the Texas Insurance Code and that the violation resulted in the insured's loss of benefits the insurer "should have paid" under the policy, even though the jury also failed to find that the insurer failed to comply with its obligations under the policy.

Recognizing the "substantial confusion" among courts and the parties regarding the issue and taking into account William Blackstone's observation that "seldom will it happen that any one rule will exactly suit with many cases," the Supreme Court set out "five distinct but interrelated rules that govern the relationship between contractual and extra-contractual claims" in the first-party context.

The General Rule—"[A]an insured cannot recover policy benefits for an insurer's statutory violation if the insured does not have a right to those benefits under the policy." The General Rule is a restatement of the Supreme Court's ruling in Republic Ins. Co. v. Stoker, 903 S.W.2d 338, 341 (Tex. 1995). In Stoker, the insurer initially denied the claim based on an improper reason, then issued a subsequent, valid denial. The trial court granted the insurer's motion for summary judgment against the insured's breach of contract claim; however, the case proceeded to trial on the bad faith claims, and the jury found the insurer liable on the extra-contractual claim and awarded policy benefits, the only damages alleged and proved at trial. The court of appeals affirmed, but the Supreme Court held that as "a general rule there can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered." Id. at 341. The Menchaca Court stated that "a more accurate statement of the rule we announced in Stoker is that 'there can be no claim for bad faith [denial of an insured's claim for policy benefits] when an insurer has promptly denied a claim that is in fact not covered.'" The Court in Menchaca expressly disagreed with USAA's argument, which carriers have been making for years, that "an insured can never recover policy benefits as damages for a statutory violation."

The Entitled-to-Benefits Rule—"[A]n insured who establishes a right to receive benefits under an insurance policy can recover those benefits as 'actual damages' under the statute if the insurer's statutory violation causes the loss of the benefits." The Court called the Entitled-to-Benefits Rule "a logical corollary to the general rule," first recognized in Vail. The Court cleared up the longstanding confusion between Vail, Stoker, and Castañeda—"We did not

reject the Vail rule in Stoker or in Castañeda." To be absolutely clear, the Court explained the interplay between the General Rule and the Entitled-to-Benefits Rule as follows:

In short, Stoker and Castañeda stand for the general rule that an insured cannot recover policy benefits as damages for an insurer's extra-contractual violation if the policy does not provide the insured a right to those benefits. Vail announced a corollary rule: an insured who establishes a right to benefits under the policy can recover those benefits as actual damages resulting from a statutory violation. We clarify and affirm both of these rules today.

Under this corollary rule, it is clear that an insured my seek policy benefits for a statutory violation without alleging or proving an independent injury, so long as the insured is entitled to those policy benefits.

The Benefits-Lost Rule—"[A]n insured can recover benefits as actual damages under the Insurance Code even if the insured has no right to those benefits under the policy, if the insurer's conduct caused the insured to lose that contractual right." The Benefits-Lost Rule appears to have limited application. As the Court stated, it has "recognized this principle in the context of claims alleging that an insurer misrepresented a policy's coverage, waived its right to deny coverage or is estopped from doing so, or committed a violation that caused the insured to lose a contractual right to benefits that it otherwise would have had." In other words, if the insurer's statutory violation causes the loss of benefits, then the insured again may seek policy benefits as damages for extra-contractual claims without alleging or proving an independent injury.

The Independent-Injury Rule—"[A]n insurer's extra-contractual liability is 'distinct' from its liability for benefits under the insurance policy." The Court explained that there are two "aspects" of this rule: First, "if an insurer's statutory violation causes an injury independent of the insured's right to recover policy benefits, the insured may recover damages for that injury even if the policy does not entitle the insured to receive benefits." The "actual damages" recoverable under this scenario, however, must be "truly independent of the insured's right to receive policy benefits." The "second aspect" of the rule states that "an insurer's statutory violation does not permit the insured to recover any damages beyond policy benefits unless the violation causes an injury that is independent from the loss of the benefits." The Court recognized that a recoverable independent injury would be rare and refused to speculate regarding possible examples.

The No-Recovery Rule—"[A]n insured cannot recover any damages based on an insurer's statutory violation unless the insured establishes a right to receive benefits under the policy or an injury independent of a right to benefits." The last rule, a "natural corollary to the first four rules," appears uncontroversial—an insured cannot recover if they cannot establish damages, either in the form of policy benefits or an independent injury.

In short, the Supreme Court made clear that no independent injury is required to support an extra-contractual claim in a first-party case if the insured is entitled to policy benefits or if the insurer's actions caused the insured to lose policy benefits. The Court's summary sets out the

standards in their logical order:

We clarify today that an insured cannot recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits. An insured who establishes a right to receive benefits under the policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits. And an insured can recover benefits as actual damages under the Insurance Code even if the insured has no contractual right to those benefits if the insurer's conduct caused the insured to lose that right. If an insurer's statutory violation causes an injury independent of the insured's right to recover policy benefits, the insured may recover damages for that injury even if the insured is not entitled to receive benefits under the policy. But if the policy does entitle the insured to benefits, the insurer's statutory violation does not permit the insured to recover any actual damages beyond those policy benefits unless the violation causes an injury that is independent from the loss of the benefits. Finally, an insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

Having recognized the confusion in the law and having set out these clarifying rules, the Court remanded Menchaca's case for a new trial in the interest of justice.

Commentary

Vindication! Lee has been saying for years that Castañeda did not overturn Vail and that the Supreme Court of Texas did not require an independent injury for extra-contractual claims if the insurer wrongfully denied policy benefits. He claims to have predicted the other rules announced in Menchaca, but we think that's the pinot talking. How many insureds over the last twenty years were told by their lawyers and the courts that their extra-contractual claims had little or no merit because they could not prove any damages beyond the loss of policy benefits? Or if they could prove an independent damage, how many insureds did not pursue their valid claims because those damages, even when trebled, were insubstantial compared to the contractual damages? Menchaca represents a "reset" for policyholders and corrects the course of developments in this area of the law over the last couple of decades. Some commentators are already saying Menchaca is unwieldy or will present challenges in its application. Others are saying the ruling muddies the waters more than clarifies the issues and rules. The Supreme Court of Texas, however, has gone a long way in Menchaca toward clearing up this area of the law after twenty years of policyholders' claims being dismissed or never being made because of a misinterpretation of the law.

Sincerely,

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Member

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APPENDIX 9

2017 WL 1311752

Supreme Court of Texas.

USAA TEXAS LLOYDS COMPANY, Petitioner,

v.

Gail MENCHACA, Respondent

No. 14–0721

|

Argued October 11, 2016

|

Opinion delivered: April 7, 2017

Synopsis

Background: Insured sued insurer alleging breach of homeowner's policy, fraud, and violations of Insurance Code. Following jury finding that insurer did not fail to comply with policy with respect to claim for wind damage resulting from hurricane but did violate Insurance Code, the 9th District Court, Montgomery County, Fred Edwards, J., rendered judgment for insured. Insurer appealed. The Corpus Christi–Edinburg Court of Appeals, 2014 WL 3804602, affirmed as modified. Insurer petitioned for review.

Holdings: The Supreme Court, Boyd, J., held that:

[1] an insurer's violation of a duty to timely investigate a claim does not provide an exception to the general rule that an insured cannot recover policy benefits as actual damages for an insurer's violation of the Insurance Code if the insured does not have a right to those benefits under the policy, abrogating *Toonen v. United Servs. Auto Ass'n*, 935 S.W.2d 937, and

[2] remand was warranted in light of Supreme Court's confusing precedent.

Reversed and remanded.

ON PETITION FOR REVIEW FROM THE COURT OF APPEALS FOR THE THIRTEENTH DISTRICT OF TEXAS

Attorneys and Law Firms

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Opinion

Justice Boyd delivered the opinion of the Court.

***1** When this Court decides a case by announcing a rule of law, the decision serves as "binding precedent ... when the very point is again presented in a subsequent suit between different parties." *Swilley v. McCain*, 374 S.W.2d 871, 875 (Tex. 1964). Yet as one of history's most renowned jurists once observed, "seldom will it happen that any one rule will exactly suit with many cases." 3 WILLIAM BLACKSTONE, COMMENTARIES *335 (1765). We have similarly acknowledged that "it is at best difficult to avoid some uncertainties in the law because of the varying facts attending the different cases." *Trapp v. Shell Oil Co.*, 145 Tex. 323, 198 S.W.2d 424, 427 (1946). When our decisions create such uncertainties, "it is our duty to settle the conflicts in order that the confusion will as nearly as possible be set at rest." *Id.*

Today we endeavor to fulfill that duty in this case involving an insured's claims against her insurance company. The primary issue is whether the insured can recover policy benefits based on jury findings that the insurer violated the Texas Insurance Code and that the violation resulted in the insured's loss of benefits the insurer "should have paid" under the policy, even though the jury also failed to find that the insurer failed to comply with its obligations under the policy. Unfortunately, our precedent in this area has led to substantial confusion among other courts, and that confusion has permeated this case. In resolving this appeal, we seek to clarify our precedent by announcing five rules that address the relationship between contract claims under an insurance policy and tort claims under the Insurance Code. Ultimately, because the trial court and the parties lacked the clarity we provide today, and because their shared confusion prevented a proper resolution of these claims, we reverse the court of appeals' judgment and remand the case to the trial court for a new trial in the interest of justice.

I.

BACKGROUND

After Hurricane Ike struck Galveston Island in September 2008, Gail Menchaca contacted her homeowner's insurance company, USAA Texas Lloyds, and reported that the storm had damaged her home. USAA sent an adjuster to investigate Menchaca's claim, and the adjuster found only minimal damage. Based on the adjuster's findings, USAA determined that its policy covered some of the damage but declined to pay Menchaca any benefits because the total estimated repair costs did not exceed the policy's deductible.[1] About five months later, at Menchaca's request, USAA sent another adjuster to re-inspect the property. This adjuster generally confirmed the first adjuster's findings, and USAA again refused to pay any policy benefits. Menchaca sued USAA for breach of the insurance policy and for unfair settlement practices in violation of the Texas Insurance Code.[2] As damages for both claims, she sought only insurance benefits under the policy, plus court costs and attorney's fees.[3]

***2** The parties tried the case to a jury. Question 1 of the jury charge, which addressed Menchaca's breach-of-contract claim, asked whether USAA failed "to comply with the terms of the insurance policy with respect to the claim for damages filed by Gail Menchaca resulting from Hurricane Ike." The jury answered "No." Question 2, which addressed Menchaca's statutory claims, asked whether USAA engaged in various unfair or deceptive practices, including whether USAA refused "to pay a claim without conducting a reasonable investigation with respect to" that claim. As to that specific practice, the jury answered "Yes."[4] Question 3 asked the jury to determine Menchaca's damages that resulted from either USAA's failure to comply with the policy or its statutory violations, calculated as "the difference, if any, between the amount USAA should have paid Gail Menchaca for her Hurricane Ike damages and the amount that was actually paid."[5] The jury answered "$11,350."[6]

Both parties moved for judgment in their favor based on the jury's verdict. USAA argued that because the jury failed to find in its answer to Question 1 that USAA failed to comply with the policy's terms, Menchaca could not recover for "bad faith or extra-contractual liability as a matter of law." Menchaca argued that the court should enter judgment in her favor based on the jury's answers to Questions 2 and 3, neither of which was conditioned on a "Yes" answer to Question 1. The trial court disregarded Question 1 and entered final judgment in Menchaca's favor based on the jury's answers to Questions 2 and 3. The court of appeals affirmed, —— S.W.3d ——,[7] and we granted USAA's petition for review.

II.

RECOVERING POLICY BENEFITS FOR STATUTORY VIOLATIONS

[1] The parties agree that the damages the jury found in response to Question 3 represent the amount of insurance policy benefits the jury concluded USAA "should have paid" to Menchaca. USAA contends that Menchaca cannot recover any amount of policy benefits because the jury failed to find that USAA breached its obligations under the policy. Although the jury did find that USAA violated the Insurance Code, USAA contends that Menchaca cannot recover policy benefits based on that finding alone.[8] USAA primarily relies on *Provident American Insurance Co. v. Castañeda*, in which

we stated that an insurance company's "failure to properly investigate a claim is not a basis for obtaining policy benefits." 988 S.W.2d 189, 198 (Tex. 1998). Menchaca argues that the jury's findings that USAA violated the Code and that USAA "should have paid" Menchaca $11,350 sufficiently support the award of policy benefits. Menchaca primarily relies on *Vail v. Texas Farm Bureau Mutual Insurance Co.*, in which we stated that an insurer's "unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld." 754 S.W.2d 129, 136 (Tex. 1988).

***3** Courts and commentators have expressed confusion over our decisions in this area, and over our statements in *Castañeda* and *Vail* in particular.[9] The United States Court of Appeals for the Fifth Circuit, for example, recently concluded that *Castañeda* and other "decisions from the Supreme Court of Texas and Texas's intermediate appellate courts arguably cast doubt on *Vail*' s continued vitality." *In re Deepwater Horizon*, 807 F.3d 689, 698 (5th Cir. 2015). In the *Deepwater Horizon* panel's view, the Fifth Circuit interpreted *Castañeda* "as setting out the opposite rule from that in *Vail*." *Id.* (citing *Great Am. Ins. Co. v. AFS/IBEX Fin. Servs.*, 612 F.3d 800, 808 & n.1 (5th Cir. 2010)).[10] Today's case presents an opportunity to provide clarity regarding the relationship between claims for an insurance policy breach and Insurance Code violations. In light of the confusing nature of our precedent in this area, we begin by returning to the underlying governing principles. *See, e.g., U.S. v. New Mexico*, 455 U.S. 720, 733, 102 S.Ct. 1373, 71 L.Ed.2d 580 (1982) (concluding that "the confusing nature of our precedents counsels a return to the underlying constitutional principle").

[2] **[3]** The first of these principles is that an "insurance policy is a contract" that sets forth the respective rights and obligations to which an insurer and its insured have mutually agreed. *RSUI Indem. Co. v. The Lynd Co.*, 466 S.W.3d 113, 118 (Tex. 2015); *see also Tex. Ass'n of Ctys. Cty. Gov't Risk Mgmt. Pool v. Matagorda Cty.*, 52 S.W.3d 128, 131 (Tex. 2000) (noting that an "insurance policy ... defines the parties' rights and obligations"). Generally, we construe a policy using the same rules that govern the construction of any other contract. *See Ulico Cas. Co. v. Allied Pilots Ass'n*, 262 S.W.3d 773, 778 (Tex. 2008) (citing *Forbau v. Aetna Life Ins., Co.*, 876 S.W.2d 132, 133 (Tex. 1994)). An insurance policy, however, is a unique type of contract because an insurer generally "has exclusive control over the evaluation, processing[,] and denial of claims," and it can easily use that control to take advantage of its insured. *Arnold v. Nat'l Cty. Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987). Because of this inherent "unequal bargaining power," we concluded in *Arnold* that the "special relationship" between an insurer and insured justifies the imposition of a common-law duty on insurers to "deal fairly and in good faith with their insureds." *Id.*

[4] **[5]** **[6]** Similar to that common-law duty, the Insurance Code supplements the parties' contractual rights and obligations by imposing procedural requirements that govern the manner in which insurers review and resolve an insured's claim for policy benefits. *See, e.g.*, TEX. INS. CODE § 541.060(a) (prohibiting insurers from engaging in a variety of "unfair settlement practices"). The Code grants insureds a private action against insurers that engage in certain discriminatory, unfair, deceptive, or bad-faith practices, and it permits insureds to recover "actual damages ... caused by" those practices, court costs, and attorney's fees, plus treble damages if the insurer "knowingly" commits the prohibited act. *Id.* §§ 541.151, .152; *Tex. Mut. Ins. Co. v. Ruttiger*, 381 S.W.3d 430, 441 (Tex. 2012).[11] "Actual damages" under the Insurance Code "are those damages recoverable at common law," *State Farm Life Ins. Co. v. Beaston*, 907 S.W.2d 430, 435 (Tex. 1995) (citing *Brown v. Am. Transfer & Storage Co.*, 601 S.W.2d 931, 939 (Tex. 1980)), which include "benefit-of-the-bargain" damages representing "the difference between the value as represented and the value received," *Arthur Andersen & Co. v. Perry Equip. Corp.*, 945 S.W.2d 812, 817 (Tex. 1997) (citing *Leyendecker & Assocs., Inc. v. Wechter*, 683 S.W.2d 369, 373 (Tex. 1984)). But the Code does not create insurance coverage or a right to payment of benefits that does not otherwise exist under the policy. *See Lyons v. Millers Cas. Ins. Co. of Tex.*, 866 S.W.2d 597, 600 (Tex. 1993) (discussing the necessity of distinguishing bad-faith issues from "the contract issue of coverage").

***4** **[7]** **[8]** An insured's claim for breach of an insurance contract is "distinct" and "independent" from claims that the insurer violated its extra-contractual common-law and statutory duties. *See Liberty Nat'l Fire Ins. Co. v. Akin*, 927 S.W.2d 627, 629 (Tex. 1996) ("Insurance coverage claims and bad faith claims are by their nature independent."); *Twin City Fire Ins. Co. v. Davis*, 904 S.W.2d 663, 666

(Tex. 1995) (noting that a bad-faith claim is "distinct" from a suit for breach of the policy); *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995) ("[A] policy claim is independent of a bad faith claim."). A claim for breach of the policy is a "contract cause of action," while a common-law or statutory bad-faith claim "is a cause of action that sounds in tort." *Twin City*, 904 S.W.2d at 666; *see also Viles v. Sec. Nat'l Ins. Co.*, 788 S.W.2d 566, 567 (Tex. 1990) ("[A] breach of the duty of good faith and fair dealing will give rise to a cause of action in tort that is separate from any cause of action for breach of the underlying insurance contract."). But the claims are often "largely interwoven," and the same evidence is often "admissible on both claims." *Akin*, 927 S.W.2d at 630.

The primary question in this case is whether an insured can recover policy benefits as actual damages caused by an insurer's statutory violation absent a finding that the insured had a contractual right to the benefits under the insurance policy. Generally, the answer to this question is "no," but the issue is complicated and involves several related questions. In an effort to clarify these issues, we distill from our decisions five distinct but interrelated rules that govern the relationship between contractual and extra-contractual claims in the insurance context. First, as a general rule, an insured cannot recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits. Second, an insured who establishes a right to receive benefits under the insurance policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits. Third, even if the insured cannot establish a present contractual right to policy benefits, the insured can recover benefits as actual damages under the Insurance Code if the insurer's statutory violation caused the insured to lose that contractual right. Fourth, if an insurer's statutory violation causes an injury independent of the loss of policy benefits, the insured may recover damages for that injury even if the policy does not grant the insured a right to benefits. And fifth, an insured cannot recover *any* damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

A. The General Rule

The general rule is that an insured cannot recover policy benefits for an insurer's statutory violation if the insured does not have a right to those benefits under the policy. This rule derives from the fact that the Insurance Code only allows an insured to recover actual damages "caused by" the insurer's statutory violation. *See* TEX. INS. CODE § 541.151; *Minn. Life Ins. Co. v. Vasquez*, 192 S.W.3d 774, 780 (Tex. 2006). We first announced this rule in *Stoker*, 903 S.W.2d at 341. The insurer in *Stoker* relied on an invalid reason to deny the insureds' claim for benefits but later asserted a valid basis for denying the claim. *See id.* at 339. The insureds sued the insurer for breach of contract and for bad-faith denial of the claim, seeking only policy benefits as damages. *Id.* at 339–40. The trial court granted summary judgment for the insurer on the breach-of-contract claim because the policy did not cover the claim. *Id.* at 339. The jury, however, found the insurer liable on the extra-contractual claims, and based on that finding, the trial court awarded policy benefits as "extra-contractual damages." *Id.* at 339–40. The court of appeals affirmed, but we reversed and rendered judgment for the insurer. We explained that as "a general rule there can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered." *Id.* at 341. [12]

***5** Some courts have read *Stoker* to hold that no claim for *any kind of* bad-faith conduct can exist if the policy does not cover the claim. But *Stoker* involved only a claim for bad-faith denial of the insureds' claim for benefits. We clarified this point the following year in *Akin*: "While *Stoker* held that a judgment for the insurer on the coverage claim prohibits recovery premised only on bad faith *denial of a claim*, it does not necessarily bar *all claims for bad faith*." 927 S.W.2d at 631 (citing *Stoker,* 903 S.W.2d at 342) (emphases added). Thus, a more accurate statement of the rule we announced in *Stoker* is that "there can be no claim for bad faith [denial of an insured's claim for policy benefits] when an insurer has promptly denied a claim that is in fact not covered." *Stoker*, 903 S.W.2d at 341.

Although *Stoker* involved only a bad-faith-denial claim, we have since applied its general rule to other types of extra-contractual violations. In doing so, we have confirmed that the rule is based on the principle that an insured who sues an insurer for statutory violations can only recover damages "caused by" those violations. In *Progressive County Mutual Insurance Co. v. Boyd*, for example, the insured alleged that the insurer breached the policy and violated the Code and its common-law duty by failing to promptly pay his claim, failing to fairly investigate the claim, and denying the claim in

bad faith. 177 S.W.3d 919, 920, 922 (Tex. 2005) (per curiam). Because these extra-contractual claims were "predicated on [the] insurance policy and the accident being covered under the insurance policy," we held that the trial court's take-nothing judgment on the contract claim "negate[d]" the extra-contractual claims. *Id.* at 920–21. Specifically addressing the statutory prompt-payment claim, we explained that there "can be no liability [under the Code] if the insurance claim is not covered by the policy." *Id.* at 922. Similarly, in *Chrysler Insurance Co. v. Greenspoint Dodge of Houston, Inc.*, we quoted *Stoker*'s general rule and held that, because the insurer "did not breach the insurance contract, no basis supports" the insured's recovery of "punitive and extra-contractual damages." 297 S.W.3d 248, 253–54 (Tex. 2009) (per curiam). And in *State Farm Lloyds v. Page*, we said, "When the issue of coverage is resolved in the insurer's favor, extra-contractual claims do not survive," and there is "no liability under [the Insurance Code] if there is no coverage under the policy." 315 S.W.3d 525, 532 (Tex. 2010) (citing *Boyd*, 177 S.W.3d at 921). Most recently, in *JAW the Pointe, L.L.C. v. Lexington Insurance Co.*, we relied on *Stoker* for the proposition that when an insurance policy does not cover the insured's claim for benefits, "the insured cannot recover for the insurer's bad faith failure to effectuate a prompt and fair settlement of the claim." 460 S.W.3d 597, 599, 602 (Tex. 2015).

[9] In the present case, the jury found that USAA violated the Code by denying the claim without conducting a reasonable investigation. *See* TEX. INS. CODE § 541.060(a)(7) (providing that an insurer that "refus[es] to pay a claim without conducting a reasonable investigation with respect to the claim" commits an unfair settlement practice). In our early decisions, we mentioned this type of statutory violation but did not specifically address whether the general rule applies to such a claim. In *Stoker*, we expressly stated that the general rule should not "be understood as retreating from the established principles regarding the duty of an insurer to timely investigate its insureds' claims." 903 S.W.2d at 341. But we did not cite any authority for those "established principles." Instead, we merely noted, "These circumstances are not present in this case." *Id.* [13] That same year, we noted in *Twin City* that "some acts of bad faith, such as a *failure to properly investigate a claim* or an unjustifiable delay in processing a claim, do not *necessarily* relate to the insurer's breach of its contractual duties to pay covered claims, and may give rise to different damages." 904 S.W.2d at 666 n.3 (emphases added). The following year, we noted in *Akin* that the insured alleged that the insurer violated its statutory duties by failing to "properly investigate" the claim, 927 S.W.2d at 629, and we explained that the general rule "does not necessarily bar all claims for bad faith," *id.* at 631 (citing *Stoker*, 903 S.W.2d at 342), but we did not specifically address whether the general rule applies to an improper-investigation claim.

***6** We did address something akin to an improper-investigation claim, however, in *Castañeda*. The insured in that case sued her insurer alleging statutory violations "arising out of the denial of her claim for benefits under a health insurance policy and the manner in which her claim was handled." 988 S.W.2d at 191. But she did not assert a claim for breach of contract or seek a finding that the policy covered her claim. *Id.* at 196, 201. Instead, she argued that she was entitled to recover damages "*equivalent* to policy benefits" based on the jury's finding that the insurer violated the statute by failing to acknowledge communications about the claim and by failing "to adopt reasonable standards for investigating claims." *Id.* at 198 (emphasis added). We found no evidence that the insurer violated the statute in either manner. *Id.* at 192. We also explained that, even if there had been evidence of a violation, a "failure to properly investigate a claim is not a basis for obtaining policy benefits." *Id.* at 198 (citing *Stoker*, 903 S.W.2d at 341). We ultimately rendered judgment for the insurer because "no support in the evidence for any of the extra-contractual claims" existed and because the insured "did not plead and did not obtain a determination [that the insurer] was liable for breach of the insurance contract." *Id.* at 201. We held similarly in *Boyd*, 177 S.W.3d at 922. Because the claim there was predicated on the accident being covered under the insurance policy, when the trial court granted a take-nothing judgment on the insured's breach-of-contract claim, the insured's failure-to-fairly-investigate claim failed as well. *Id.* at 920–21; *see also In re Allstate Cnty. Mut. Ins. Co.*, 447 S.W.3d 497, 501 (Tex. App.–Houston [1st Dist.] 2014, orig. proceeding) (citing *Boyd* for the proposition that an "insurer generally cannot be liable for failing to settle or investigate a claim that it has no contractual duty to pay").

Here, Menchaca contends that she can recover policy benefits as damages resulting from USAA's statutory violation because that claim is independent from her claim for policy breach. The court of appeals agreed,

reasoning that the statute "imposes a duty on an insurer, above and beyond the duties established by the insurance policy itself, to conduct a reasonable investigation prior to denying a claim," and thus "USAA could have fully complied with the contract even if it failed to reasonably investigate Menchaca's claim." —— S.W.3d ——. While we agree with the court's premise that USAA could have complied with the policy even if it failed to reasonably investigate the claim, we reject its conclusion just as we expressly rejected it in *Stoker*. Although we accepted the argument's premise that "a policy claim is independent of a bad faith claim," we found that the "asserted conclusion ... does not necessarily follow," at least when the claim seeks benefits "not covered by the policy." *Id.* at 340–41.

The reason we reject Menchaca's independent-claims argument—indeed, the very reason for the general rule—derives from the fact that the Insurance Code only allows an insured to recover actual damages "caused by" the insurer's statutory violation. TEX. INS. CODE § 541.151. "Actual damages" are the common-law damages the insured sustains "as a result of" the statutory violation. *Kish v. Van Note*, 692 S.W.2d 463, 466 (Tex. 1985) (citing *Smith v. Baldwin*, 611 S.W.2d 611, 617 (Tex. 1980)). If the insurer violates a statutory provision, that violation—at least generally [14]—cannot cause damages in the form of policy benefits that the insured has no right to receive under the policy. We acknowledged this reasoning in *Castañeda*, noting that the "concurring Justices in *Stoker* agreed that the manner in which a claim is investigated must be the proximate cause of damages before there could be a recovery." 988 S.W.2d at 198 (citing *Stoker*, 903 S.W.2d at 345 (Spector, J., concurring)). [15] We held that, in the absence of a finding that the insurer had breached the policy, the insured could not recover any damages because none of the insurer's alleged statutory violations "was the producing cause of any damage separate and apart from those that would have resulted from a wrongful denial of the claim." *Id.* Because the insured only sought damages that "flow[ed]" and "stemmed from the denial of benefits," *id.* at 198, 199, she could not recover anything because she "did not plead and did not obtain a determination [that the insurer] was liable for breach of the insurance contract." *Id.* at 201. [16]

***7** Relying on these decisions, USAA contends that the general rule applies here and Menchaca cannot recover policy benefits based on a statutory violation because the jury failed to find that USAA "breached" the insurance contract. In response, Menchaca argues that she can avoid the general rule by obtaining a finding that the policy "covers" her losses, and she did not have to obtain a finding that USAA "breached" the policy to recover under the statute. Our precedent is confusing on this point because we have actually used both phrases to describe the general rule. *See, e.g., JAW the Pointe*, 460 S.W.3d at 599 (holding that insured could not recover benefits as statutory damages because "the policy *did not cover* the insured's losses") (emphasis added); *Page*, 315 S.W.3d at 532 ("There can be no liability under [the Insurance Code] if there is *no coverage* under the policy.") (emphasis added); *Chrysler*, 297 S.W.3d at 254 (holding that insured could not recover extra-contractual damages because the insurer "*did not breach* the insurance contract") (emphasis added); *Boyd*, 177 S.W.3d at 920–21 (concluding that a take-nothing judgment on a breach-of-contract claim negated recovery of benefits as statutory damages); *Castañeda*, 988 S.W.2d at 201 (holding that insured could not recover statutory damages "equivalent to policy benefits" because she did not plead or establish that the insurer "was *liable for breach* of the insurance contract") (emphasis added); *Stoker*, 903 S.W.2d at 341 ("[T]here can be no claim for bad faith when an insurer has promptly denied a claim that is in fact *not covered*.") (emphasis added).

In one sense, no relevant distinction exists between "breach" and "coverage" in this context because no breach can occur unless coverage exists, and if there is coverage, there is necessarily a breach if the insurer fails to pay the amount covered. If the policy does not cover the insured's loss, the insurer does not breach the policy by failing to pay benefits for that loss, because the insured is not entitled to those benefits. Conversely, if the policy does cover the loss, the insurer necessarily breaches the policy if it fails to pay benefits for the loss because the insured is entitled to those benefits. In another sense, however, an important distinction does exist because USAA contends that Menchaca could not recover policy benefits unless she prevailed on her breach-of-contract claim. According to USAA, in other words, an insured can never recover policy benefits as damages for a statutory violation.

We disagree. Although our prior decisions refer interchangeably to both "breach" and "coverage," our focus in those cases was on whether the insured was

entitled to benefits under the policy, because an insurer's statutory violation cannot "cause" the insured to suffer the loss of benefits unless the insured was entitled to those benefits. Thus, although we have referred to both "breach" and "coverage," what matters for purposes of causation under the statute is whether the insured was entitled to receive benefits under the policy. While an insured cannot recover policy benefits for a statutory violation unless the jury finds that the insured had a right to the benefits under the policy, the insured does not *also* have to establish that the insurer breached the policy by refusing to pay those benefits. As we explain further in the following section, if the jury finds that the policy entitles the insured to receive the benefits and that the insurer's statutory violation caused the insured to not receive those benefits, the insured can recover the benefits as "actual damages ... caused by" the statutory violation. *See* TEX. INS. CODE § 541.151.

[10] Nevertheless, an insurer's obligation to pay policy benefits and the insured's right to receive them derive solely from the insurance policy's terms: "If the loss is covered, then the insurer is obligated to pay the claim according to the terms of the insurance contract." *Moriel,* 879 S.W.2d at 17. Because an insurer's statutory violation permits an insured to receive only those "actual damages" that are "caused by" the violation, we clarify and affirm the general rule that an insured cannot recover policy benefits as actual damages for an insurer's statutory violation if the insured has no right to those benefits under the policy.

B. The Entitled-to-Benefits Rule

The second rule from our precedent is that an insured who establishes a right to receive benefits under an insurance policy can recover those benefits as "actual damages" under the statute if the insurer's statutory violation causes the loss of the benefits. This rule, a logical corollary to the general rule, is what we recognized in *Vail*. The insureds in *Vail* sued their insurer for common-law bad faith and statutory violations (but not for breach of contract), alleging a "bad faith failure to pay the claim" and seeking "the full amount" of policy benefits plus statutory damages. 754 S.W.2d at 130. The jury found that the insurer violated the statute by failing to "attempt [ ] in good faith to effectuate a prompt, fair, and equitable settlement" when "liability had become reasonably clear," and breached its common-law duty of good faith and fair dealing by failing "to exercise good faith in the investigation and processing of the claim." *Id.* at 134. Based on these findings, the trial court awarded benefits in the amount of the "full policy limit" plus treble that amount, attorney's fees, and prejudgment interest. *Id.* at 131.

***8** The insurer argued that the insureds could not recover policy benefits as damages for statutory violations because "the amount due under the policy solely represents damages for breach of contract and does not constitute actual damages in relation to a claim of unfair claims settlement practices." *Id.* at 136. We rejected that argument and held that "an insurer's unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld." *Id.* We explained that the insureds "suffered a *loss* ... for which they were entitled to make a claim under the insurance policy," and that loss was "transformed into a legal *damage*" when the insurer "wrongfully denied the claim." *Id.* "That damage," we held, "is, at minimum, the amount of policy proceeds wrongfully withheld by" the insurer. *Id.* Because the Insurance Code provides that the statutory remedies are cumulative of other remedies, we concluded that the insureds could elect to recover the benefits under the statute even though they also could have asserted a breach-of-contract claim. *Id.*

USAA contends, and some Texas courts have concluded, that we later rejected the *Vail* rule in *Castañeda* and *Stoker*, and thus an insured can never recover policy benefits as actual damages for statutory or common-law bad-faith violations. *See, e.g., Mai v. Farmers Tex. Cnty. Mut. Ins. Co.*, 2009 WL 1311848, at *6 (Tex. App.–Houston [14th Dist.] May 7, 2009, pet. denied) (mem. op.) ("This position, that expected policy benefits can equate to bad faith damages, has been firmly rejected by the Texas Supreme Court."). The United States Court of Appeals for the Fifth Circuit reached the same conclusion in *Parkans International, LLC v. Zurich Insurance Co.*, holding that, in light of *Castañeda*, there "can be no recovery for extra-contractual damages for mishandling claims unless the complained of actions or omissions caused injury independent of those that would have resulted from a wrongful denial of policy benefits." 299 F.3d 514, 519 (5th Cir. 2002). The Fifth Circuit later relied on *Parkans* to reject an insured's argument that "it did not need to prove a separate injury in order to maintain its extra-contractual claims" because the insurer's "denial of insurance proceeds, standing alone, entitled it to recover

on its extra-contractual claims." *Great Am. Ins. Co. v. AFS/IBEX Fin. Servs., Inc.*, 612 F.3d 800, 808 n.1 (5th Cir. 2010). [17]

We did not reject the *Vail* rule in *Stoker* or in *Castañeda*. While we could have made the point more clearly, the distinction between the cases is that the parties in *Vail* did not dispute the insured's entitlement to the policy benefits, and the only issue was whether the insured could recover those benefits as statutory damages. *Vail*, 754 S.W.2d at 136. The rule we announced in *Vail* was premised on the fact that the policy undisputedly covered the loss in that case, and the insurer therefore "*wrongfully* denied" a "*valid* claim." *Id.* at 136–37 (emphases added). [18] If an insurer's "wrongful" denial of a "valid" claim for benefits results from or constitutes a statutory violation, the resulting damages will necessarily include "at least the amount of the policy benefits wrongfully withheld." *Id.* at 136. We confirmed this reading of *Vail* and reaffirmed the general rule in *Twin City*, 904 S.W.2d at 666. There, we explained that "*Vail* was only concerned with the insurer's argument that policy benefits *improperly withheld* were not 'actual damages in relation to a claim of unfair claims settlement practices.' " *Id.* (emphasis added) (quoting *Vail*, 754 S.W.2d at 136). We further explained that the Court rejected the insurer's argument in *Vail* because "policy benefits *wrongfully withheld* were indeed actual damages" under the statute. *Id.* (emphasis added).

***9** By contrast, in *Castañeda*, the insured did not establish and the insurer did not concede that the insured had a right to benefits under the policy. To the contrary, the insured "never sought and did not receive any contractual relief," *Castañeda*, 988 S.W.2d at 196, and never even alleged that the insurer "was liable for breach of the insurance contract," *id.* at 201. Instead, she sought only to recover damages "*equivalent* to policy benefits" based solely on her statutory claims that the insurer failed to acknowledge communications about her claim and failed to "adopt reasonable standards for investigating claims." *Id.* at 198 (emphasis added). We expressly refused to provide any opinion on "whether there was contractual coverage." *Id.* at 196. We first addressed whether any evidence existed that the insurer violated the statute or its common-law duties, and in deciding that issue we concluded that, even *assuming* that there was coverage, the mere existence of coverage would not prove that the insurer violated the statute or its common-law duties by denying the claim. *Id.* at 196–97. We made no such assumption, however, when we later addressed the insured's separate argument regarding "the damages that might be recoverable if an insurer failed to adequately investigate a claim." *Id.* at 198. On that issue, we held that an insurer's "failure to properly investigate a claim is not a basis for obtaining policy benefits," but we did not assume that coverage existed when deciding that separate issue. *Id.* Instead, we relied on the fact that the insured "did not plead and did not obtain a determination [that the insurer] was liable for breach of the insurance contract." *Id.* at 198, 201.

[11] **[12]** In short, *Stoker* and *Castañeda* stand for the general rule that an insured cannot recover policy benefits as damages for an insurer's extra-contractual violation if the policy does not provide the insured a right to those benefits. *Vail* announced a corollary rule: an insured who establishes a right to benefits under the policy can recover those benefits as actual damages resulting from a statutory violation. We clarify and affirm both of these rules today.

C. The Benefits–Lost Rule

A third rule that our precedent recognizes is the rule that an insured can recover benefits as actual damages under the Insurance Code even if the insured has no right to those benefits under the policy, *if the insurer's conduct caused the insured to lose that contractual right*. We have recognized this principle in the context of claims alleging that an insurer misrepresented a policy's coverage, waived its right to deny coverage or is estopped from doing so, or committed a violation that caused the insured to lose a contractual right to benefits that it otherwise would have had. In each of these contexts, the insured can recover the benefits even though it has no contractual right to recover them because the benefits are actual damages "caused by" the insurer's statutory violation.

[13] In the first context, we have recognized that an insurer that violates the statute by misrepresenting that its policy provides coverage that it does not in fact provide can be liable under the statute for such benefits if the insured is "adversely affected" or injured by its reliance on the misrepresentation. *See Royal Globe Ins. Co. v. Bar Consultants, Inc.*, 577 S.W.2d 688, 694 (Tex. 1979). [19] Although the policy does not give the insured a contractual right to receive the benefits, the insurer's misrepresentation of the policy's coverage constitutes a statutory violation that causes actual damages in the

amount of the benefits that the insured reasonably believed she was entitled to receive. *Id.* When, for example, a health insurer's agent represented that a policy "offered full coverage without qualification" for preexisting medical conditions, and the insured reasonably relied on that representation, the insured could recover the full coverage even though the policy actually limited such coverage to a specific maximum amount. *Kennedy v. Sale*, 689 S.W.2d 890, 891–92 (Tex. 1985); *see also Tapatio Springs Builders Inc. v. Md. Cas. Ins. Co.*, 82 F.Supp.2d 633, 647 (W.D. Tex. 1999) ("A misrepresentation claim is independent, and may exist in the absence of coverage. To allege a misrepresentation claim under the DTPA, a plaintiff must plead a misrepresentation that caused actual damages.") (citing TEX. BUS. & COM. CODE § 17.5(a); *Castañeda*, 988 S.W.2d at 199–200); *In re Allstate Cnty. Mut. Ins. Co.*, 447 S.W.3d 497, 502 (Tex. App.–Houston [1st Dist.] 2014, orig. proceeding) ("[M]isrepresentation claims ... are not dependent upon a determination that [the insurer] has a contractual duty to pay ... benefits to the [insureds], and will not be rendered moot if [the insurer] prevails on the breach of contract claim.") (citing TEX. BUS. & COM. CODE §§ 17.46(b)(5), (b)(12); TEX. INS. CODE §§ 541.061(3)–(5)).

***10** **[14]** The second context in which the benefits-lost rule might apply involves claims based on waiver and estoppel. We have explained that waiver and estoppel cannot be used to re-write a policy so that it provides coverage it did not originally provide. *Ulico*, 262 S.W.3d at 775. But if the insurer's statutory violations prejudice the insured, the insurer may be estopped "from denying benefits that would be payable under its policy as if the risk had been covered." *Id.* Under such circumstances, the insured may recover "any damages it sustains because of the insurer's actions," even though the policy does not cover the loss. *Id.* at 787.

Finally, the benefits-lost rule may apply when the insurer's statutory violation actually caused the policy not to cover losses that it otherwise would have covered. *See, e.g., JAW the Pointe,* 460 S.W.3d at 602. The insured in *JAW the Pointe* sought policy benefits to cover its costs to demolish and rebuild an apartment complex that sustained significant damage from Hurricane Ike. *See id.* at 599. The primary insurance policy covered three hundred otherwise unrelated apartment complexes but limited the total coverage to $25 million per occurrence. *Id.* When the insurer denied the insured's claim for some of the losses, the insured filed suit asserting claims for both breach of contract and statutory violations. *Id.* at 601. As the parties continued efforts to resolve their dispute, the insurer continued paying claims filed by the other covered apartment complexes until the insurer reached the policy's $25 million limit. *Id.* The insurer then filed for summary judgment on the insured's contract claim, arguing that it no longer had a contractual duty to cover the losses because it had paid the policy limits. *Id.* at 600. The insured did not oppose the motion and the trial court granted it, leaving only the statutory claims for trial. *Id.* A jury found that the insurer had violated the statute, and based on the statutory violations the trial court awarded the insured both actual damages in the form of the policy benefits and additional statutory damages based on the insurer's "bad faith" statutory violations. *Id.* at 601–02.

[15] The insurer appealed, arguing that the insured could not recover policy benefits or statutory damages because the policy did not cover the insured's losses. *See id.* at 602. But instead of relying on the policy limits to defeat coverage, the insurer argued that the policy never covered the losses even before the insurer paid out the limits because a policy exclusion applied and negated any coverage. *See id.* We acknowledged that as "a general rule there can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered." *Id.* (quoting *Stoker,* 903 S.W.2d at 341) (internal quotation marks omitted). But we also noted that the insured argued that "the policy covered [the insured's losses] and [the insurer] should have paid those costs before it made other payments that exhausted the policy limits." *Id.* In other words, the insured argued that, although it could no longer prevail on its breach-of-contract claim because the insurer had paid out its policy limits, the insurer's statutory violations caused the insured to lose its contractual right to the policy benefits by delaying the payments until after the limits had been reached. We accepted this argument, but ultimately concluded that the insured was never entitled to the policy benefits because the exclusion negated any coverage under the policy. Because the policy "excluded coverage for [the insured's] losses, [the insured] cannot recover against [the insurer] on its statutory bad-faith claims." *Id.* at 610. Put simply, an insurer that commits a statutory violation that eliminates or reduces its contractual obligations cannot then avail itself of the general rule.

D. The Independent–Injury Rule

***11** The fourth rule from our precedent derives from the fact that an insurer's extra-contractual liability is "distinct" from its liability for benefits under the insurance policy. *See Aranda v. Ins. Co. of N. Am.*, 748 S.W.2d 210, 214 (Tex. 1988), *overruled on other grounds by Ruttiger*, 381 S.W.3d at 441. In *Stoker*, after we announced the general rule that "there can be no claim for bad faith when an insurer has promptly denied a claim that is in fact not covered," we explained that we were not excluding "the possibility that in denying the claim, the insurer may commit some act, so extreme, that would cause injury independent of the policy claim." 903 S.W.2d at 341 (citing *Aranda,* 748 S.W.2d at 214).

[16] **[17]** **[18]** There are two aspects to this independent-injury rule. The first is that, if an insurer's statutory violation causes an injury independent of the insured's right to recover policy benefits, the insured may recover damages for that injury even if the policy does not entitle the insured to receive benefits. *Id.* We recognized this in *Twin City*, explaining that some extra-contractual claims may not "relate to the insurer's breach of contractual duties to pay covered claims" and may thus "give rise to different damages." 904 S.W.2d at 666 n.3. If such damages result from an independent injury "caused by" the insurer's statutory violation, the insured can recover those damages, just as insureds have always been able to recover "compensatory damages for the tort of bad faith" under the common law. *Moriel*, 879 S.W.2d at 17. Thus, an insured can recover actual damages caused by the insurer's bad-faith conduct if the damages "are separate from and ... differ from benefits under the contract." *Twin City*, 904 S.W.2d at 666 (identifying mental anguish damages as an example). We reaffirmed this aspect of the independent-injury rule in *Castañeda*, recognizing that "there might be liability for damage to the insured other than policy benefits or damages flowing from the denial of the claim if the insured mishandled a claim." 988 S.W.2d at 198. We concluded that the insured could not recover anything in that case, however, because "none of the [insurer's] actions or inactions ... was the producing cause of any damage separate and apart from those that would have resulted from a wrongful denial of the claim." *Id.*

This aspect of the independent-injury rule applies, however, only if the damages are truly independent of the insured's right to receive policy benefits. It does not apply if the insured's statutory or extra-contractual claims "are predicated on [the loss] being covered under the insurance policy," *Boyd*, 177 S.W.3d at 920, or if the damages "flow" or "stem" from the denial of the claim for policy benefits, *see Castañeda*, 988 S.W.2d at 198–99. When an insured seeks to recover damages that "are predicated on," "flow from," or "stem from" policy benefits, the general rule applies and precludes recovery unless the policy entitles the insured to those benefits. *See Boyd*, 177 S.W.3d at 920–22 (concluding that insured's common-law conversion claim, common-law bad-faith claim, and statutory claims were all "negated" because policy did not cover underlying losses and insured did "not allege that he suffered any damages unrelated to and independent of the policy claim"); *Castañeda*, 988 S.W.2d at 199 (holding that insured could not recover damages for loss of credit reputation because any such loss "stemmed from the denial of benefits" that were not owed under the policy).

[19] The second aspect of the independent-injury rule is that an insurer's statutory violation does not permit the insured to recover *any* damages beyond policy benefits unless the violation causes an injury that is independent from the loss of the benefits. Thus, we held in *Twin City* that an insured who prevails on a statutory claim cannot recover punitive damages for bad-faith conduct in the absence of independent actual damages arising from that conduct. 904 S.W.2d at 666; *see also Powell Elec. Sys., Inc. v. Nat'l Union Fire Ins. Co.*, 2011 WL 3813278, at *9 (S.D. Tex. Aug. 29, 2011) (granting summary judgment for the insured on its breach-of-contract claim but for the insurer on common-law and statutory bad-faith claims because the insured "failed to allege damage independent of the damages arising from the underlying breach of the insurance contract").

***12** Our reference in *Stoker* to "the possibility" that a statutory violation could cause an independent injury suggested that a successful independent-injury claim would be rare, and we in fact have yet to encounter one. *See, e.g., Mid–Continent Cas. Co. v. Eland Energy, Inc.*, 709 F.3d 515, 521–22 (5th Cir. 2013) ("The *Stoker* language has frequently been discussed, but in seventeen years since the decision appeared, no Texas court has yet held that recovery is available for an insurer's extreme act, causing injury independent of the policy claim ...."). This is likely because the Insurance Code offers procedural protections against misconduct likely to lead to an improper denial of benefits and little else. *See, e.g.*, TEX. INS. CODE § 541.060 (prohibiting an insurer from "requiring a claimant as a condition of settling a claim

to produce the claimant's federal income tax returns"). We have further limited the natural range of injury by insisting that an "independent injury" may not "flow" or "stem" from denial of policy benefits. *See Castañeda*, 988 S.W.2d at 198. Today, although we reiterate our statement in *Stoker* that such a claim could exist, we have no occasion to speculate what would constitute a recoverable independent injury.

E. The No–Recovery Rule

[20] The fifth and final rule is simply the natural corollary to the first four rules: An insured cannot recover *any* damages based on an insurer's statutory violation unless the insured establishes a right to receive benefits under the policy or an injury independent of a right to benefits. *Castañeda*, 988 S.W.2d at 198; *see also Lundstrom v. United Servs. Auto. Ass'n–CIC*, 192 S.W.3d 78, 96 (Tex. App.–Houston [14th Dist.] 2006, pet. denied) (rendering judgment for insurer because policy did not cover claim and insureds "have not alleged any act so extreme as to cause an injury independent of [the insurer's] denial of their policy claim"); *Bailey v. Progressive Cnty. Mut. Ins. Co.*, 2004 WL 1193917, at *1 (Tex. App.–Dallas June 1, 2004, no pet.) (mem. op., not designated for publication) (rendering judgment against insureds because policy did not cover claim and insureds demonstrated no "independent injury arising from" statutory violations); *see also Alaniz v. Sirius Int'l Ins. Corp.*, 626 Fed.Appx. 73, 79 (5th Cir. 2015) (per curiam) (citing *Boyd*, 177 S.W.3d at 922) (affirming summary judgment for insurer on all claims because no coverage or breach and insured put forth no evidence of "extreme conduct or of damages suffered independent of those that would have resulted from an alleged wrongful denial of his claim").

F. Summary

We clarify today that an insured cannot recover policy benefits as damages for an insurer's statutory violation if the policy does not provide the insured a right to receive those benefits. An insured who establishes a right to receive benefits under the policy can recover those benefits as actual damages under the Insurance Code if the insurer's statutory violation causes the loss of the benefits. And an insured can recover benefits as actual damages under the Insurance Code even if the insured has no contractual right to those benefits if the insurer's conduct caused the insured to lose that right. If an insurer's statutory violation causes an injury independent of the insured's right to recover policy benefits, the insured may recover damages for that injury even if the insured is not entitled to receive benefits under the policy. But if the policy does entitle the insured to benefits, the insurer's statutory violation does not permit the insured to recover any actual damages beyond those policy benefits unless the violation causes an injury that is independent from the loss of the benefits. Finally, an insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy and sustained no injury independent of a right to benefits.

III.

MENCHACA'S CLAIMS AGAINST USAA

Having clarified the governing rules, we now turn to the case before us. As explained above, the jury in this case (1) failed to find that USAA failed to comply with its obligations under the insurance policy; (2) found that USAA violated the Insurance Code by failing to reasonably investigate Menchaca's claim for policy benefits; and (3) found that USAA's statutory violation resulted in damages of $11,350, representing the amount of policy benefits USAA "should have paid" Menchaca. Ever since the jury returned its verdict, the parties have disputed the effect of these findings. Relying on the jury's answer to Question 1 and on its misunderstanding of the general rule, USAA contends that Menchaca cannot recover any policy benefits because the jury failed to find that USAA "breached" its obligations under the policy. Relying on the jury's answers to Questions 2 and 3 and on her misunderstanding of *Vail*'s holding that damages under the Insurance Code were "at minimum, the amount of policy proceeds wrongfully withheld," 754 S.W.2d at 136, Menchaca contends that she can recover the policy benefits because the jury found that USAA violated the statute and the violation caused damages in the form of policy benefits USAA "should have paid" to Menchaca.

***13** The trial court resolved the parties' dispute by disregarding the jury's answer to Question 1, and USAA argues that the court erred by doing so. We agree. As a result, we are left to decide the effect of the jury's answers based on arguments the parties have made without the benefit of the clarifications we have provided today. Under these circumstances, and because we have found it necessary to clarify the confusion resulting from our

decisions, we conclude that it is proper to remand the case for a new trial in the interest of justice.

A. Disregarding Question 1

After the jury returned its verdict, both parties accepted it without objection, and the trial court dismissed the jury. Both parties then filed motions for judgment in their favor based on the jury's verdict. Relying primarily on *Stoker* and *Castañeda*, USAA argued that Menchaca could not recover any damages based on the jury's finding of a statutory violation because the jury failed to find that USAA had "breached" the policy in answer to Question 1. Relying primarily on *Vail* and on the jury's answers to Questions 2 and 3, Menchaca argued that she could recover the amount of policy benefits the jury found because "the jury found there was coverage," even if she failed to find that USAA breached the contract. Although neither party argued that the jury's answers created a conflict, the trial court believed they did. Instead of considering how to address and resolve the conflict, however, the court decided to disregard Question 1 because it found the question to be "poorly worded" and "incomprehensible." Specifically, the court explained that Question 1:

> says, "Breach of contract," but it doesn't say what kind of breach.[20] It doesn't even explain breach of contract. It doesn't even give a definition for breach of contract. There's all kinds of other things that should have been put in there about what's material breach, definition of material breach. The question fails altogether. It shouldn't have been submitted in the first place. If you remember correctly, I didn't want that question submitted. But it was insisted upon by the plaintiffs, so they've got to reap what they sow. But I think that I can easily ignore question number one as being incomprehensible to a layman and that it has no effect. I can go with what I wanted to go with in the first place which was question number two, damage question, then attorney's fees. That's what I'm going to do. I'm going to ignore question number one entirely because I think it was poorly worded.

The court of appeals affirmed the trial court's decision to disregard Question 1, but for different reasons. First, the court concluded that it was impossible to know why the jury answered "No" to the question. *See* —— S.W.3d at ——. In the court's view, the jury could have answered "No" because it mistakenly believed that USAA could only "fail to comply with the terms of the insurance policy" if it failed to pay the amount that USAA *subjectively* believed it had to pay. *See id.* Second, it concluded that the jury's "No" answer to Question 1 did not "definitively establish that there was no coverage," because USAA agreed that the policy provided coverage for Menchaca's losses and instead only contended that the amount of the losses did not exceed the policy's deductible. *See id.* Finally, the court concluded that the jury's finding in answer to Question 2 that USAA violated the statute rendered its answer to Question 1 immaterial because Question 3 "instructed the jury to award the same damages regardless of which theory of liability was adopted." *See id.*

***14** **[21]** **[22]** We conclude that the trial court erred by disregarding the jury's answer to Question 1. "A trial court may disregard a jury finding only if it is unsupported by evidence ... or if the issue is immaterial." *Spencer v. Eagle Star Ins. Co. of Am.*, 876 S.W.2d 154, 157 (Tex. 1994) (citing *C. & R. Transp., Inc. v. Campbell*, 406 S.W.2d 191, 194 (Tex. 1966)). Contrary to the court of appeals' conclusion, the fact that the court cannot determine the reasons for a jury's answer does not permit the court to disregard that answer. Here, the jury's answer to Question 1 was neither unsupported by the evidence nor immaterial.

First, in light of USAA's evidence that Menchaca's damages were less than the amount of her deductible, at least some evidence supported the jury's finding that USAA did not fail to comply with its obligations under the policy. Although USAA did not dispute that the policy provided "coverage" for some of Menchaca's damages, it provided evidence that the amount of her loss was less than the policy's deductible, and that evidence supports the jury's failure to find that USAA "failed to comply" with its obligations under the policy.[21]

[23] **[24]** Second, Question 1 was not immaterial. A jury finding is immaterial when the question "should not have been submitted, or when it was properly submitted but has been rendered immaterial by other findings." *Spencer*, 876 S.W.2d at 157 (citing *C. & R. Transp.*, 406 S.W.2d at 194). Contrary to the trial court's conclusion, the fact that a question is defective does not render the jury's answer immaterial. *See id.* (concluding that, "while [a question] was defective, it was not immaterial."). Question 1 was material because Menchaca sued USAA for breach of the insurance policy as well as for statutory violations, and she sought to recover on either claim. The jury's answers to Questions 2 and 3 did not render its "No" answer to Question 1 immaterial because that answer was necessary to resolve Menchaca's breach-of-contract claim. We therefore conclude that the court of appeals erred by affirming the trial court's decision to disregard the jury's answer to Question 1.

B. Reversal and Remand in the Interest of Justice

[25] **[26]** Having concluded that the trial court and court of appeals erred in disregarding the jury's answer to Question 1, we will reverse the judgment in Menchaca's favor. In the interest of justice, however, we may "remand the case to the trial court even if a rendition of judgment is otherwise appropriate." TEX. R. APP. P. 60.3. Such a remand is particularly appropriate when it appears that one or more parties "proceeded under the wrong legal theory," *Boyles v. Kerr*, 855 S.W.2d 593, 603 (Tex. 1993), especially when "the applicable law has ... evolved between the time of trial and the disposition of the appeal." *Natural Gas Pipeline Co. of Am. v. Justiss*, 397 S.W.3d 150, 162 (Tex. 2012); *see also Hamrick v. Ward*, 446 S.W.3d 377, 385 (Tex. 2014) (remanding in the interest of justice "in light of our clarification of the law"); *Moriel*, 879 S.W.2d at 26 (same, in light of our "substantial clarification"). In light of the parties' obvious and understandable confusion over our relevant precedent and the effect of that confusion on their arguments in this case, we conclude that a remand is necessary here in the interest of justice.

***15** Specifically, USAA has steadfastly maintained that Menchaca cannot recover policy benefits for a statutory violation unless she also obtains a finding that USAA "breached" the insurance policy or that USAA's statutory violation caused an injury independent of her right to benefits. At trial, USAA objected to the charge's failure to condition Question 2 on a "Yes" finding to Question 1 and objected to the submission of Question 3 on the ground that "Texas courts have held that extra[-]contractual damages need to be independent from policy damages." After the jury returned its verdict, USAA argued that it should prevail because "the jury found 'NO' breach of contract" and awarded only policy benefits "for repairs to the property which Plaintiff and her experts testified were proximately caused by Hurricane Ike." After the trial court entered its judgment, USAA argued in its motion for new trial that Menchaca cannot recover in the absence of a finding of breach because she did not seek damages "separate and apart from those sought under the breach of contract theory." Although we have clarified today that Menchaca did not have to prevail on her breach-of-contract claim to recover policy benefits for a statutory violation, the confusing nature of our precedent precludes us from faulting USAA for the position it has maintained throughout this litigation.

Meanwhile, Menchaca has consistently argued that she can recover, even in the absence of a finding of "breach," based on the jury's findings in answer to Questions 2 and 3 that USAA violated the statute and that the violation "caused" Menchaca to incur damages in the form of policy benefits that USAA "should have paid." In support of its motion for judgment on the verdict, Menchaca argued that through these answers "the jury found there was coverage," and that finding supported the judgment even though the jury failed to find a "material breach." Before us, Menchaca argues that the jury "did not find that [she] suffered no covered losses or that USAA paid for all Menchaca's covered losses," but in fact "found the contrary" in response to Question 3, "finding that USAA failed to pay $11,350 it should have paid (and would have paid but for its unreasonable investigation) in accordance with the policy." As with USAA's arguments, we conclude that the confusing nature of our precedent precludes us from faulting Menchaca for asserting throughout this litigation that she did not have to prove breach.

In their briefing to this Court, the parties make additional arguments regarding such issues as whether USAA adequately objected to the jury charge; whether the jury's answer to Question 1 established that Menchaca was not entitled to any benefits under the policy; whether the answer to Question 2 established that USAA breached the policy; whether the answer to Question 3 established that the policy entitled Menchaca to receive $11,350 in benefits; whether the jury's answers irreconcilably conflict; and if

so, whether and how we can resolve that conflict. We conclude that the parties' confusion about our precedent has affected these arguments as well, to such an extent that justice requires that we remand the case for a new trial without addressing them.

IV.

CONCLUSION

The trial court erred by disregarding the jury's answer to Question 1, and the court of appeals erred by affirming the trial court's judgment. In light of the confusion that our precedent caused in the litigation and appeal of this case, we reverse the court of appeals' judgment and remand this case in the interest of justice for a new trial consistent with the rules we have clarified today.

Justice Johnson did not participate in the decision.

All Citations

--- S.W.3d ----, 2017 WL 1311752, 60 Tex. Sup. Ct. J. 672

Footnotes

1 The policy's declaration page provides that the policy covers “only that part of the loss over the deductible stated,” and then lists the deductible amounts for “wind and hail” and for “all other perils.”

2 Menchaca initially alleged a fraud claim, but it was not submitted to the jury. She also sued the first adjuster who inspected her property but later nonsuited those claims. Although the policy provided for an appraisal process to resolve disputes over the amount of covered losses, it appears that neither party ever invoked that alternative method for resolving this dispute. *See* —— S.W.3d at —— n.9.

3 As damages for USAA's alleged breach of the insurance contract, Menchaca sought the “benefit of her bargain” under the policy, “which is the amount of her claim [for policy benefits], together with attorney fees.” As damages for USAA's alleged statutory violations, she sought “actual damages, which include the loss of the benefits that should have been paid pursuant to the policy, mental anguish, court costs[,] and attorney's fees.” She later disclaimed any mental anguish or consequential damages.

4 Question 2 also separately asked whether USAA engaged in an unfair or deceptive act or practice by: “Failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim when the liability under the insurance policy issued to Gail Menchaca had become reasonably clear;” “Failing to promptly provide to Gail Menchaca a reasonable explanation of the factual and legal basis in the policy for the denial of a claim(s);” “Failing to affirm or deny coverage within a reasonable time;” or “Misrepresenting to Gail Menchaca a material fact or policy provision relating to the coverage at issue.” As to each of these specific practices, the jury answered “No.”

5 Specifically, Question 3 asked: “What sum of money ... would fairly and reasonably compensate Gail Menchaca for her damages, if any, that resulted from the failure to comply you found in response to Question number 1 and/or that were caused by an unfair or deceptive act that you found in response to Question number 2[?]” The question thus required the jury to determine damages resulting from either a contract breach or a statutory violation or both. The charge instructed the jury to answer Question 3 only if it “answered ‘Yes' to Question No. 1 *or* any part of Question No. 2 *or* both questions.” The charge then instructed the jury that the “sum of money to be awarded is the difference, if any, between the amount USAA should have paid Gail Menchaca for her Hurricane Ike damages and the amount that was actually paid.”

6 The jury also found that Menchaca's reasonable and necessary attorney's fees “for representation in the trial court” totaled $130,000, and did not find that Menchaca failed to mitigate her damages or that USAA “knowingly” violated the Insurance Code.

7 The court of appeals modified the judgment to delete an award of penalty interest and affirmed as modified. —— S.W.3d ——. Menchaca does not complain here about that aspect of the court's judgment.

8 Menchaca argues that USAA waived this argument because it (1) did not object that Question 2 was not predicated on a “yes” answer to Question 1; (2) did not request an instruction that the jury should answer “no” to Question 2 if they answered “no” to Question 1; (3) did not object to Question 2 on the ground that it imposed liability without a finding that Menchaca was entitled to benefits under the policy; and, (4) did not object to Question 3 on the ground that it permitted a recovery of policy benefits without a finding that Menchaca was entitled to benefits under the policy. USAA did object to Question 3, however, on the ground that the question impermissibly combined “contractual damages from Question

1 and statutory damages from Question 2, [because] Texas courts have held that extra[-]contractual damages need to be independent from policy damages." USAA complained that submitting just one damages question for all damages arising either under the policy or under the statute or both would make it "unclear potentially if we get 'yes' answers to [Questions] 1 and 2 what the damages are based on." We conclude that USAA's objections were sufficient to make clear its position that contractual damages are independent from statutory damages and must be based on a finding that USAA breached the policy. *See State Dep't of Highways & Pub. Transp. v. Payne*, 838 S.W.2d 235, 241 (Tex. 1992) (holding that an objection should make "the trial court aware of the complaint, timely and plainly"). We also conclude that USAA's argument raises a purely legal issue that does not affect the jury's role as fact-finder, and that USAA thus preserved the argument by asserting it as a ground for its motion for judgment based on the jury's verdict. *Hoffmann–La Roche Inc. v. Zeltwanger*, 144 S.W.3d 438, 450 (Tex. 2004) (holding that when "the issue presented a pure legal question which did not affect the jury's role as fact finder, the post-verdict motion [can be] sufficient to preserve error"); *see also Felton v. Lovett*, 388 S.W.3d 656, 660 n.9 (Tex. 2012) (citing *Waffle House, Inc. v. Williams*, 313 S.W.3d 796, 802 (Tex. 2010); *Hoffmann–La Roche*, 144 S.W.3d at 450; *Holland v. Wal–Mart Stores, Inc.*, 1 S.W.3d 91, 94 (Tex. 1999)) (holding that "a purely legal issue which does not affect the jury's role as fact-finder" may preserve error when "raised for the first time post-verdict"). Because USAA raises a purely legal argument that the jury's failure to find a contractual breach precludes Menchaca from recovering policy benefits as a matter of law, USAA preserved error by raising the argument in its motion for judgment.

9 *See, e.g.*, Richard G. Wilson, *Policy Benefits—Are They Recoverable Under Extra–Contractual Theories When a Covered Claim is Denied?*, 12 J. TEX. INS. L. 17, 23 (2014) ("In some circumstances, it appears that courts have simply failed to follow the Texas Supreme Court precedent that is *Vail*."); Robert M. Hoffman & Jaclyn M. O'sullivan, *What the Insurance Code Giveth, the Courts Cannot Taketh Away: Judicial Confusion Over Whether Insurance Proceeds Can be Trebled*, 11 J. TEX. INS. L. 23, 24 (2011) ("Unfortunately, it is easy to confuse the independent injury issue due to a line of cases that misapplied the 1998 Texas Supreme Court decision in ... *Castañeda*.").

10 In *Deepwater Horizon*, the Fifth Circuit certified to us the question of whether, "to maintain a cause of action under Chapter 541 of the Texas Insurance Code against an insurer that wrongfully withheld policy benefits, an insured must allege and prove an injury independent from the denied policy benefits?" 807 F.3d at 701. We accepted the certified question but later dismissed the cause as moot because the parties settled. *See id. certified question accepted* (Dec. 4, 2015) *and dism'd as moot* (Apr. 8, 2016).

11 Similarly, a claim for bad-faith conduct that breaches the common-law duty "can potentially result in three types of damages: (1) benefit of the bargain damages for an accompanying breach of contract claim, (2) compensatory damages for the tort of bad faith, and (3) punitive damages for intentional, malicious, fraudulent, or grossly negligent conduct." *Transp. Ins. Co. v. Moriel*, 879 S.W.2d 10, 17 (Tex. 1994), *abrogated on other grounds by U–Haul Intl. v. Waldrip*, 380 S.W.3d 118, 140 (Tex. 2012).

12 We cited the following non-Texas authorities in support of this general rule:

> *O'Malley v. United States Fidelity & Guar. Co.*, 776 F.2d 494, 500 (5th Cir. 1985) (noting that no Mississippi case has ever allowed bad faith recovery for the insured without first establishing liability under the policy); *Gilbert v. Cong. Life Ins. Co.*, 646 So.2d 592, 593 (Ala. 1994) (plaintiff bears the burden of proving a breach of contract by the defendant); *Reuter v. State Farm Mut. Auto. Ins. Co., Inc.,* 469 N.W.2d 250, 253 (Iowa 1991) ("[A] bad faith failure to pay the insured when the insured event occurs ... may subject the insurer to tort liability"); *Wittmer v. Jones*, 864 S.W.2d 885, 890 (Ky. 1993) (noting that in order to establish a tort action for bad faith the insured must first prove that the insurer was obligated to pay under the policy); *Pemberton v. Farmers Ins. Exchange*, 109 Nev. 789, 858 P.2d 380, 382 (1993) ("An insurer fails to act in good faith when it refuses 'without proper cause' to compensate the insured for a loss covered by the policy."); *Bartlett v. John Hancock Mut. Life Ins. Co.*, 538 A.2d 997, 1000 (R.I. 1988) ("[T]here can be no cause of action for an insurer's bad faith refusal to pay a claim until the insured first establishes that the insurer breached its duty under the contract of insurance."); *see also* OSTRAGER & NEWMAN, INSURANCE COVERAGE DISPUTES § 12.01 at 503 (7th ed. 1994) ("The determination of whether an insurer acted in bad faith generally requires as a predicate a determination that coverage exists for the loss in question."); 15A RHODES, COUCH ON INSURANCE LAW 2D § 58:1 at 249 (Rev. ed. 1983) ("As a general rule, there may be no extra-contractual recovery where the insured is not entitled to benefits under the contract of insurance which establishes the duties sought to be sued upon.").

Stoker, 903 S.W.2d at 341.

13 At least one court of appeals has held that in *Stoker* we recognized an inadequate-investigation violation as an "exception" to the general rule. *See Toonen v. United Servs. Auto Ass'n*, 935 S.W.2d 937, 941–42 (Tex. App.–San Antonio 1996, no writ) (citing *Stoker*, 903 S.W.2d at 341). That holding misconstrues *Stoker*, as our subsequent decisions demonstrate.

14 We say “generally” here because in some cases the insurer's statutory violation may cause the policy to not cover the claim when, but for the statutory violation, the policy would cover the claim. *See, e.g., JAW the Pointe*, 460 S.W.3d at 602. We discuss this situation further below.

15 Justice Spector authored the concurrence in *Stoker*, joining the Court's judgment because she agreed that no evidence supported the claim that the insurer's “bad faith caused damages to the Stokers.” *Stoker*, 903 S.W.2d at 342 (Spector, J., concurring). Notably, Justice Spector joined Justice Gonzalez's dissent in *Castañeda* in which Justice Gonzalez argued that *Stoker* does not apply when the policy covers the claim. *See Castañeda*, 988 S.W.2d at 203, 208 (Gonzalez, J., dissenting).

16 Although we did not explain the reason for the general rule in *Stoker*, we alluded to it by acknowledging “the possibility that in denying the claim, the insurer may commit some act, so extreme, that would *cause* injury independent of the policy claim.” *Stoker*, 903 S.W.2d at 341 (emphasis added). We made similar allusions to the causation requirement in *Boyd*, 177 S.W.3d at 920–21 (holding that insured could not recover benefits based on the insurer's improper investigation when the policy did not cover the claim for benefits because the improper-investigation claim was “predicated” on policy coverage), and in *Twin City*, 904 S.W.2d at 667 n.3 (noting that some bad-faith acts may “give rise” to damages other than policy benefits).

17 At least one federal district court expressly disagreed with *Great American*' s reading of *Castañeda*, but it ultimately concluded that it was compelled to follow the Fifth Circuit's precedent. *See In re Oil Spill by the Oil Rig Deepwater Horizon*, 2014 WL 5524268, at *15 (E.D. La. Oct. 31, 2014) (disagreeing with insurer's argument that the insured could not recover policy benefits as actual damages under the statute because we “considered and rejected” that argument in *Vail,* but nevertheless concluding that it was required to follow *Great American*), *aff'd in part, question certified sub nom, Deepwater Horizon*, 807 F.3d at 689.

18 Although four justices dissented in *Vail* in two separate opinions, none of them objected to the Court's opinion or judgment on the basis that the insureds failed to plead or obtain a finding that the insureds were entitled to receive benefits under the policy. Although the Court's majority opinion did not expressly explain the circumstances, it noted that the insureds “pleaded and proved” the amount of the policy's coverage and “offered evidence that [the insurer] had wrongfully denied the claim, resulting in a failure to pay [the policy benefits] when due.” *Vail*, 754 S.W.2d at 137. The majority thus concluded that the insureds sustained the policy limits “as actual damages as a result of [the insurer's] unfair claims settlement practices.” *Id.* JUSTICE GONZALEZ provided more clarity in his dissent, noting that the insurer “*admits* that it owes [the insured] the full amount of the policy” and thus “the sole issue on appeal is whether [the insured] is entitled to treble damages under the [statute].” *Id.* at 138 n.1 (GONZALEZ, J., dissenting) (emphasis added). Apparently, the Court's majority did not insist upon a jury finding of coverage or breach because the insurer admitted that the insured was entitled to the benefits. *Vail* should not be read, however, as suggesting that an insured can recover benefits for a statutory violation when the insured fails to establish and the insurer does not concede that the insured has a contractual right to the benefits.

19 *Royal Globe*, which was also a DTPA case, preceded the 1979 amendments to the DTPA that changed the causation standard from “adversely affected” to “producing cause.” *See Metro Allied Ins. Agency, Inc. v. Lin*, 304 S.W.3d 830, 835 (Tex. 2009) (explaining effect of the 1979 amendments).

20 We note that in fact Question 1 did not say “breach of contract” or ask whether there was a “breach of contract,” and neither did any other question. Instead, Question 1 asked whether USAA “failed to comply” with the policy.

21 We do not agree with the court of appeals' reliance on the fact that USAA conceded that the policy “covered” some of Menchaca's losses. While USAA did in fact concede that point, it contested Menchaca's claim that her covered losses exceeded the amount of her deductible. By contending that Menchaca's covered losses did not exceed the amount of her deductible, USAA disputed that the policy “covered” the benefits for which she sued because the policy expressly provided that USAA would “cover only that part of the loss over the deductible stated.”

APPENDIX 10

CAUSE NO. 09-05-04702-CV

GAIL MENCHACA	§	**IN THE DISTRICT COURT OF**
PLAINTIFF,	§	
	§	
V.	§	**MONTGOMERY COUNTY, TEXAS**
	§	
USAA TEXAS LLOYD'S COMPANY	§	
DEFENDANT	§	**9TH JUDICIAL DISTRICT**

CHARGE OF THE COURT

LADIES AND GENTLEMEN OF THE JURY:

After the closing arguments, you will go to the jury room to decide the case, answer the questions that are attached, and reach a verdict. You may discuss the case with other jurors only when you are all together in the jury room.

Remember my previous instructions: Do not discuss the case with anyone else, either in person or by any other means. Do not do any independent investigation about the case or conduct any research. Do not look up any words in dictionaries or on the Internet. Do not post information about the case on the Internet. Do not share any special knowledge or experiences with the other jurors. Do not use your phone or any other electronic device during your deliberations for any reason.

Any notes you have taken are for your own personal use. You may take your notes back into the jury room and consult them during deliberations, but do not show or read your notes to your fellow jurors during your deliberations. Your notes are not evidence. Each of you should rely on your independent recollection of the evidence and not be influenced by the fact that another juror has or has not taken notes.

You must leave your notes with the bailiff when you are not deliberating. The bailiff will give your notes to me promptly after collecting them from you. I will make sure your notes are kept in a safe, secure location and not disclosed to anyone. After you complete your deliberations, the bailiff will collect your notes. When you are released from jury duty, the bailiff will promptly destroy your notes so that nobody can read what you wrote.

Here are the instructions for answering the questions.

1. Do not let bias, prejudice, or sympathy play any part in your decision.

2. Base your answers only on the evidence admitted in court and on the law that is in these instructions and questions. Do not consider or discuss any evidence that was not admitted in the courtroom.

3. You are to make up your own minds about the facts. You are the sole judges of the credibility of the witnesses and the weight to give their testimony. But on matters of law, you must follow all of my instructions.

4. If my instructions use a word in a way that is different from its ordinary meaning, use the meaning I give you, which will be a proper legal definition.

5. All the questions and answers are important. No one should say that any question or answer is not important.

6. Answer "yes" or "no" to all questions unless you are told otherwise. A "yes" answer must be based on a preponderance of the evidence unless you are told otherwise. Whenever a question requires an answer other than "yes" or "no," your answer must be based on a preponderance of the evidence unless you are told otherwise.

The term "preponderance of the evidence" means the greater weight of credible evidence presented in this case. If you do not find that a preponderance of the evidence supports a "yes" answer, then answer "no." A preponderance of the evidence is not measured by the number of witnesses or by the number of documents admitted in evidence. For a fact to be proved by a preponderance of the evidence, you must find that the fact is more likely true than not true.

7. Do not decide who you think should win before you answer the questions and then just answer the questions to match your decision. Answer each question carefully without considering who will win. Do not discuss or consider the effect your answers will have.

8. Do not answer questions by drawing straws or by any method of chance.

9. Some questions might ask you for a dollar amount. Do not agree in advance to decide on a dollar amount by adding up each juror's amount and then figuring the average.

10. Do not trade your answers. For example, do not say, "I will answer this question your way if you answer another question my way."

11. Unless otherwise instructed, the answers to the questions must be based on the decision of at least 10 of the 12 jurors. The same 10 jurors must agree on every answer. Do not agree to be bound by a vote of anything less than 10 jurors, even if it would be a majority.

As I have said before, if you do not follow these instructions, you will be guilty of juror misconduct, and I might have to order a new trial and start this process over again. This would

waste your time and the parties' money, and would require the taxpayers of this county to pay for another trial. If a juror breaks any of these rules, tell that person to stop and report it to me immediately.

QUESTION NO. 1:

1. Did USAA Texas Lloyd's Company ("USAA") fail to comply with the terms of the insurance policy with respect to the claim for damages filed by Gail Menchaca resulting from Hurricane Ike?

   Answer "Yes" or "No".

   Answer: No

QUESTION NO. 2:

2. Did USAA engage in any unfair or deceptive act or practice that caused damages to Gail Menchaca?

Answer "Yes" or "No" as to each subpart.

"Unfair or deceptive act or practice" means any one or more of the following:

A. Failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim when the liability under the insurance policy issued to Gail Menchaca had become reasonably clear; or

Answer: NO

B. Failing to promptly provide to Gail Menchaca a reasonable explanation of the factual and legal basis in the policy for the denial of a claim(s); or

Answer: NO

C. Failing to affirm or deny coverage within a reasonable time; or

Answer: NO

D. Refusing to pay a claim without conducting a reasonable investigation with respect to a claim(s); or

Answer: YES

E. Misrepresenting to Gail Menchaca a material fact or policy provision relating to the coverage at issue.

Answer: NO

If you answered "Yes" to Question No. 1 or any part of Question 2 or both questions, then answer the following question. Otherwise, do not answer the following question.

QUESTION NO. 3:

3. What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Gail Menchaca for her damages, if any, that resulted from the failure to comply you found in response to Question number 1 and/or that were caused by an unfair or deceptive act that you found in response to Question number 2.

   The sum of money to be awarded is the difference, if any, between the amount USAA should have paid Gail Menchaca for her Hurricane Ike damages and the amount that was actually paid.

   In answering questions about damages, answer each question separately. Do not increase or reduce the amount in one answer because of your answer to any other question about damages. Do not speculate about what any party's ultimate recovery may or may not be. Any recovery will be determined by the court when it applies the law to your answers at the time of judgment. Do not add any amount for interest on damages, if any.

   Answer in dollars and cents for damages, if any.

   Answer: $ 11,350.00

If you answered yes to Question No. 3, then answer the following Question No. 3a. Otherwise, do not answer Question No. 3a.

QUESTION NO. 3a:

3a. Do you find from a preponderance of the evidence that Gail Menchaca could have avoided her damages, if any, through the exercise of reasonable care in protecting the property from further damage or making reasonable and necessary repairs.

Answer "Yes" or "No".

Answer: No

If you answered yes to Question No. 3a, then answer the following Question No. 3b. Otherwise, do not answer Question No. 3b

QUESTION NO. 3b:

3b. By what amount of money, if any, should Gail Mencahca's damages be reduced due to her failure to exercise reasonable care to avoid her damages?

Answer in dollars and cents for damages, if any.

Answer: N/A

If you answered "Yes" to any subpart of Question 2, then answer the following Question No. 4. Otherwise, do not answer the following Question No. 4 and skip to Question No. 6.

QUESTION NO.4:

4. Did USAA engage in any such conduct knowingly?

"Knowingly" means actual awareness of the falsity, unfairness, or deceptiveness of the act or practice on which a claim for damages is based. Actual awareness may be inferred if objective manifestations indicate that a person acted with actual awareness.

In answering this question, consider only the conduct that you found resulted in damages to Gail Menchaca.

Answer "Yes" or "No".

Answer: NO

If you have answered "Yes" to Question No. 4, then answer the following Question No. 5. Otherwise, do not answer the following Question No. 5 and skip to Question No. 6.

QUESTION NO. 5:

5. What sum of money, if any, in addition to actual damages, should be awarded to Gail Menchaca against USAA because USAA's conduct was committed knowingly?

INSTRUCTIONS

The factors to consider in awarding additional damages, if any, include:
(a) The nature of the wrong;
(b) The character of the conduct involved;
(c) The degree of culpability of USAA;
(d) The situation and sensibilities of the parties; and
(e) The extend to which the conduct in question offers a public sense of justice and propriety

Answer in dollars and cents, if any:

Answer: $ N/A

If you answered "Yes" to any part of Questions 1 or any part of Question 2, then answer the following Question No. 6. Otherwise, do not answer the following Question No. 6.

QUESTION NO. 6:

6. What is a reasonable fee for the necessary services of Gail Menchaca's attorneys in this case, stated in dollars and cents?

Answer with an amount for each of the following:

A. For representation in the trial court

Answer: $ 130,000.00

B. For representation through appeal to the court of appeals.

Answer: $ NO

C. For representation at the petition for review stage in the Supreme Court of Texas.

Answer: $ NO

D. For representation at the merits briefing stage in the Supreme Court of Texas.

Answer: $ NO

E. For representation through oral argument and the completion of proceedings in the Supreme Court of Texas.

Answer: $ NO

Presiding Juror:

1. When you go into the jury room to answer the questions, the first thing you will need to do is choose a presiding juror.

2. The presiding juror has these duties:

a. have the complete charge read aloud if it will be helpful to your deliberations;
b. preside over your deliberations, meaning manage the discussions, and see that you follow these instructions;
c. give written questions or comments to the bailiff who will give them to the judge;
d. write down the answers you agree on;
e. get the signatures for the verdict certificate; and
f. notify the bailiff that you have reached a verdict.

Do you understand the duties of the presiding juror? If you do not, please tell me now.

Instructions for Signing the Verdict Certificate:

1. Unless otherwise instructed, you may answer the questions on a vote of 10 jurors. The same 10 jurors must agree on every answer in the charge. This means you may not have one group of 10 jurors agree on one answer and a different group of 10 jurors agree on another answer.

2. If 10 jurors agree on every answer, those 10 jurors sign the verdict. If 11 jurors agree on every answer, those 11 jurors sign the verdict. If all 12 of you agree on every answer, you are unanimous and only the presiding juror signs the verdict.

3. All jurors should deliberate on every question. You may end up with all 12 of you agreeing on some answers, while only 10 or 11 of you agree on other answers. But when you sign the verdict, only those 10 who agree on every answer will sign the verdict.

Do you understand these instructions? If you do not, please tell me now.

Judge Presiding

Verdict Certificate

Check one:

_____ Our verdict is unanimous. All 12 of us have agreed to each and every answer. The presiding juror has signed the certificate for all 12 of us.

_____ _____

Signature of Presiding Juror Printed Name of Presiding Juror

_____ Our verdict is not unanimous. Eleven of us have agreed to each and every answer and have signed the certificate below.

__✓__ Our verdict is not unanimous. Ten of us have agreed to each and every answer and have signed the certificate below.

	SIGNATURE	NAME PRINTED
1.		MELANIE SMITH
2.		MARK R STRACE
3.		JOHN HOGG
4.		Kathy Murdock
5.		David Scott Carpenter
6.		Robert A. HAWNE
7.		Jason Hancock
8.		Benjamin E. Schmidt
9.		Tracey Wilson
10.		Karen CHANEY
11.		

APPENDIX 11

RECEIVED

08-94-00240-CV

No. 96-0249

96-0249

ORIGINAL

IN THE TEXAS SUPREME COURT

GRANTED
PTS.

PROVIDENT AMERICAN INSURANCE COMPANY,

Petitioner,

v.

DENISE CASTANEDA,

Respondent.

SET FOR ORAL ARGUMENT
ON
AT 9:00 A.M.
DNF (MINUTES)

PETITIONER PROVIDENT AMERICAN INSURANCE COMPANY'S
APPLICATION FOR WRIT OF ERROR

Scott Patrick Stolley
THOMPSON & KNIGHT
A Professional Corporation
1700 Pacific Ave. Suite 3300
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Telephone: 214-969-1700
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COUNSEL FOR PETITIONER
PROVIDENT AMERICAN INSURANCE CO.

LIST OF PARTIES

Petitioner/Defendant	Counsel
Provident American Insurance Company	Scott Patrick Stolley, Esq. Thompson & Knight A Professional Corporation 1700 Pacific Avenue, Suite 3300 Dallas, Texas 75201-4693 (on appeal only) Julie Caruthers Parsley, Esq. Thompson & Knight A Professional Corporation 98 San Jacinto Blvd., Suite 1200 Austin, Texas 78701 (on appeal only) Colbert N. Coldwell, Esq. Guevara, Rebe, Baumann, Coldwell & Garay 4171 North Mesa, Suite A-201 El Paso, Texas 79902 (at trial only)
Respondent/Plaintiff	**Counsel**
Denise Castaneda	Ben H. Langford, Esq. 444 Executive Center, Suite 222 El Paso, Texas 79902 Timothy Patton, Esq. Pozza & Patton 7979 Broadway, Suite 207 San Antonio, Texas 78209-2657 (on appeal only)

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Provident American's Points of Error

Issue One: *Watson* Trumps *Vail*

First Point of Error

The court of appeals erred in overruling Provident American's first point of error, and in holding that subparts H. and J. of Question 1 are legally recognized causes of action. (Germane to: 1st Pt. of Error on Reh.; 914 S.W.2d at 278-279, 280)

Issue Two: Provident American's Right to Contest the Claim

Second Point of Error

The court of appeals erred in compelling Provident American to attempt settlement when liability becomes reasonably clear, even though there is also reasonable evidence that the claim is not covered. (Germane to: 2nd Pt. of Error on Reh.; 914 S.W.2d at 278-280)

Third Point of Error

By compelling Provident American to attempt settlement, the court of appeals violated Provident American's rights to due process, open courts, and trial by jury, under both the United States and Texas constitutions. (Germane to: 3rd Pt. of Error on Reh.; 914 S.W.2d at 278-280)

Issue Three: No Evidence of Liability

Fourth Point of Error

The court of appeals erred in overruling Provident American's second point of error, and in holding that there is legally sufficient evidence to support jury findings that Provident American: (1) failed to attempt in good faith to make a prompt, fair settlement when liability

became reasonably clear; and (2) failed to acknowledge with reasonable promptness pertinent communications. (Germane to: 4th Pt. of Error on Reh.; 914 S.W.2d at 279-280)

Fifth Point of Error

The court of appeals erred in holding that Provident American's liability ever became reasonably clear. (Germane to: 5th Pt. of Error on Reh.; 914 S.W.2d at 280)

Sixth Point of Error

The court of appeals erred in holding that there is legally sufficient evidence to support a finding that it was reasonably clear to Provident American that Ms. Castaneda's disease had manifested after expiration of the 30-day waiting period. (Germane to: 9th Pt. of Error on Reh.; 914 S.W.2d at 280)

Seventh Point of Error

The court of appeals erred in failing to address the point that Provident American's conduct was not a producing cause of any damages. (Germane to: 10th Pt. of Error on Reh.; 914 S.W.2d at 279-282)

Issue Four: No Damages

Eighth Point of Error

The court of appeals erred in overruling Provident American's fourth point of error, and in holding that there is legally sufficient evidence to support the jury's answer to the damage question. (Germane to: 8th Pt. of Error on Reh.; 914 S.W.2d at 280-282)

Ninth Point of Error

The court of appeals erred in overruling Provident American's sixth point of error, and in holding that the submitted damage elements are proper and that the jury's damage finding is

supported by sufficient evidence. (Germane to: 12th Pt. of Error on Reh.; 914 S.W.2d at 280-282)

Tenth Point of Error

The court of appeals erred in holding that Ms. Castaneda did not have to prove medical expenses in accordance with the contractual measure of damages. (Germane to: 9th Pt. of Error on Reh.; 914 S.W.2d at 281)

Eleventh Point of Error

The court of appeals erred in overruling Provident American's seventh point of error, and in holding that the actual-damage award need not be reduced to the amount of covered benefits. (Germane to: 13th Pt. of Error on Reh.; 914 S.W.2d at 282)

Issue Five: The Impenetrable Jury Charge

Twelfth Point of Error

The court of appeals erred in overruling Provident American's third point of error, and in holding that, if any one liability theory is legally recognized and factually supported, the judgment must be affirmed, even if other theories are not legally recognized or factually supported. (Germane to: 7th Pt. of Error on Reh.; 914 S.W.2d at 277-278, 280)

Thirteenth Point of Error

The court of appeals erred in overruling Provident American's fifth point of error, and in holding that, if any one liability theory is legally recognized and factually supported, the judgment must be affirmed, even if it is impossible to determine whether the jury's damage finding relates to that theory. (Germane to: 11th Pt. of Error on Reh.; 914 S.W.2d at 277-278, 280)

Fourteenth Point of Error

The court of appeals erred in overruling Provident American's ninth point of error, and in holding that, if any one liability theory is legally recognized and factually supported, the judgment for additional statutory damages must be affirmed, even if it is impossible to determine if the "knowing" findings relate to that theory. (Germane to: 15th Pt. of Error on Reh.; 914 S.W.2d at 277-278, 280)

Issue Six: Attorney's Fees as a Percentage of the "Recovery"

Fifteenth Point of Error

The court of appeals erred in overruling Provident American's eleventh point of error, and in holding that Ms. Castaneda can recover attorney's fees, even though the attorney's-fee question required the jury to speculate about the amount of Ms. Castaneda's "recovery." (Germane to: 16th Pt. of Error on Reh.; 914 S.W.2d at 283)

STATEMENT OF THE CASE

Respondent Denise Castaneda alleged that Petitioner Provident American Insurance Company wrongfully denied her claim for approximately $14,000 in benefits under her father's health-insurance policy. (Tr. 30-35; S.F. 607, 877) Denise did not pursue a breach-of-contract claim, and after she abandoned her common-law bad-faith claim, the jury found "knowing" violations of the DTPA and Tex. Ins. Code art. 21.21. (Tr. 30-34; S.F. 835; Tr. 84-97) Based on those findings, the trial court entered judgment against Provident American for just over $220,000. (Tr. 211-213) The court of appeals reversed the 12% penalty awarded under Tex. Ins. Code art. 3.62, but otherwise affirmed the judgment. 914 S.W.2d 273, 284 (Tex.App.--El Paso 1996).

ISSUES

This appeal raises five primary issues:

(1) ***Watson* Trumps *Vail*** -- The Insurance Code requires an insurer to respond promptly to communications and to attempt settlement after liability becomes reasonably clear. Relying on *Vail*, the court of appeals held that violation of these requirements is actionable under the DTPA. Did the court err, given the later *Watson* holding that the DTPA and article 21.21 do not declare such conduct to be actionable?

(2) **Right to Contest the Claim** -- The court of appeals held, in essence, that an insurer must attempt to settle if there is evidence that the claim *is covered.* But in *Aranda, Lyons,* and their progeny, this court held, in essence, that an insurer has a right to litigate if there is reasonable evidence that the claim *is not covered.* Does the court of appeals' holding not only contravene *Aranda, Lyons*, and their progeny, but also violate an insurer's constitutional right to litigate questionable claims?

(3) **No Evidence of Liability** -- The trial court submitted a charge asking about various alleged violations of the DTPA and the Insurance Code. Denise offered evidence of

sloppy claim handling, but Provident American offered evidence that it had a reasonable basis to deny. Is there evidence to support jury findings that Provident American committed statutory violations that were the producing cause of damage?

(4) No Damages -- The jury's $50,000 damage award necessarily includes approximately $36,000 for past loss of credit reputation. Denise offered no evidence of her past or current credit standing, but she believed that her credit was ruined because she had been turned down for several credit cards. Even if the evidence supports the other $14,000 of the award, must the judgment be reversed, given that Denise's subjective belief is the only evidence linking the credit-card denials to Provident American's conduct?

(5) The Impenetrable Jury Charge -- When a jury question contains multiple liability theories or damage elements -- but only one answer blank -- it is impossible to determine which theories or damages the jury found. This impossibility precludes a showing of harmful error -- namely, that the jury probably based its verdict on a legally, factually, or procedurally defective theory or element. Does that impossibility, by definition, establish the other type of harmful error -- namely, error precluding the appellant from making a proper presentation on appeal?

STATEMENT OF JURISDICTION

This court has jurisdiction on at least two bases. First, the court of appeals' opinion conflicts with Texas Supreme Court opinions.[1] Specifically, the court of appeals held, contrary to *Watson*, that the DTPA and art. 21.21 declare Provident American's alleged conduct to be actionable.[2] The court further contravened *Aranda, Lyons*, and their progeny, by holding that Provident American had a duty to attempt settlement, even though there is reasonable evidence

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[1] *See* Tex. Gov't Code Ann. § 22.001(a)(2) (Vernon 1988).

[2] 914 S.W.2d at 278-279, 280; *Allstate Ins. Co. v. Watson*, 876 S.W.2d 145, 147-149 (Tex. 1994).

that the claim is not covered.[3] The court's opinion also conflicts with opinions stating that error in the jury charge is harmful if it is impossible to determine what findings the jury made.[4]

Second, the court of appeals committed errors that require correction.[5] For example, the court held paradoxically that *Watson* both does and does not trump *Vail*;[6] that an insurer must attempt to settle when there is reasonable evidence of coverage, even if the insurer has reasonable evidence of noncoverage;[7] that there is no harm when it is impossible to prove that the jury relied on a defective subpart of a jury question;[8] and that evidence that the plaintiff was turned down for credit cards is enough to support a finding of past loss of credit reputation, even though there is no evidence linking the credit denials to the defendant's conduct.[9]

STATEMENT OF FACTS

Hereditary Spherocytosis

Plaintiff Denise Castaneda and her brother (Guillermo Castaneda, Jr.) suffer from a congenital condition that goes by various names, but is often called hereditary spherocytosis (or HS) for short. (P.Ex. 2, 3, 4, 5, 8; D.Ex. 5; R.Ex. 3 at 9-13)[10] Sufferers of HS have

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[3] 914 S.W.2d at 278-279, 280; *see, e.g., Lyons v. Millers Cas. Ins. Co. of Tex.*, 866 S.W.2d 597, 600-601 (Tex. 1993); *Aranda v. Ins. Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex. 1988).

[4] 914 S.W.2d at 277-278; *see, e.g., Scott v. Atchison, Topeka & Santa Fe Ry. Co.*, 572 S.W.2d 273, 277 (Tex. 1978); *Haney Elec. Co. v. Hurst*, 624 S.W.2d 602, 610 (Tex.Civ.App.--Dallas 1981, writ dism'd as moot).

[5] *See* Tex. Gov't Code Ann. § 22.001(a)(6) (Vernon 1988).

[6] 914 S.W.2d at 277-279; *see Watson*, 876 S.W.2d at 147-149; *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 133-136 (Tex. 1988).

[7] 914 S.W.2d at 278-280.

[8] *Id.* at 277-278.

[9] *Id.* at 280-282.

[10] The abbreviation "R.Ex. ____" stands for "Reporter's Exhibit." Rather than transcribing three videotape depositions that the jury viewed, the court reporter simply attached the deposition transcripts as Reporter's Exhibits.

misshapen red blood cells that are destroyed as the cells attempt to pass through the sufferer's spleen. (R.Ex. 3 at 9-10, 12; D.Ex. 5) When enough red blood cells are destroyed, the sufferer will exhibit anemia, as well as jaundice (or yellowing) of the skin. (R.Ex. 3 at 9-10, 12; D.Ex. 5) But before the sufferer's skin turns yellow, the white portion (or sclera) of the patient's eyes will turn yellow. (R.Ex. 3 at 16-17, 49-50) Most HS sufferers also develop an enlarged spleen. (D.Ex. 5) In addition, about 90% of HS sufferers develop gallstones early in life, which can cause pain in the right upper quadrant of the sufferer's abdomen. (R.Ex. 3 at 12-14, 25-26, 31, 43; D.Ex. 5; P.Exs. 3, 8) A less common symptom is skin ulcerations. (S.F. 261, 809-810; D.Ex. 5) HS sufferers can be asymptomatic or only mildly symptomatic, with the jaundice or abdominal pain being intermittent. (R.Ex. 3 at 42-43, 45-46; D.Ex. 5; S.F. 669-670)

As its name connotes, HS is an inherited disorder, but it is more commonly inherited from the mother's side of the family. (R.Ex. 3 at 9-11; D.Ex. 5; S.F. 764-766, 770) When one family member is diagnosed with HS, doctors recommend that other family members be checked, especially those who appear jaundiced. (R.Ex. 3 at 10-11, 43; P.Ex. 19; S.F. 577-578, 602, 629, 654) After diagnosis, the common treatment is to remove the sufferer's spleen, which generally halts the destruction of red blood cells. (D.Exs. 4, 5; P.Ex. 3) If the sufferer has gallstones, the surgeon will also remove the gallbladder. (*See* P.Exs. 3, 8; D.Ex. 4)

Purchase of the Policy

In May 1991, a school nurse recommended that Guillermo Jr. see a doctor, because the boy was drastically jaundiced and lethargic. (P.Exs. 19, 40) After five days of jaundice, the boy was taken to see Dr. Edward Juarez, who suspected hepatitis and anemia. (P.Exs. 19, 39, 40) Dr. Juarez noted that the boy had yellow sclerae and tenderness of the right upper quadrant. (P.Ex. 40)

At that time, the Castaneda family had no health insurance. (S.F. 554-555) About two

years before this, Mr. Castaneda had turned down the chance to apply for a health insurance policy with Provident American. (S.F. 693-694, 697-698) But two days after Guillermo Jr.'s visit to Dr. Juarez, Mr. Castaneda met with an insurance agent to apply for a policy with Provident American. (D.Ex. 1; S.F. 559-560, 699-700) Mr. Castaneda had called about one week before to schedule the meeting. (S.F. 699-700, 718)

During the meeting, the agent posed a series of questions about the family medical history. (D.Ex. 1; S.F. 562-566, 701-708) Mr. and Mrs. Castaneda answered that no family member: (1) was presently receiving treatment or medication; (2) had received any medical advice or treatment in the last five years; (3) had ever had a liver disorder; or (4) had ever had any other illness or disorder. (D.Ex. 1; S.F. 563-566, 701-706) The Castanedas failed to disclose that their son was jaundiced, had seen Dr. Juarez, and was suspected of having a liver disorder -- namely, hepatitis. (D.Ex. 1; S.F. 458-460, 551, 563-566, 630-631, 701-706, 725-726) This information would have been material to Provident American for underwriting purposes. (S.F. 451-454, 458-460, 535) The Castanedas also failed to disclose that Denise had been treated in the past for "funny color" skin and possible hepatitis. (D.Ex. 1; P.Exs. 3, 17; S.F. 251-252, 269-270, 400-401, 603-604) Mr. Castaneda later gave the implausible excuse that to him hepatitis is not an illness or disease. (S.F. 564)

In addition, the Castanedas failed to disclose their true immigration status. (D.Ex. 1; S.F. 566-568, 707-708) Specifically, they answered that they were permanent residents of the United States, when in fact, they were living in the U.S. on a businessman's visa, and in Denise's case, on a student visa. (D.Ex. 1; S.F. 566-568, 612-613, 707-708) This information would have been material to Provident American, because the policy was guaranteed renewable for life or until age 65. (S.F. 852-854) If the insured is not a permanent resident and moves out of the U.S. while the policy is in force, it becomes difficult (or sometimes impossible) to administer the policy -- for example, to collect premiums, send notices, and obtain medical

records. (S.F. 852-854)

During the meeting, the agent explained that the policy contains two important limitations. (S.F. 704-706, 724-725; P.Ex. 1) First, the policy covers only those expenses resulting from sickness that first "manifests" more than 30 days after the policy's effective date. (P.Ex. 1) Second, there is no coverage for sickness or disorder involving certain organs (including the gallbladder), unless the loss occurs more than six months after the policy's effective date. (P.Ex. 1)

Five days after the Castanedas completed the application, Dr. Alfred Varela performed a follow-up exam on Guillermo Jr. (P.Exs. 19, 40) Based on the lab results, Dr. Varela ruled out hepatitis, but maintained the diagnosis of anemia. (P.Exs. 19, 40)

One week later, a Provident American employee phoned Mr. Castaneda to conduct an underwriting interview. (D.Ex. 2; S.F. 448-453, 551-552, 575) Mr. Castaneda again failed to disclose his son's recent bout with jaundice and anemia. (D.Ex. 2; S.F. 448-453, 551-552) Six days later, unaware of the Castanedas' nondisclosures, Provident American issued a policy with an effective date of June 17, 1991. (P.Ex. 1; S.F. 194, 463; R.Ex. 2 at 33) Therefore, the 30-day "manifestation" clause dictated coverage only for illnesses that manifested on or after July 18, 1991. (P.Ex. 1)

Double Surgery

That very day (July 18), Mrs. Castaneda took Guillermo Jr. to see pediatrician Carlos Gutierrez. (S.F. 655-656, 665-667; D.Ex. 8) She did so because on either July 9 or July 14, her brother told her that he recently had his spleen removed because of a diagnosis of HS. (S.F. 549, 577-578, 602, 629, 641-649, 654, 657-658; P.Ex. 19; D.Ex. 7) Her brother's doctor advised that all family members with yellow skin should be checked for HS. (S.F. 549, 577-578, 602, 629, 654, 657; P.Ex. 19) Her brother further explained that the only cure was surgery. (S.F. 585) Therefore, at a minimum, the Castanedas knew during the 30-day waiting

period that their children might have a genetic disorder that would require surgery. (S.F. 585)

Of the three Castaneda children, only Denise and Guillermo Jr. had yellow skin, so the Castanedas consequently decided to have Denise and Guillermo Jr. examined. (S.F. 549-550, 579-580, 602, 604-605, 625-626, 629-630; P.Ex. 19) At trial, however, Denise and her parents claimed that they thought that Denise and Guillermo Jr. had normal skin, because Denise and Guillermo Jr. (like their father) always looked yellow, and their skin color never changed. (S.F. 549-550, 579-580, 602, 604-605, 625-626, 629-630) Dr. Gutierrez noted, however, that Guillermo Jr. did not appear yellow on July 18, although Mrs. Castaneda told Dr. Gutierrez that Guillermo Jr. periodically turned yellow. (S.F. 667) When Mrs. Castaneda explained that her brother had HS, Dr. Gutierrez referred the family to a specialist. (S.F. 665-667)

Consequently, Denise and Guillermo Jr. saw hematologist Roberto Canales two days later, on July 20. (P.Exs. 2, 4; S.F. 759-761) Based on what Dr. Gutierrez had told him about the family history and the symptoms, Dr. Canales concluded even before he saw them that they probably had HS. (S.F. 761-762) He found Denise to be jaundiced and with yellow sclerae. (S.F. 760, 763, 769) A later test showed that Denise had an elevated bilirubin level of 3. Bilirubin is a pigment appearing in blood. (S.F. 249-250, 669)[11] According to Provident American's medical expert, the sclerae turn yellow when bilirubin exceeds 2.5. (R.Ex. 3 at 16-17) In a report, Dr. Canales also noted that Denise had been anemic and that she had sore sites (skin ulcerations), although in his deposition he recanted and testified that she actually had no sore sites. (P.Ex. 3; S.F. 670, 671, 673; *see* S.F. 627) After conducting a test, he confirmed the diagnosis of HS. (S.F. 668, 672, 766-767; P.Exs. 3, 4) He referred the Castanedas to surgeon Jose Castillo for further treatment. (P.Ex. 8)

About two weeks later, Dr. Castillo operated on both Denise and Guillermo Jr. and removed their spleens and gallbladders. (P.Exs. 3, 8) In his preoperative examination, Dr.

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[11] *See Webster's New Collegiate Dictionary* 108 (1981).

Castillo found Denise to be jaundiced and with yellow sclerae. (P.Ex. 3; D.Ex. 4) In his reports, he noted:

(1) that Denise was recently found to be suffering from jaundice;

(2) that Denise's grandmother had recently visited and commented that Denise looked quite yellow;

(3) that Denise had a history of jaundice;

(4) that Denise had suffered from recurrent episodes of abdominal pain that she thought was mild indigestion;

(5) that in the past, Denise had been diagnosed with or treated for mild hepatitis and "funny-colored" skin; and

(6) that about one month before, a lab test had confirmed that Denise had HS.

(P.Ex. 3; D.Ex. 4) A diagnosis made one month before the surgery would have been within the 30-day waiting period. (R.Ex. 3 at 20; P.Ex. 1; S.F. 482) As it later turned out, there was no evidence of a diagnosis that early, but at the time of the denial, Provident American could only rely on what the records said. (S.F. 537-541; *see* Tr. 87)

During the operation, Dr. Castillo found that Denise's spleen was enlarged about four or five times normal size. (P.Ex. 3) He further found numerous embedded stones in her gallbladder. (P.Exs. 3, 8; D.Ex. 4; R.Ex. 3 at 24-26) According to Provident American's medical expert, such gallstones take over one month to develop and probably had been developing for years. (R.Ex. 3 at 24-26, 31) According to the expert, the gallstones probably caused Denise's recurrent abdominal pain. (R.Ex. 3 at 13-14, 26)

Provident American's Denial

After the Castanedas submitted claims for both operations, Provident American learned that both Castaneda children had their gallbladders removed. (S.F. 472) Based on the six-month waiting period for sickness or disorder involving the gallbladder, Provident American denied both claims on October 30, 1991. (P.Ex. 9; S.F. 195, 472; R.Ex. 1 at 25, 30; R.Ex.

2 at 11, 20) After Mr. Castaneda protested that the gallbladder condition was secondary to the HS disorder, Provident American decided that the original reason for denial was incorrect. (P.Exs. 2, 5, 6, 10; R.Ex. 1 at 27, 42-43, 55-56; R.Ex. 2 at 41-42; S.F. 198-199) Provident American then reopened the claims, but based on the medical records, again denied Guillermo Jr.'s claim, this time on the ground that his HS disorder had manifested before the 30-day waiting period expired. (S.F. 198-199, 532-533, 791-792; R.Ex. 1 at 25-26, 27, 29-30, 47, 48-49; R.Ex. 2 at 12-13, 21; D.Exs. 3, 39)

Based on (1) a review of medical literature concerning HS, (2) consultation with Provident American's staff doctor, and (3) a review of Denise's available medical records, Provident American also believed that Denise's claim was not payable, because her symptoms (such as jaundice and abdominal pains) must have manifested before expiration of the 30-day waiting period. (R.Ex. 1 at 25-28, 35-37, 50; R.Ex. 2 at 25-26, 29-31, 44; S.F. 199, 201, 210-211, 250-252, 255, 257-258, 266-267, 413-414, 469-471, 473-476, 499-500, 508-514; P.Ex. 16) But Provident American was willing to reconsider Denise's claim if further information was provided. (S.F. 199, 250-252; R.Ex. 1 at 25-26, 35-37; P.Ex. 16) Thus, Provident American sent a December 12, 1991 letter, informing Mr. Castaneda of the 30-day waiting period, and asking for complete records from Dr. Canales and for the names of other doctors who treated Denise. (P.Ex. 16; S.F. 250, 397-398, 477) At that time, Provident American believed that Drs. Varela and Juarez might have some records, that Denise had seen a Dr. Vera, and that there should be records from Denise's earlier treatment for suspected hepatitis. (S.F. 199-200, 250, 398-399, 401, 412-413, 416, 520-521; R.Ex. 1 at 37) The letter further stated that Provident American would reopen Denise's claim upon receipt of the additional information, but Provident American never received all of that additional information. (P.Ex. 16; S.F. 200-201, 397, 398-399, 413-414, 520-521)

After December 12, Provident American did, however, receive further information

confirming prior manifestation of Denise's HS. (P.Exs. 17, 19) First, Dr. Canales' office confirmed some of Denise's symptoms and history, including Denise's earlier case of suspected hepatitis. (P.Ex. 17; S.F. 251-252; 398) Second, Mr. Castaneda sent a letter in which he mentioned the call from Denise's uncle. (P.Ex. 19; S.F. 211-212) In the letter, Mr. Castaneda also admitted that Denise and Guillermo Jr. had always appeared yellow. (P.Ex. 19; R.Ex. 1 at 48-50)

The Lawsuit

Dissatisfied with Provident American's decision, Mr. Castaneda filed suit on Guillermo Jr.'s claim. (Tr. 7-12) Being an adult, Denise filed her own lawsuit concerning her claim. (Tr. 13-18) The two lawsuits were consolidated, but before trial, Mr. Castaneda nonsuited his claims. (Tr. 21-25, 36-39) Denise asserted no breach-of-contract claim, and at trial abandoned her common-law bad-faith claim. (Tr. 30-34; S.F. 835)

Thus, the trial court submitted only Denise's claims under the DTPA and Tex. Ins. Code art. 21.21. (Tr. 84-97) The evidence showed that Provident American had no contact with and made no representations to Denise. (S.F. 397, 433, 606, 621) In fact, the policy states that Mr. Castaneda is the "insured," that the contract is made with the "insured," that any benefits shall be paid to the "insured" for all covered family members, and that every transaction shall be between Provident American and the "insured."[12] (P.Ex. 1) Nevertheless, the jury found that Provident American "knowingly" engaged in various unfair, false, deceptive, or misleading acts or practices that were a producing cause of damage to Denise. (Tr. 88-91) The format of the questions precludes a determination of which acts or practices the jury found. (Tr. 88-91)

As for damages, Denise offered medical bills totalling $14,348.90, but contrary to the policy measure of damages, there was no testimony that the amounts were within the reasonable,

[12] Texas law authorizes this policy provision. Tex. Ins. Code Ann. art. 3.70-3(E) (Vernon 1981).

usual, and customary charges. (S.F. 660-663, 673-676; P.Exs. 1, 29-35) The bills reflect that $1,925 was related to the removal of Denise's gallbladder and, thus, was excluded by the 6-month waiting period. (P.Exs. 1, 29, 31, 32) Provident American's president also testified that an additional $589 was not covered. (S.F. 740-741; P.Exs. 1, 29, 30, 34) These adjustments reduce the total to $11,834.90.

Denise also claimed loss of credit reputation, but she offered no evidence of such a loss. (S.F. 606-607, 814-816)[13] She first testified only that she was afraid to answer the phone or open her mail because it might be from a bill collector. (S.F. 606-607) Based on the fact that she has been turned down for credit cards, she also offered her subjective belief that her credit had been ruined. (S.F. 606-607, 814-816) But she never offered: (1) any evidence that she ever had a favorable credit record; or (2) any independent evidence that lenders or creditors viewed her credit negatively because of anything Provident American did. (S.F. 606-607, 814-816) Instead, the record reflects that she is now a 24-year old college student, living in the U.S. on a student visa, and that she earns about $400 per month as a part-time research assistant. (S.F. 600-601, 614-615) Contrary to a statement in the court of appeal's opinion, there is no evidence that her credit-card applications were "rejected for delinquencies on her credit report." 914 S.W.2d at 281.

Despite these shortcomings in Denise's damage evidence, the jury found a combined $50,000 for lost policy benefits and past loss of credit reputation, but the format of the question precludes a determination of how much the jury found for each element. (Tr. 92) The jury found no future damages and no damages for mental anguish. (Tr. 92-93)

On Provident American's defensive issues, the jury found that Denise's HS did not manifest before the 30-day waiting period expired, and that Denise's illness did not involve her

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[13] The sum total of Denise's testimony about loss of credit is attached to this brief at Tab B. (S.F. 606-607, 814-816)

gallbladder. (Tr. 94-95)

Based on the jury findings, the trial court entered a judgment in Denise's favor for just over $220,000, plus post-judgment interest. (Tr. 211-213) The court of appeals deleted the 12% penalty under Tex. Ins. Code art. 3.62, but otherwise affirmed the damage awards, and remanded for a recalculation of attorneys' fees and prejudgment interest. 914 S.W.2d at 284.

Issue One: *Watson* Trumps *Vail*

First Point of Error (Restated)

The court of appeals erred in overruling Provident American's first point of error, and in holding that subparts H. and J. of Question 1 are legally recognized causes of action.

Arguments Germane to Point One

The trial court submitted three liability questions (Questions, 1, 3, and 4) containing 20 subparts that for the most part track various provisions of the DTPA, the Insurance Code, and the insurance regulations.[14] Provident American complained that *Watson* banned this type of submission.[15] The court of appeals agreed in part, holding that even in a first-party case such as this one, the insured "does not have a legally recognized cause of action for unfair claims settlement practices under [DTPA] § 17.46(a)."[16] Thus, the court of appeals held that the trial court erroneously included a § 17.46(a) claim in subpart A. of Question 1.[17]

This holding is consistent with the *Watson* holding that claims for unlisted DTPA

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[14] Tr. 88, 90, 91. Appendix A to this brief is a copy of the charge that has been annotated to show which statute or regulation is apparently the source for each subpart.

[15] *See Allstate Ins. Co. v. Watson*, 876 S.W.2d 145, 147-149 (Tex. 1994).

[16] 914 S.W.2d at 277 (citing *Watson*).

[17] *Id.*; Tr. 88.

violations (under § 17.46(a)) are not actionable under Tex. Ins. Code art. 21.21, § 16.[18] But the court's holding is inconsistent with *Vail*, which holds that a first-party insured can bring a § 17.46(a) claim under art. 21.21.[19] Thus, by ignoring *Vail* and holding that the trial court erroneously submitted a § 17.46(a) claim, the court of appeals in effect found that *Watson* trumps *Vail* -- a conclusion that the same court reached earlier in *Hart v. Berko, Inc.*[20] In reaching this conclusion, the court expressed no concern about *Watson's* explicit statement that *Vail* remains the law in first-party cases.[21]

With respect to other subparts in the jury charge, the court of appeals then contradicted itself by giving credence to the *Watson* statement that *Vail* remains the law. Specifically, the court held that subparts H. and J. of Question 1 are legally recognized causes of action under *Vail*.[22] Subpart H. inquired whether Provident American failed to "acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies," while subpart J. inquired whether Provident American failed to attempt "in good faith to effectuate a prompt, fair, and equitable settlement of a claim when liability has become

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[18] *Watson*, 876 S.W.2d at 149; *accord Hart v. Berko, Inc.*, 881 S.W.2d 502, 508-509 (Tex.App.--El Paso 1994, writ denied) (holding that *Watson* modified *Vail* by prohibiting § 17.46(a) claims under art. 21.21); *Mobile County Mut. Ins. Co. v. Jewell*, 555 S.W.2d 903, 910-911 (Tex.Civ.App.--El Paso 1977) (holding that § 17.46(a) claims are not actionable under art. 21.21), *writ ref'd n.r.e.*, 566 S.W.2d 295 (Tex. 1978); *see Thrash v. State Farm Fire & Cas. Co.*, 992 F.2d 1354, 1357 n.18 (5th Cir. 1993) (stating that the *Vail* holding regarding unlisted DTPA violations makes no sense); *Wm. H. McGee & Co. v. Schick*, 792 S.W.2d 513, 518-519 (Tex.App.--Eastland 1990) (suggesting that unlisted DTPA practices cannot be incorporated into art. 21.21), *writ dism'd pursuant to settlement*, 843 S.W.2d 473 (Tex. 1992); Tex. Ins. Code art. 21.21, § 16(a) (Vernon 1981); Tex. Bus. & Com. Code Ann. § 17.46(a) (Vernon 1987).

[19] *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 135-136 (Tex. 1988).

[20] 914 S.W.2d at 277; *Hart*, 881 S.W.2d at 508-509.

[21] 914 S.W.2d at 277; *Watson*, 876 S.W.2d at 149.

[22] 914 S.W.2d at 278-279.

reasonably clear."[23] Both of these subparts are based on Tex. Ins. Code art. 21.21-2 and regulations promulgated under that article.[24]

But *Watson* dictates that neither subpart H. nor subpart J. is a legally recognized cause of action under art. 21.21. To be actionable under art. 21.21, the conduct must be: (1) *declared* in art. 21.21, § 4 to be a unfair or deceptive act or practice; (2) *declared* to be an unfair or deceptive act or practice in rules adopted under art. 21.21; or (3) *defined* by DTPA § 17.46 to be an unlawful deceptive trade practice.[25] Subparts H. and J. fit within none of these statutory categories.

With respect to the first category, art. 21.21, § 4 does not *declare* that failure to attempt settlement or failure to promptly communicate are unfair or deceptive acts.[26]

With respect to the second category, the rules after which subparts H. and J. are patterned cannot support the trial court's submission, because those rules were adopted under art. 21.21-2, not under art. 21.21.[27] Moreover, at the time in question, those rules required a showing that Provident American acted with "such frequency as to indicate a general business practice."[28] Because there is no evidence of such "frequency," Denise cannot recover under

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[23] Tr. 89.

[24] Tex. Ins. Code Ann. art. 21.21-2, § 2(b) & (d) (Vernon 1981) (now renumbered as § 2(b)(2) & (4)); 28 Tex. Admin. Code § 21.203(2) & (4) (derived from State Bd. of Ins., *Amendment to the Unfair Claim Settlement Practices Rules*, Board Order 41454 (Aug. 10, 1982)).

[25] Tex. Ins. Code Ann. art. 21.21, § 16(a) (Vernon 1981); *Watson*, 876 S.W.2d at 147.

[26] Tex. Ins. Code Ann. art. 21.21, § 4 (Vernon 1981); *see Watson*, 876 S.W.2d at 147; *see also Tri-Legends Corp. v. Ticor Title Ins. Co. of Calif.*, 889 S.W.2d 432, 440 (Tex App.--Houston [14th Dist.] 1994, writ denied) (holding that art. 21.21, § 4 does not define misrepresentation in a title commitment to be an unfair or deceptive act).

[27] *Watson*, 876 S.W.2d at 148; *Lee v. Safemate Life Ins. Co.*, 737 S.W.2d 84, 86 (Tex.App.--El Paso 1987, writ dism'd); State Bd. of Ins., *Amendment to the Unfair Claim Settlement Practices Rules*, Board Order 41454 (Aug. 10, 1982) (now 28 Tex. Admin. Code §§ 21.201 - 21.205).

[28] *Watson*, 876 S.W.2d at 148.

those rules.[29]

Furthermore, Denise cannot recover under those rules by incorporating them in Board Order 18663.[30] That order does not *declare* that failure to attempt settlement and failure to promptly communicate are unfair or deceptive acts.[31] For the same reason, Denise cannot recover by incorporating art. 21.21-2 into Board Order 18663.[32] In addition, because art. 21.21-2 does not by itself create a private cause of action, art. 21.21-2 also cannot create a cause of action by incorporation into Board Order 18663.[33] In short, subparts H. and J. do not fall in the second statutory category -- conduct *declared* in the rules adopted under art. 21.21.

Subparts H. and J. also do not fall in the third category -- conduct *defined* in DTPA § 17.46. As discussed above, the court of appeals in this case agreed with *Watson* that there is no cause of action by which DTPA § 17.46(a) is incorporated into art. 21.21.[34] Also, failing to settle and failing to communicate are not defined in DTPA § 17.46(b) to be false, misleading, or deceptive acts.[35] Thus, subparts H. and J. did not inquire about conduct *defined* in DTPA § 17.46.

Finally, the court of appeals held that the judgment was based on incorporation of art. 21.21 into the DTPA.[36] But the DTPA simply provides a cause of action for violation of art.

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[29] *See id.*; *Chitsey v. National Lloyds Ins. Co.*, 738 S.W.2d 641, 643 (Tex. 1987).

[30] State Bd. of Ins., *Rules and Regulations on Unfair Competition and Unfair Practices*, Board Order 18663 (Dec. 3, 1971) (now 28 Tex. Admin. Code § 21.1 - 21.5).

[31] *See Watson*, 876 S.W.2d at 147-148; *Tri-Legends*, 889 S.W.2d at 441.

[32] *Watson*, 876 S.W.2d at 147-148.

[33] *Id.* at 148-149; *see American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842, 847 n.11 (Tex. 1994).

[34] 914 S.W.2d at 277.

[35] Tex. Bus. & Com. Code Ann. § 17.46(b) (Vernon Supp. 1996); *see Tri-Legends*, 889 S.W.2d at 441.

[36] 914 S.W.2d at 278-280, 284.

21.21 or the rules issued under art. 21.21.[37] For the reasons discussed earlier, art. 21.21 and the rules under that article do not create a cause of action. Thus, incorporation of art. 21.21 into the DTPA does not support the judgment.

Overall, given the holding that Question 1.A. is improper under *Watson*, but that Questions 1.H. and 1.J. are proper under *Vail*, the court of appeals' opinion is inherently contradictory. And this contradiction vividly illustrates the difficulty that Texas courts are having with *Watson* and *Vail*. In a first-party case, the Fourteenth Court of Appeals has applied *Watson* to hold that art. 21.21, § 4, Board Order 18663, and DTPA § 17.46 do not create a private cause of action.[38] In this case and in *Hart*, the El Paso Court of Appeals held that *Watson* only partially trumps *Vail*.[39] By contrast, the Texarkana Court of Appeals has rejected this baby-splitting approach, instead holding that *Vail* governs over *Watson*.[40]

The judiciary's puzzlement is understandable. Although this court stated in *Watson* that *Vail* remains the law in first-party cases, the rationale in *Watson* is inherently lethal to the rationale in *Vail*. But as a third-party case, *Watson* technically did not present the opportunity to directly overrule *Vail* in the first-party context. This case, however -- being a first-party case -- does present that opportunity. Provident American therefore asks this court to overrule *Vail* and hold that Questions 1.H. and 1.J. are not legally recognized causes of action. Even though

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[37] Tex. Bus. & Com. Code Ann. § 17.50(a)(4) (Vernon Supp. 1996).

[38] *Tri-Legends*, 889 S.W.2d at 440-441.

[39] 914 S.W.2d at 277, 278-279; *Hart*, 881 S.W.2d at 508-509.

[40] *Southland Lloyd's Ins. Co. v. Tomberlain*, No. 06-94-00131-CV, 1996 WL 69073 at *6 (Tex.App.--Texarkana, February 16, 1996, n.w.h.) (holding that *Watson* does not apply to first-party cases); *Maryland Ins. Co. v. Head Indus. Coatings & Serv., Inc.*, 906 S.W.2d 218, 225-226 (Tex.App.--Texarkana 1995, writ requested) (applying *Vail* in a third-party context); *Crum & Forster, Inc. v. Monsanto Co.*, 887 S.W.2d 103, 116-118 (Tex.App.--Texarkana 1994, no writ) ("We shall follow the *ratio decidendi* of *Vail* until the Texas Supreme Court tells us that it is not to be followed in a case involving an insured."); *see Webb v. International Trucking Co.*, 909 S.W.2d 220, 224-228 (Tex.App.--San Antonio 1995, no writ) (distinguishing *Watson* and refusing to apply it to a claim by a third party).

the court of appeals did not rely on the other subparts in Questions 1, 3, and 4, Provident American also asks this court to hold (for the reasons discussed above) that those other subparts are not legally recognized causes of action in the context of this case. With these holdings, the court should reverse and render, because Denise failed to obtain an affirmative finding on any legally recognized course of action.[41]

By reversing *Vail*, the court will not be depriving first-party insureds of all remedies, because insureds can still bring breach-of-contract and common-law bad-faith claims. Certain insureds can also recover a 12% penalty under two now-repealed statutes.[42] Moreover, both of those statutes have been replaced by a broader and more demanding statute with an 18% penalty.[43] And the laundry list in art. 21.21 has been amended to directly include many of the unfair-claim-settlement practices from art. 21.21-2 and the insurance regulations.[44] Thus, insureds like Denise will still have remedies, although Denise forsook her other available remedies by abandoning her common-law bad-faith claim and by not pleading breach of contract or violation of Tex. Ins. Code art. 3.62.[45]

If this court should decide not to overrule *Vail*, Provident American asks the court to at least limit *Vail* to its proper scope. Over the years, courts have erroneously broadened *Vail*, by incorporating all of art. 21.21-2 and all of the insurance regulations into art. 21.21 and the

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[41] *See, e.g., Southwestern Bell Tel. Co. v. DeLanney*, 809 S.W.2d 493, 495 (Tex. 1991) (judgment rendered for the defendant where the plaintiff omitted the legal theory that applied to the case).

[42] Tex. Ins. Code Ann. arts. 3.62, 3.62-1 (Vernon 1981) (*repealed by* Act of June 6, 1991, 72nd Leg., R.S., ch. 242, § 11.03(a), 1991 Tex. Gen. Laws 939, 1043-1054).

[43] Tex. Ins. Code Ann. art. 21.55 (Vernon Supp. 1996).

[44] Tex. Ins. Code Ann. art. 21.21, § 4(10) & (11) (Vernon Supp. 1996).

[45] Tr. 30-34; S.F. 835.

DTPA.[46] But in *Vail*, this court merely held that in a case alleging unfair-claim-settlement practices, the insured could incorporate: (1) Tex. Ins. Code art. 21.21-2, § 2(d) and the corresponding regulation into art. 21.21 and the DTPA; and (2) common-law bad faith into Board Order 18663 and the DTPA.[47] Thus, *Vail* authorizes a statutory claim for unfair-claim-settlement practices only when the insurer: (1) commits bad faith; or (2) fails to attempt a prompt, fair settlement after liability becomes reasonably clear.[48] When properly limited to its holding, *Vail* does not allow a cause of action for unfair-claim-settlement practices to be premised on the other laundry-list items in the DTPA, art. 21.21, art. 21.21-2, or the insurance regulations. And this limitation makes sense, given that most of the items in those laundry lists do not relate to claim-settlement conduct.[49]

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[46] *See, e.g., St. Paul Surplus Lines Ins. Co. v. Dal-Worth Tank Co.*, No. 07-93-0197-CV, 1995 WL 508001 at * 17-18 (Tex.App.--Amarillo 1995, 130(d) mot. filed); *Commonwealth Lloyds Ins. Co. v. Downs*, 853 S.W.2d 104, 114-117 (Tex.App.--Fort Worth 1993, writ denied); *State Farm Fire & Cas. Co. v. Price*, 845 S.W.2d 427, 430-431 (Tex.App.--Amarillo 1992, writ dism'd by agr.).

[47] *Vail*, 754 S.W.2d at 133-136. Art. 21.21-2, § 2(d) prohibits failure to attempt settlement when liability becomes reasonably clear. Tex. Ins. Code Ann. art. 21.21-2, § 2(d) (Vernon 1981) (now renumbered as § 2(b)(4)). The identically worded regulation (derived from Board Order 41454) is 28 Tex. Admin. Code § 21.203(4).

[48] *Vail*, 754 S.W.2d at 133-136; *see Crawford & Co. v. Garcia*, 817 S.W.2d 98, 103 (Tex.App.--El Paso 1991, writ denied) (stating that *Vail* does not apply when there is no allegation of failure to effectuate a fair settlement).

[49] *See Thrash v. State Farm Fire & Cas. Co.*, 992 F.2d 1354, 1356 (5th Cir. 1993) (stating that the DTPA laundry list does not address settlement practices and therefore does not provide a private remedy for bad-faith settlement practices); *American Physicians Ins. Exchange v. Garcia*, 876 S.W.2d 842, 846 n.8 (Tex. 1994) (stating that the laundry lists in art. 21.21, § 4 and the DTPA do not address settlement practices under liability policies); *Commonwealth Lloyds Ins. Co. v. Downs*, 853 S.W.2d 104, 114-115, 117 (Tex.App.--Fort Worth 1993, writ denied) (holding that jury questions based on the DTPA pertained only to conduct during the procurement phase of the policy); *Lee v. Safemate Life Ins. Co.*, 737 S.W.2d 84, 86 (Tex.App.--El Paso 1987, writ dism'd) (laundry lists in the DTPA, art. 21.21, and Board Order 41060 (now 28 Tex. Admin. Code §§ 21.1 - 21.5) do not pertain to unfair claim settlement practices); *cf. Tri-Legends Corp. v. Ticor Title Ins. Co. of Calif.*, 889 S.W.2d 432, 440-441 (Tex.App.--Houston [14th Dist.] 1994, writ denied) (holding that certain insurance regulations create a cause of action only for misrepresentations in advertising).

In this case, only subparts F. through K. of Question 1 are based on statutes or regulations that address claim-settlement conduct. And of those subparts, only G. and J. have support in the actual holding of *Vail*. Subpart G. essentially inquired about bad faith, while subpart J. inquired about failure to settle after liability became reasonably clear. Therefore, if *Vail* governs, then only Questions 1.G. and 1.J. (or at most, only Questions 1.F. through 1.K.) are legally recognized causes of action. For the reasons discussed on pages 19-37 below, however, Denise still cannot recover, because those causes of action either do not apply here or have no evidentiary support in the record.

Issue Two: Provident American's Right to Contest the Claim

Second Point of Error (Restated)

The court of appeals erred in compelling Provident American to attempt settlement when liability becomes reasonably clear, even though there is also reasonable evidence that the claim is not covered.

Third Point of Error (Restated)

By compelling Provident American to attempt settlement, the court of appeals violated Provident American's rights to due process, open courts, and trial by jury, under both the United States and Texas constitutions.

Arguments Germane to Points Two and Three

By holding that Question 1.J. is a legally recognized cause of action, the court of appeals in effect imposed a duty on all insurers to attempt "in good faith to effectuate a prompt, fair, and equitable settlement of a claim when liability has become reasonably clear."[50] The court then held that there is sufficient evidence to support a finding that Provident American breached this duty, because it allegedly was reasonably clear to Provident that Denise's HS had not

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[50] 914 S.W.2d at 278-279; Tr. 89; *see Texas Farmers Ins. Co. v. Cooper*, No. 08-96-00005-CV, 1996 WL 64032 at *2 n.2 (Tex.App.--El Paso, Feb. 15, 1996, orig. proceeding) (stating that failure to promptly settle is "the very heart" of a bad-faith claim).

manifested before the 30-day waiting period expired.[51] At the same time, however, the court mentioned conflicting evidence that Denise exhibited symptoms of HS before the 30-day waiting period expired.[52] Thus, the court implicitly recognized that Provident American had reasonable evidence of noncoverage.

In *Aranda, Lyons*, and their progeny, this court recognized that when there is reasonable evidence of noncoverage, the insurer has a right to contest the claim.[53] Instead of applying this rule, however, the court of appeals in essence held that, even when there is a jury question on coverage, the insurer cannot present the case to a jury without first attempting to settle. Under this holding, an insurer that fails to attempt settlement will face statutory penalties.

This holding undermines *Aranda*, *Lyons*, and their progeny, because under this holding, it becomes irrelevant that an insurer had a reasonable basis to contest the claim. Under the court of appeals' reasoning, if there is reasonable evidence of coverage -- if liability is "reasonably clear" -- the insurer must attempt to settle and thereby forfeit its right to contest the claim. The insurer must attempt to settle even those claims that a jury could find are outside of coverage. Because this result is contrary to *Aranda*, *Lyons*, and their progeny, this court should hold that Question 1.J. does not create a cause of action.

This result is also contrary to Provident American's constitutional rights to due process, open courts, and trial by jury.[54] By compelling Provident American to attempt settlement, the

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[51] 914 S.W.2d at 279-280.

[52] *Id.* at 279 ("There is some evidence in the record that Ms. Castaneda was jaundiced and felt occasional abdominal pain before and within the thirty-day exclusion period. Jaundice and abdominal pain are symptoms of HS and its secondary gallstone problem.").

[53] *See, e.g., Transportation Ins. Co. v. Moriel*, 879 S.W.2d 10, 17-18 (Tex. 1994); *Lyons v. Millers Cas. Ins. Co. of Tex.*, 866 S.W.2d 597, 600-601 (Tex. 1993); *Aranda v. Ins. Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex. 1988).

[54] U.S. Const. Amend. XIV, § 1; Tex. Const. art. I, §§ 13, 15, 19, art. V, § 10; *see, e.g., Gulf, C. & S. Ry. Co. v. Ellis*, 165 U.S. 150, 154 (1897) (corporations are considered "persons" with constitutional rights); *Texas Bitulithic Co. v. Abilene St. Ry. Co.*, 166 S.W.

court of appeals has infringed -- or at least chilled the exercise of -- these rights. For example, it is not a court's place to compel parties to settle.[55] "A court cannot force the disputants to peacefully resolve or negotiate their differences."[56] Rather, due process requires courts to provide an opportunity for a full hearing.[57] And appellate courts will strictly scrutinize any restriction on the right to be heard before a jury.[58] "Ready access to the courts is a 'fundamental constitutional right.' Regulations and practices that unjustifiably obstruct such access are invalid."[59]

Being under a compulsion to attempt settlement, companies like Provident American no longer have ready access to the courts. They are no longer free to contest fact issues before a jury -- not when the price for exercising that right is the prospect of treble damages. "A litigant's rights to assert contractual defenses in a court of law should not be burdened by the threat of tort damages for erroneously predicting the outcome of the contract lawsuit."[60] Contrary to this principle, the court of appeals' holding penalizes Provident American for

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433, 436 (1914) (Tex.Civ.App.--Fort Worth 1914, writ refused) (corporations are entitled to equal-protection rights).

[55] *See, e.g., Decker v. Lindsay*, 824 S.W.2d 247, 251-252 (Tex.App.--Houston [1st Dist.] 1992, orig. proceeding) (holding that an order requiring the parties to negotiate in good faith was void).

[56] *E.g., Hansen v. Sullivan*, 886 S.W.2d 467, 469 (Tex.App.--Houston [1st Dist.] 1994, orig. proceeding) (holding that an order that sanctioned a party for failing to attend mediation in good faith was void).

[57] *See, e.g., Derbigny v. Bank One*, 809 S.W.2d 292, 295 (Tex.App.--Houston [14th Dist.] 1991, no writ).

[58] *E.g., Bell Helicopter Textron, Inc. v. Abbott*, 863 S.W.2d 139, 141 (Tex.App.--Texarkana 1993, writ denied).

[59] *Ruiz v. Estelle*, 679 F.2d 1115, 1153 (5th Cir.) (footnotes omitted), *modified*, 688 F.2d 266 (5th Cir. 1982) (per curiam), *cert. denied*, 460 U.S. 1042 (1983).

[60] *State Farm Lloyds Ins. Co. v. Maldonado*, No. 04-93-00046-CV, 1994 WL 723670 at * 7 (Tex.App.--San Antonio, Dec. 30, 1994, reh. en banc requested).

exercising the constitutional right to litigate questionable claims.[61]

Finally, the court of appeals' holding undermines the rule of evidence that settlement offers are not admissible.[62] Under the court's ruling, the absence of any attempt to settle triggers liability. To defend itself, therefore, an insurer must necessarily waive the evidentiary exclusion and offer evidence that it tried to settle. But such evidence is highly prejudicial to an insurer's position that the claim is not covered.[63] A jury will no doubt wonder: "If the insurer believes that the claim is not covered, why did the insurer nevertheless offer to settle?" Also, by offering to settle, and thereby admitting that liability is "reasonably clear," does the insurer in effect concede that the claim is covered, and thus expose itself to treble damages for not paying sooner or for not actually achieving a settlement? By allowing insureds to recover for failure to attempt settlement, the court of appeals has therefore put insurers in a trap: either offer to settle and have the jury hold that offer against the insurer in assessing liability for actual and treble damages, or decline to offer a settlement and face treble-damage exposure.

To preserve the evidentiary exclusion of settlement offers, to preserve insurers' constitutional rights, and to preserve the integrity of this court's bad-faith decisions, Provident American asks the court to hold that Question 1.J. does not constitute a legally recognized cause of action.[64]

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[61] *See, e.g., Lockett v. Prudential Ins. Co. of Am.*, 870 F.Supp. 735, 740 (W.D.Tex 1994) ("Mere non-payment of a claim and the exercise by the insurer of its constitutional right to litigate before a jury the merits or demerits of the underlying claim is not in and of itself bad faith.").

[62] Tex.R.Civ.Evid. 408.

[63] *See, e.g., F.A. Richard & Assoc. v. Millard*, 856 S.W.2d 765, 767 (Tex.App.--Houston [1st Dist.] 1993, orig. proceeding); *General Accid. Fire & Life Assurance Corp. v. Callaway*, 429 S.W.2d 548, 553 (Tex.Civ.App.--Houston [1st Dist.] 1968, no writ).

[64] *Cf. Abbott Lab., Inc. v. Segura*, 907 S.W.2d 503, 507 (Tex. 1995) (a legally prohibited antitrust claim cannot be brought under the guise of the DTPA).

Issue Three: No Evidence of Liability

Fourth Point of Error (Restated)

The court of appeals erred in overruling Provident American's second point of error, and in holding that there is legally sufficient evidence to support jury findings that Provident American: (1) failed to attempt in good faith to make a prompt, fair settlement when liability became reasonably clear; and (2) failed to acknowledge with reasonable promptness pertinent communications.

Fifth Point of Error (Restated)

The court of appeals erred in holding that Provident American's liability ever became reasonably clear.

Sixth Point of Error (Restated)

The court of appeals erred in holding that there is legally sufficient evidence to support a finding that it was reasonably clear to Provident American that Ms. Castaneda's disease had manifested after expiration of the 30-day waiting period.

Seventh Point of Error (Restated)

The court of appeals erred in failing to address the point that Provident American's conduct was not a producing cause of any damages.

Arguments Germane to Points Four Through Seven

Failure to Attempt Settlement

If Question 1.J. is a legally recognized cause of action, then it was Denise's burden to prove that Provident American failed to attempt a prompt, fair settlement after liability became reasonably clear.[65] As the El Paso Court of Appeals has stated, this duty to settle is essentially a codified version of the duty of good faith and fair dealing.[66] Under the duty of good faith and fair dealing, insurers have the right to deny questionable claims without being subjected to

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[65] Tr. 89.

[66] *Stewart Title Guar. Co. v. Aiello*, 911 S.W.2d 463, 470 (Tex.App.--El Paso 1995, writ requested); *see Texas Farmers Ins. Co. v. Cooper*, No. 08-96-00005-CV, 1996 WL 64032 at * 2 n.2 (Tex.App.--El Paso, Feb. 15, 1996, orig. proceeding) (stating that failure to settle is "the very heart" of a bad-faith claim).

extracontractual liability.[67] "Evidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad-faith."[68] To establish bad-faith liability, Denise therefore had to prove a negative -- that Provident American had no reasonable basis to deny.[69] It follows that proof of the affirmative -- namely, proof of a reasonable basis -- defeats the bad-faith claim.[70] Thus, there is no duty to attempt settlement when there is a reasonable basis to deny the claim -- that is, when liability is reasonably unclear.[71]

The record here shows as a matter of law that Provident American had a reasonable basis to deny on the ground that Denise's illness manifested before the 30-day waiting period expired. Specifically, the record shows that HS sufferers will exhibit anemia and jaundice, that most HS sufferers develop an enlarged spleen, that a less common symptom is skin ulcerations, and that most HS sufferers develop gallstones, causing abdominal pain.[72] The record also shows that

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[67] *See, e.g., Aranda v. Ins. Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex. 1988).

[68] *Transportation Ins. Co. v. Moriel*, 879 S.W.2d 10, 17 (Tex. 1994).

[69] *E.g., National Union Fire Ins. Co. v. Dominguez*, 873 S.W.2d 373, 376 (Tex. 1994).

[70] *E.g., Lockett v. Prudential Ins. Co. of Am.*, 870 F. Supp. 735, 740 (W.D.Tex. 1994); *Cortez v. Liberty Mut. Fire Ins. Co.*, 885 S.W.2d 466, 469-470 (Tex.App.--El Paso 1994, writ denied). For a fuller explanation of the reasonable-basis defense, *see* the article attached to this brief at Tab C. Scott Patrick Stolley, *Reasoning Through the Reasonable-Basis Defense*, 3 Tex. Ins. L.J. 57 (March 1994).

[71] *Lockett*, 870 F.Supp. at 742-743 (liability did not become reasonably clear until the jury found coverage); *State Farm Lloyds Ins. Co. v. Maldonado*, No. 04-93-00046-CV, 1994 WL 723670 at * 6-7 (Tex.App.--San Antonio 1994, reh. en banc requested) (because there were legitimate reasons to question coverage, the insurer was not liable for failing to settle); *State Farm Fire & Cas. Co. v. Taylor*, 832 S.W.2d 645, 649-650 (Tex.App.--Fort Worth 1992, writ denied) (plaintiffs did not establish that the insurer's liability ever became reasonably clear); *Koral Indus., Inc. v. Security-Connecticut Life Ins. Co.*, 788 S.W.2d 136, 147 (Tex.App.--Dallas) (no duty to settle a claim that is not covered), *writ denied*, 802 S.W.2d 650 (Tex. 1990); *Progressive County Mut. Ins. Co. v. Boman*, 780 S.W.2d 436, 440-441 (Tex.App.--Texarkana 1989, no writ) (because there was a reasonable basis to deny, the insurer's liability was not reasonably clear).

[72] R.Ex. 3 at 9-10, 12-14, 16-17, 25-26, 31, 43, 49-50; D.Ex. 5; P.Exs. 3, 8; S.F. 261, 809-810.

HS is an inherited disorder, more commonly inherited from the mother's side of the family.[73] Denise's medical records -- upon which Provident American relied -- contained all of these indications of HS. Specifically, the records stated:

(1) that Denise was jaundiced;

(2) that Denise had a history of jaundice;

(3) that Denise was anemic;

(4) that Denise had skin ulcerations;

(5) that Denise had an elevated bilirubin level of 3;

(6) that Denise had recurrent bouts of abdominal pain;

(7) that Denise had previously been treated for "funny-colored" skin and possible hepatitis;

(8) that Denise had an enlarged spleen (4-5 times normal size);

(9) that Denise had gallstones;

(10) that a close relative had HS;

(11) that tests confirmed that Denise had HS; and

(12) that Denise's condition was congenital and hereditary.[74]

In addition, the record shows that Denise's bilirubin level was high enough to cause jaundice and yellow sclerae.[75] Finally, the record shows that Denise's numerous embedded gallstones would have taken over one month to develop, had probably been developing for years, and probably caused Denise's recurrent abdominal pain.[76] Given all of these facts, it was reasonable for Provident American to conclude that the claim was not covered because Denise's

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[73] R.Ex. 3 at 9-11; D.Ex. 5; S.F. 764-766, 770.

[74] P.Exs. 3, 4; S.F. 201, 473-476, 478, 510-513, 520, 541, 543-544; R.Ex. 1 at 27-28.

[75] R.Ex. 3 at 16-17.

[76] R.Ex. 3 at 13-14, 24-26, 31; P.Exs. 3, 8; D.Ex. 4.

HS had manifested before the 30-day waiting period expired.[77]

Further supporting that conclusion is the Castanedas' failure to disclose Guillermo Jr.'s recent sickness and Denise's prior treatment for "funny color" skin and possible hepatitis. Moreover, the record shows a suspicious coincidence between: (1) the timing of Mr. Castaneda's decision to buy coverage; (2) the nondisclosure of Guillermo Jr.'s recent illness and Denise's prior symptoms; (3) the timing of the call from Mrs. Castaneda's brother; (4) the timing of the visit to Dr. Gutierrez (one day after the 30-day waiting period expired); and (5) the timing of subsequent doctor visits and the double surgery. From this, Provident American could reasonably conclude that the Castanedas manipulated the timing -- in an attempt to create coverage -- because they had noticed symptoms of some known or unknown illness in their children.[78] In short, Denise's HS had manifested (even if the disease was undiagnosed), the Castanedas had noticed the symptoms, and the Castanedas then set about to create coverage. The Castanedas' suspicious conduct therefore supports Provident American's reasonable conclusion that Denise's condition manifested before the 30-day waiting period expired.

Overall, the evidence -- especially the medical evidence -- created a fact issue, because a jury could believe that Denise's HS first manifested before the 30-day waiting period expired. Given this fact issue, Provident American had a reasonable basis to deny.[79] In similar situations, many courts have found that medical evidence -- even conflicting medical evidence -- provides the insurer with a reasonable basis to deny.[80] Thus, Provident American's liability

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[77] R.Ex. 3 at 27, 30, 38-39.

[78] *See* R.Ex. 3 at 30, 50-51.

[79] *See, e.g., Rogers v. Cigna Ins. Co. of Tex.*, 881 S.W.2d 177, 185 (Tex.App.--Houston [1st Dist.] 1994, no writ) (no bad faith where there was evidence on which a reasonable tribunal could find for the insurer on the coverage issue); *State Farm Lloyds, Inc. v. Polasek*, 847 S.W.2d 279, 286-287 (Tex.App.--San Antonio 1992, writ denied).

[80] *E.g., National Union Fire Ins. Co. v. Dominguez*, 873 S.W.2d 373, 376-377 (Tex. 1994); *Connolly v. Service Lloyds Ins. Co.*, 910 S.W.2d 557, 563 (Tex.App.--Beaumont

was never "reasonably clear," which means that there is no evidence to support an affirmative answer to Question 1.J.[81]

In holding to the contrary, the court of appeals mischaracterized Provident American's denial letter as acknowledging that Denise's jaundice "was associated with a prior bout with hepatitis."[82] The letter actually says: "Dr. Canales' records indicate a history of jaundice and treatment of hepatitis."[83] Thus, the letter did not associate Denise's jaundice exclusively with a prior bout of hepatitis. Moreover, the medical records state that Denise was treated for *suspected* hepatitis, not that she definitely had hepatitis.[84] Thus, Denise's records suggest prior manifestation of her HS, masked as symptoms of possible hepatitis -- precisely what happened when Dr. Juarez treated Guillermo Jr. for possible hepatitis right before Mr. Castaneda applied for the policy.[85]

The court of appeals also mischaracterized a letter that Mr. Castaneda sent (after Provident American had denied the claim) as stating that Denise "always had a yellowish cast

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1995, no writ); *Cortez v. Liberty Mut. Fire Ins. Co.*, 885 S.W.2d 466, 470 (Tex.App.--El Paso 1994, writ denied); *Ramirez v. Transcontinental Ins. Co.*, 881 S.W.2d 818, 825-826 (Tex.App.--Houston [14th Dist.] 1994, writ denied); *Packer v. Travelers Indem. Co. of R.I.*, 881 S.W.2d 172, 176-177 (Tex.App.--Houston [1st Dist.] 1994, no writ); *Rogers*, 881 S.W.2d at 184-185; *see Fuentes v. Texas Employers Ins. Ass'n*, 757 S.W.2d 31, 33 (Tex.App.--San Antonio 1988, no writ).

[81] *See, e.g., Lockett v. Prudential Ins. Co. of Am.*, 870 F.Supp. 735, 742-743 (W.D.Tex. 1994); *State Farm Lloyds Ins. Co. v. Maldonado*, No. 04-93-00046-CV, 1994 WL 723670 at * 6-7 (Tex.App.--San Antonio, Dec. 30, 1994, reh. en banc requested); *State Farm Fire & Cas.Co. v. Taylor*, 832 S.W.2d 645, 649-650 (Tex.App.--Fort Worth 1992, writ denied); *Progressive County Mut. Ins. Co. v. Boman*, 780 S.W.2d 436, 440-441 (Tex.App.--Texarkana 1989, no writ).

[82] 914 S.W.2d at 279-280.

[83] P.Ex. 16.

[84] P.Ex. 3 ("This is a twenty one year old female who has a history of jaundice and questionably treated for hepatitis recently . . . .").

[85] *See* R.Ex. 3 at 15-16, 27-28, 29.

to her skin and that her color had not changed significantly prior to diagnosis."[86] The letter actually stated that Denise and her brother "had their skin a little yellow throughout their whole lives . . . ."[87] The letter does not state that Denise's color never changed significantly, but even if the letter did, Provident American could reasonably rely on the records showing that Denise had previously exhibited jaundice.[88]

The court of appeals further relied on Denise's belief that her recurrent abdominal pain was caused by indigestion.[89] Her subjective belief does not, however, rule out a reasonable conclusion by Provident American that her abdominal pain was actually caused by gallstones secondary to HS.[90]

Accordingly, none of the court of appeals' rejoinders invalidate Provident American's reasonable belief that Denise's HS manifested before the 30-day waiting period expired. In short, the record contains no evidence to support an affirmative finding to Question 1.J., because Provident American's liability never became reasonably clear.

Failure to Promptly Communicate

Similarly, there is no evidence that Provident American failed to acknowledge with reasonable promptness pertinent communications. Provident American promptly denied the claim (the first time) less than two months after the surgery. Provident American then reopened the claim and issued a second denial one-and-a-half months later. As a matter of law, therefore,

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[86] 914 S.W.2d at 280.

[87] P.Ex. 19.

[88] P.Ex. 3.

[89] 914 S.W.2d at 280.

[90] *See* S.F. 510, 513; D.Ex. 5.

Provident American acted with sufficient promptness.[91]

To the extent that Provident American may have failed to promptly respond to any communications, Denise suffered no harm. For example, her counsel complained that Provident American did not promptly respond to a letter that Ms. Castaneda sent to the Department of Insurance.[92] But Mr. Castaneda's letter essentially demanded a settlement after Provident American had already denied the claim. Because Provident American had a reasonable basis to deny, Provident American had no duty to settle. Because Provident American had no duty to settle, Provident American's response (even if it was late) could not have been the producing cause of any damage.[93]

Overall, there is no evidence that a failure (if any) to promptly communicate was a producing cause of either loss of benefits or past loss of credit reputation.[94] Thus, an affirmative answer to Question 1.H. cannot support the judgment.

Misrepresentation Questions

Where alternative grounds could support a judgment, the appellant must attack those grounds.[95] Thus, even though the court of appeals relied on subparts 1.H. and 1.J. only, Provident American reluctantly feels obligated to attack the possible jury answers to the other

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[91] *Cf. Lyons v. Millers Cas. Ins. Co. of Tex.*, 866 S.W.2d 597, 599 (Tex. 1993) (initial denial occurred less than one month after the loss, and after reexamination, second denial occurred about five months after the loss); *Connolly v. Service Lloyds Ins. Co.*, 910 S.W.2d 557, 561-562 (Tex.App.--Beaumont 1995, n.w.h.) (no bad-faith delay where the insurer approved surgery within 4 months after the doctor's recommendation).

[92] S.F. 862-863; P.Exs. 24, 25.

[93] *See State Farm Fire & Cas. Co. v. Taylor*, 832 S.W.2d 645, 650 (Tex.App.--Fort Worth 1992, writ denied) (where there was no duty to settle, the insurer's failure to acknowledge a settlement offer could not have been a producing cause of any harm).

[94] *See, e.g., Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 342-343 (Tex. 1995) (Spector, J., concurring) (the insurer's claim-handling conduct caused no damages).

[95] *See, e.g., State Farm Mut. Auto. Ins. Co. v. Cowley*, 468 S.W.2d 353, 354 (Tex. 1971).

subparts. For analytical purposes, it is helpful to group those subparts by general topic: (1) misrepresentation questions; (2) reasonable-basis questions; (3) claim-procedure question; and (4) unconscionable-conduct question.

Subparts A. through F. of Question 1 and all of Question 4 fall in the first category -- misrepresentation questions. In one form or another, each of these questions inquired whether Provident American made a misleading representation or engaged in a misleading omission.[96] To carry her burden on these questions, Denise had to prove more than a mere denial of her claim.[97] She had to prove more than the fact that Provident American issued a policy and then failed to pay the claim.[98] Denise failed to carry her burden.

First, as Denise admitted, Provident American had no contact with and made no misrepresentations to her.[99] In a similar context, the El Paso Court of Appeals held that the plaintiff could not recover.[100] In that case, the plaintiff was an additional insured under his employer's auto liability policy. Because the plaintiff admitted that the insurer made no misrepresentations to him, the court held that the insurer was entitled to summary judgment on the plaintiff's DTPA claims.[101] Similarly, in this case, Provident American is entitled to judgment on the misrepresentation questions, because Provident American made no

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[96] Tr. 88-89, 91.

[97] *See, e.g., Walker v. Federal Kemper Life Assurance Co.*, 828 S.W.2d 442, 454 (Tex.App.--San Antonio 1992, writ denied); *Yancey v. Floyd West & Co.*, 755 S.W.2d 914, 922 (Tex.App.--Fort Worth 1988, writ denied).

[98] *See, e.g., Aetna Cas. & Sur. Co. v. Iso-Tex, Inc.*,75 F.3d 216, 219 (5th Cir. 1996) (Texas law -- no actionable misrepresentation when the issuer issued a policy, but failed to pay); *Crawford v. Ace Sign, Inc.*, 39 Tex. Sup. Ct. J. 296, 298 (Feb. 9, 1996) (failure to perform a contract is not a misrepresentation of performance and, hence, is not a DTPA violation).

[99] S.F. 397, 433, 606, 621.

[100] *Hopkins v. Highlands Ins. Co.*, 838 S.W.2d 819, 823 (Tex.App.--El Paso 1992, no writ).

[101] *Id.*

misrepresentation to Denise.[102]

Second, there is no evidence that Provident American made any misrepresentations during the marketing of the policy or before the denial.[103] Denise argued, however, that Provident American represented to two doctors that Provident American would cover the surgery expenses. One doctor complained that his office obtained preapproval for the surgery, while the other was allegedly told after the denial that there was no doubt that the claim would be paid.[104] In both instances, because there is no evidence that Denise or her father were contemporaneously aware of these statements, it follows that neither statement could have been a factual cause of damage to Denise.[105] There is also no evidence that Denise acted on the alleged preapproval.[106]

In addition, Provident American cannot be liable for a preapproval given before a claim is submitted and Provident American has a chance to investigate. None of the relevant records (showing manifestation during the 30-day waiting period) had been generated, let alone sent to

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[102] *Cf. Amstadt v. United States Brass Corp.*, 39 Tex. Sup. Ct. J. 351, 356 (March 7, 1996) (no evidence that information provided by a component-part manufacturer was passed to the consumers); *State Farm Fire & Casualty Co. v. Taylor*, 832 S.W.2d 645, 650 (Tex.App.--Fort Worth 1992, writ denied) (an insurer's representation in a court pleading was not a misrepresentation to the *claimant*).

[103] *See, e.g., McCracken v. U.S. Fire Ins. Co.*, 802 F.Supp. 30, 35 (W.D.Tex 1992) (no evidence of pre-accident misrepresentations); *Parkins v. Texas Farmers Ins. Co.*, 645 S.W.2d 775, 776-777 (Tex. 1983) (no evidence of a misrepresentation of coverage); *Commonwealth Lloyds Ins. Co. v. Downs*, 853 S.W.2d 104, 118 (Tex.App.--Fort Worth 1993, writ denied) (finding no evidence to support the jury's misrepresentation findings).

[104] P.Exs. 8, 27.

[105] *See Hopkins*, 838 S.W.2d at 823 (no liability where the purported insured was not aware of any representations by the insurer); *see also Crawford & Co. v. Garcia*, 817 S.W.2d 98, 102 (Tex.App.--El Paso 1991, writ denied) (no evidence that the defendants' conduct was a producing cause); *First Am. Title Co. of El Paso v. Prata*, 783 S.W.2d 697, 701, 703 (Tex.App.--El Paso 1989, writ denied) (no evidence that the defendants' conduct was a factual cause of damage).

[106] *See, e.g., Cavallini v. State Farm Mut. Auto. Ins. Co.*, 44 F.3d 256, 263-264 (5th Cir. 1995) (Texas law -- no evidence that the insureds acted on the alleged misrepresentations).

Provident American, so Provident American had no opportunity to learn that coverage was (at best) questionable. Preapproval is not a blanket guarantee that a claim will be paid regardless of later facts showing noncoverage.[107]

Denise's counsel also argued that Provident American made a post-denial misrepresentation in the company's response to the Department of Insurance.[108] The response stated that: "The policy contract specifies that the origin of symptoms is evidence of the existence of an illness under ... [the] thirty day sickness limitations."[109] For two reasons, however, this statement is not actionable. First, Provident American was merely expressing its understanding of the 30-day "manifestation" clause: that the policy excludes coverage where the symptoms were active and perceivable before the 30-day waiting period expired.[110] Provident American's statement of belief as to the meaning of the policy is not actionable conduct.[111] Second, Provident American's post-denial statement to the Department could not have been the producing cause of any harm to Denise. Provident American had already denied the claim and was merely responding to the Department's inquiry. Under these circumstances,

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[107] S.F. 464, 468.

[108] S.F. 863, 877; P.Ex. 25.

[109] P.Ex. 25.

[110] S.F. 215, 223, 394-396; *see Webster's New Collegiate Dictionary* 693 (1981) (defining "manifest" as "1: readily perceived by the senses and esp. by the sight 2: easily understood or recognized by the mind: OBVIOUS"); *cf. Bartlett v. American Republic Ins. Co.*, 845 S.W.2d 342, 347 (Tex.App.--Dallas 1992, no writ) (preexisting-condition clause did not require diagnosis of the condition); *Hannum v. General Life & Accid. Ins. Co.*, 745 S.W.2d 500, 501-502 (Tex.App.--Corpus Christi 1988, no writ) (holding that a preexisting condition can be one that is manifest but not yet diagnosed).

[111] *See, e.g., West Anderson Plaza v. Feyznia*, 876 S.W.2d 528, 532-534 (Tex.App.--Austin 1994, no writ) (holding that a party's interpretation of contract language is not actionable under the DTPA); *Walker v. Federal Kemper Life Assurance Co.*, 828 S.W.2d 442, 454 (Tex.App.--San Antonio 1992, writ denied) (stating that "an insurance company asserting an alternative interpretation of a policy, even if wrong, does not violate the Insurance Code").

Provident American's post-denial statements caused no harm.[112]

Reasonable-Basis Questions

Question 1.G. posed a bad-faith inquiry: whether Provident American denied the claim without a reasonable basis.[113] Question 1.K. basically repeated this inquiry, by essentially asking whether Provident American failed to offer a fair settlement.[114]

As discussed above on pages 23-28, Provident American had a reasonable basis to deny the claim and to refuse to settle the claim. It follows that "[a]s long as there exists a reasonable basis for the insured's claim, the insurer does not violate any provision of Article 21.21-2."[115] This includes the provision on which Question 1.K. is based.[116] Thus, there is no evidence to support affirmative findings to Questions 1.G. and 1.K.

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[112] *See, e.g., McCracken v. U.S. Fire Ins. Co.*, 802 F.Supp. 30, 35 n.1 (W.D.Tex. 1992) (holding that post-accident misrepresentations could not have harmed the plaintiffs); *Royal Globe Ins. Co. v. Bar Consultants, Inc.*, 577 S.W.2d 688, 694-695 (Tex. 1979) (post-loss misrepresentation caused no harm); *State Farm Fire & Cas. Co. v. Taylor*, 832 S.W.2d 645, 650 (Tex.App.--Fort Worth 1992, writ denied) (stating that the court could not conclude, as a matter of law, that a statement in a pleading was a producing cause of damage); *Texas Cookie Co. v. Hendricks & Peralta, Inc.*, 747 S.W.2d 873, 880 (Tex.App.--Corpus Christi 1988, writ denied) (post-transaction misrepresentations generally cause no injury and, therefore, are generally not actionable under the DTPA).

[113] Tr. 89; *see Lockett v. Prudential Ins. Co. of Am.*, 870 F.Supp. 735, 741 (W.D.Tex. 1994) (statutory bad faith requires proof of the same elements as common-law bad faith).

[114] Tr. 89; *cf. Tri-Legends Corp. v. Ticor Title Ins. Co. of Calif.*, 889 S.W.2d 432, 441 (Tex.App.--Houston [14th Dist.] 1994, writ denied) (stating that alternative DTPA allegations were only "semantical recharacterizations" of the plaintiff's true claim).

[115] *Love of God Holiness Temple Church v. Union Standard Ins. Co.*, 860 S.W.2d 179, 182 (Tex.App.--Texarkana 1993, writ denied); *see State Farm Lloyds Ins. Co. v. Maldonado*, No. 04-93-00046-CV, 1994 WL 723670 (Tex.App.--San Antonio, Dec. 10, 1994, reh. en banc requested) (stating that "the treble-damage remedy should not apply to insurers who assert plausible coverage questions"); *Progressive County Mut. Ins. Co. v. Boman*, 780 S.W.2d 436, 440-441 (Tex.App.--Texarkana 1989, no writ).

[116] *Love of God*, 860 S.W.2d at 182 (holding that the insurer's reasonable basis defeated an allegation that the insurer violated the provision on which Question 1.K. is based); *see Walker v. Federal Kemper Life Assurance Co.*, 828 S.W.2d 442, 454 (Tex.App.--San Antonio 1992, writ denied) (stating that "a post-loss denial of liability for a questionable claim is not actionable under the DTPA or the Ins. Code").

And it is irrelevant that Provident American originally denied based on the 6-month waiting period for gall-bladder conditions. Even though that was an incorrect reason for denying the non-gall-bladder-related expenses, the *Stoker* decision defeats a bad-faith claim for relying on this incorrect reason.[117] Under *Stoker*, an insurer is not liable for denying based on an invalid reason, when at the time, facts existed supporting a valid reason for denial.[118] In short, an insurer is not liable when it had a reasonable (even if unasserted) basis for denial. Here, at the time of the original denial based on the 6-month waiting period, there were facts supporting a reasonable denial based on the 30-day waiting period.[119] Thus, Provident American did not commit bad faith, even though it originally denied based on a partially incorrect reason. In summary, there is no evidence to support "yes" answers to Questions 1.G. and 1.K.

Claim-Procedure Question

Question 1.I. inquired whether Provident American failed to adopt and implement reasonable standards for prompt claim investigation.[120] This question required Denise to prove that Provident American had *no* standards for claim investigation. Although Denise certainly contends that Provident American's claim handling was deficient, she offered no evidence that Provident had *no* standards. Furthermore, even if Provident American had no standards, the fact remains that Provident American did investigate the claim, did deny promptly, and did have a reasonable basis for denial. Thus, any lack of standards could not have been a producing cause of any harm.[121]

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[117] *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 340-341 (Tex. 1995).

[118] *Id.*

[119] *See* pp. 23-28 above.

[120] Tr. 89.

[121] *Cf. Stoker*, 903 S.W.2d at 342-343 (Spector, J., concurring) (insurer's claim-handling conduct caused no damages).

Unconscionable-Conduct Question

Question 3 inquired whether Provident American engaged in "unconscionable conduct," in the form of conduct that either: (i) took advantage of the consumer's lack of knowledge to a grossly unfair degree; or (ii) resulted in a gross disparity between the value received and the consideration paid.[122] "Unconscionability is defined not in terms of the defendant's intent or conduct, but according to the objective result of the transaction."[123] Also, unconscionability is established only by proof of such conduct occurring *at the time of the sale.*[124] Thus, a disparity in value caused by later events does not support a claim of unconscionability.[125] Moreover, a breach of contract is not unconscionable conduct.[126] Finally, "[t]aking advantage of a consumer's lack of knowledge to a grossly unfair degree . . . requires a showing that the resulting unfairness was glaringly noticeable, flagrant, complete and unmitigated."[127]

In this case, there is no evidence that, at the time the policy was purchased, Provident American took advantage of Denise in a glaringly noticeable or flagrant way. Mr. Castaneda, who handled the transaction, is an industrial psychologist with a bachelor's degree, and Mrs. Castaneda, who participated in the meeting with the agent, is a dentist.[128] Denise is a civil engineering student, who earns A's and B's.[129] At the meeting with Mr. and Mrs. Castaneda,

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[122] Tr. 90; Tex. Bus. & Com. Code Ann. § 17.45(5) (Vernon 1987).

[123] *Willcox v. American Home Assurance Co.*, 900 F.Supp. 850, 861 (S.D.Tex. 1995).

[124] *Parkway Co. v. Woodruff*, 901 S.W.2d 434, 441 (Tex. 1995); *Chastain v. Koonce*, 700 S.W.2d 579, 584 (Tex. 1985).

[125] *Parkway*, 901 S.W.2d at 441.

[126] *Gulf States Underwriters of La., Inc. v. Wilson*, 753 S.W.2d 422, 430 (Tex.App.--Beaumont 1988, writ denied).

[127] *Chastain*, 700 S.W.2d at 584.

[128] S.F. 533, 562-3, 631-632.

[129] S.F. 600, 611-612.

the agent spoke in the Castanedas' native language (Spanish) and explained the policy provisions, including the 30-day waiting period.[130] The Castanedas have never complained that they did not understand the policy. In short, there is no evidence that Provident American took advantage of the Castanedas, all of whom are intelligent, educated people.[131] If anything, Mr. Castaneda tried to take advantage of Provident American by failing to disclose material information.[132]

There is also no evidence that, at the time of the sale, there was a gross disparity between the premium paid and the coverage received. The Castanedas received the policy they paid for, and despite the Castanedas' misrepresentations about the family medical history, Provident American decided not to rescind the policy, because the surgeries obviated any future claims related to the HS.[133] Thus, even if the policy does not cover the HS claim, the policy still covered other medical expenses.[134] And Provident American's later denial -- even if a breach of contract -- did not render the policy valueless.[135] Rather, Denise still had a valuable right -- the right to sue for breach of contract.[136] Thus, there is no evidence to support an affirmative finding to the unconscionable-conduct question.

Summary

Denise nevertheless accuses Provident American of committing DTPA and Insurance

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[130] S.F. 562, 702-706, 724.

[131] *See Willcox*, 900 F.Supp. at 861.

[132] *See Tri-Legends Corp. v. Ticor Title Ins. Co. of Calif.*, 889 S.W.2d 432, 439-440 (Tex.App.--Houston [14th Dist.] 1994, writ denied).

[133] S.F. 205-206, 246-247, 249-250, 534-535, 738-739.

[134] P.Ex. 1.

[135] *See Willcox*, 900 F.Supp. at 861-862; *Gulf States*, 753 S.W.2d at 430.

[136] *See Lone Star Life Ins. Co. v. Griffin*, 574 S.W.2d 576, 580 (Tex.Civ.App.--Beaumont 1978, writ ref'd n.r.e.).

Code violations, for example, by giving inconsistent reasons for denial, denying for undisclosed reasons, failing to respond to her father's letters, giving inconsistent claim-status reports, suggesting to doctors that the claim would be paid, and creating an allegedly misleading claim-summary form. But regardless of the method by which Provident American reached its decision to deny, the fact remains that Provident American had a reasonable basis to deny.[137] Moreover, to the extent that Denise's catalogue of complaints establishes any statutory violations, Denise still cannot recover, because the conduct was not a producing cause of any damages.[138] The court of appeals -- which never addressed Provident American's arguments about producing cause -- therefore erred in affirming the judgment.[139]

In summary, there is no evidence to support the jury's answers to the statutory liability questions, either because there is no evidence that Provident American engaged in prohibited conduct or because the conduct was not a producing cause of damages.[140] Thus, Provident American asks this court to reverse and render a judgment in Provident American's favor.

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[137] *See Packer v. Travelers Indem. Co. of R.I.*, 881 S.W.2d 172, 176-177 (Tex.App.--Houston [1st Dist.] 1994, no writ) (adjusters' subjective desire to deny the claim did not defeat the fact that the medical records gave the insurer a reasonable basis to deny).

[138] *See Stoker*, 903 S.W.2d at 342-343 (Spector, J., concurring); *First Am. Title Co. of El Paso v. Prata*, 783 S.W.2d 697, 701 (Tex.App.--El Paso 1989, writ denied) (holding that the damages were not factually caused by the defendants' conduct).

[139] *See McKelvy v. Barber*, 381 S.W.2d 59, 64 (Tex. 1964) (the court of appeals "plainly errs when it affirms without considering a contention that might lead to a reversal . . . .").

[140] *See Millers Casualty Ins. Co. of Texas v. Lyons*, 798 S.W.2d 339, 344-345 (Tex.App.--Eastland 1990) (holding that there was no evidence of "false, misleading, or deceptive acts or practices"), *aff'd on other grounds*, 866 S.W.2d 597 (Tex. 1993).

Issue Four: No Damages

Eighth Point of Error (Restated)

The court of appeals erred in overruling Provident American's fourth point of error, and in holding that there is legally sufficient evidence to support the jury's answer to the damage question.

Ninth Point of Error (Restated)

The court of appeals erred in overruling Provident American's sixth point of error, and in holding that the submitted damage elements are proper and that the jury's damage finding is supported by sufficient evidence.

Tenth Point of Error (Restated)

The court of appeals erred in holding that Ms. Castaneda did not have to prove medical expenses in accordance with the contractual measure of damages.

Eleventh Point of Error (Restated)

The court of appeals erred in overruling Provident American's seventh point of error, and in holding that the actual-damage award need not be reduced to the amount of covered benefits.

Arguments Germane to Points Eight Through Eleven

In the damage question (Question 6), the jury awarded a combined $50,000 for loss of benefits and past loss of credit reputation.[141] Because Question 6 contained only one answer blank, there is no way to determine how the jury apportioned the $50,000 between loss of benefits and past loss of credit reputation. Regardless, there is no evidence to support the jury's award.

Lost Benefits

First, as to lost benefits, Denise offered medical bills totaling $14,348.90.[142] When

[141] Tr. 92.

[142] S.F. 660-663, 673-676; P.Exs. 1, 29-35.

adjusted to delete uncovered expenses, her lost benefits are $11,834.90.[143] But Denise offered no evidence establishing her loss under the contractual measure of benefits -- namely, that the charges did not exceed the reasonable, usual, and customary charges.[144] Because she failed to offer evidence conforming to the contractual measure of damages, Denise is not entitled to recover lost benefits.[145]

The court of appeals excused Denise's failure on the ground that the DTPA does not restrict her to the contractual measure of damages.[146] In fashioning this excuse, the court correctly recognized that the DTPA's liberal approach allows a party to recover many types of damages.[147] But the court failed to acknowledge that the jury charge specifically defined loss of benefits to mean "the amount of benefits *due under the policy*."[148] Having been charged to prove lost benefits in accordance with the contractual measure of damages, Denise cannot escape this obligation on the ground that the DTPA would allow her to recover damages measured another way. Despite what the DTPA may allow, the charge in this case does not allow Denise to recover damages measured another way. Accordingly, because she offered no evidence of lost benefits in conformance with the contractual measure of damages, Denise cannot recover lost benefits.

Moreover, there is no evidence that Provident American's claim-handling conduct was

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[143] S.F. 740-741; P.Exs. 1, 29, 30, 34.

[144] P.Ex. 1.

[145] *See, e.g., National Union Fire Ins. Co. v. Valero Energy Corp.*, 777 S.W.2d 501, 510 (Tex.App.--Corpus Christi 1989, writ denied) (reversing where there was no evidence in conformity with the policy measure of damages).

[146] 914 S.W.2d at 281 (citing *Henry S. Miller Co. v. Bynum*, 836 S.W.2d 160, 162 (Tex. 1992)).

[147] *See, e.g., Bynum*, 836 S.W.2d at 162-163.

[148] Tr. 92 (emphasis added).

a producing cause of lost benefits.[149] Denise lost the policy benefits because Provident American denied the claim, not because of Provident American's claim-handling conduct. Given the denial, Denise would have lost the policy benefits even if Provident American had handled the claim flawlessly.[150] In short, Denise failed to prove that she was injured in some way "other than the injury that would always occur when an insured is not promptly paid . . . ."[151]

Credit Reputation

The court of appeals correctly noted that Denise's medical expenses are not sufficient to support the $50,000 award.[152] Thus, part of the award -- approximately $36,000 to $39,000 -- must represent damages for past loss of credit reputation. In the damage question, the trial court defined "credit" to mean "the ability of an individual to borrow on the opinion conceived by the lender that he will be repaid."[153] Thus, the charge required Denise to prove that lenders viewed her negatively. She also had to prove that Provident American's conduct was a producing cause of the lenders' negative opinions.[154] Denise proved neither.

The only evidence Denise offered was her subjective belief that her credit was ruined

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[149] *See Stoker*, 903 S.W.2d at 342 (Spector, J., concurring) ("The investigation of the claim clearly did not cause the damages to the Stokers' vehicle . . . .").

[150] *See id.* (Spector, J. concurring) ("[T]he Stokers would have incurred [the contract] damages even if their claim had been investigated properly."); *Walker v. Federal Kemper Life Assurance Co.*, 828 S.W.2d 442, 454 (Tex.App.--San Antonio 1992, writ denied) (misrepresentations caused no recoverable injury -- only the injury that always occurs when a claim is not promptly paid).

[151] *Walker*, 828 S.W.2d at 454; *cf. State Farm Fire & Cas. Co. v. Taylor*, 832 S.W.2d 645, 650 (Tex.App.--Fort Worth 1992, writ denied) (liability insurer's conduct was not a producing cause of the judgment entered against the insured).

[152] 914 S.W.2d at 281.

[153] Tr. 92.

[154] *See, e.g., Seneca Resources Corp. v. Marsh & McLennan, Inc.*, 911 S.W.2d 144, 150 (Tex.App.--Houston [1st Dist.] 1995, no writ); *First Am. Title Co. of El Paso v. Prata*, 783 S.W.2d 697, 701 (Tex.App.--El Paso 1989, writ denied).

because she was turned down for several credit cards.[155] The court of appeals recast this testimony, stating that Denise was "rejected for delinquencies on her credit report."[156] This is the court's most egregious mischaracterization of the record, for there is no evidence of a credit report or any delinquencies on a credit report. Even though federal law allows a consumer to obtain her credit report, Denise failed to introduce her formal credit report, and she offered no evidence that she ever had a good credit record.[157] She also offered no evidence that she ever had a need for credit in the past. Under these circumstances, there is no evidence of past loss of credit reputation.[158]

The San Antonio Court of Appeals dealt with similar factual circumstances in the 1985 *Roberts* case.[159] In *Roberts*, the court noted that the crucial inquiry is whether the plaintiff suffered credit problems that were different from any prior credit problems.[160] The plaintiff in *Roberts* failed this inquiry, because he could not show that his credit problems after the event were any different from his credit problems before the event.[161] Similarly, Denise failed to show that she suffered credit problems any different from those she suffered before the claim denial. The *Roberts* court further held that the plaintiff failed to prove causation because no

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[155] S.F. 606-607, 814-816.

[156] 914 S.W.2d at 281.

[157] 15 U.S.C.A. §§ 1681g, 1681m (West 1982 & Supp. 1996).

[158] *See Automobile Ins. Co. of Hartford v. Davila*, 805 S.W.2d 897, 908 (Tex.App.--Corpus Christi 1991, writ denied) (no evidence to support the plaintiffs' conclusion that their credit was ruined), *overruled on other grounds*, *Hines v. Hash*, 843 S.W.2d 464, 469-470 (Tex. 1992); *Worthey Motor Co., Inc. v. Frazier*, 443 S.W.2d 762, 763 (Tex.Civ.App.--Fort Worth 1969, no writ) (no evidence of future credit impairment).

[159] *Roberts v. U.S. Home Corp.*, 694 S.W.2d 129 (Tex.App.--San Antonio 1985, no writ).

[160] *Id.* at 134-135.

[161] *Id.*

lender stated that the refusal of credit was due to the defendant's conduct.[162] There was no way to tell whether the credit refusals were due to the defendant's conduct or due to other credit factors.[163] Denise's proof suffers from the same flaw. She testified that she was turned down for several credit cards "because of [her] credit."[164] But there is no evidence linking the credit-card denials to Provident American's conduct.[165]

In sum, Denise expressed a subjective belief that her credit was ruined. But her speculation is not competent evidence.[166] At best, her speculation is "'meager circumstantial evidence' which could give rise to any number of inferences, none more probable than another."[167] When two possibilities are equally probable, neither is proven.[168] Here, it is more likely that Denise -- being a college student with limited income and living in the U.S. on a student visa -- was never a good credit risk.

Overall, even if Denise can recover lost benefits, the judgment cannot stand, because the aggregated damage finding necessarily includes an unsupported element -- namely, past loss of credit reputation.[169] Alternatively, if the judgment is not reversed for this or another reason,

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[162] *Id.* at 135.

[163] *Id.*

[164] S.F. 815-816.

[165] *See West Texas Util. Co. v. Wills*, 164 S.W.2d 405, 410 (Tex.Civ.App.--Austin 1942, no writ) (no evidence of a causal connection between a slanderous statement and the plaintiff's credit rating).

[166] *See, e.g., Texas Division-Tranter, Inc. v. Carrozza*, 876 S.W.2d 312, 314 (Tex. 1994) (plaintiff's belief that he was fired for filing a worker's compensation claim was incompetent evidence).

[167] *Blount v. Bordens, Inc.*, 910 S.W.2d 931, 933 (Tex. 1995).

[168] *E.g., Transport Ins. Co. v. Faircloth*, 898 S.W.2d 269, 278 (Tex. 1995).

[169] *See, e.g., State v. Munday Enter.*, 868 S.W.2d 319, 320-321 (Tex. 1993), *cert. denied* 115 S.Ct. 64 (1994); *National Union Fire Ins. Co. v. Valero Energy Corp.*, 777 S.W.2d 501, 513 (Tex.App.--Corpus Christi 1989, writ denied); *Dawson v. Garcia*, 666 S.W.2d 254, 261 (Tex.App.--Dallas 1984, no writ).

this court should at least reform the judgment to award only the recoverable medical expenses.[170]

Issue Five: The Impenetrable Jury Charge

Twelfth Point of Error (Restated)

The court of appeals erred in overruling Provident American's third point of error, and in holding that, if any one liability theory is legally recognized and factually supported, the judgment must be affirmed.

Thirteenth Point of Error (Restated)

The court of appeals erred in overruling Provident American's fifth point of error and in holding that, if any one liability theory is legally recognized and factually supported, the judgment must be affirmed, even if it is impossible to determine whether the jury's damage finding relates to that theory.

Fourteenth Point of Error (Restated)

The court of appeals erred in overruling Provident American's ninth point of error, and in holding that, if any one liability theory is legally recognized and factually supported, the judgment for additional statutory damages must be affirmed, even if it is impossible to determine if the "knowing" findings relate to that theory.

Arguments Germane to Points Twelve Through Fourteen

Even if some of the liability questions submitted legally recognized causes of action for which there is evidence to support affirmative findings, the judgment still cannot stand, because it is impossible to ascertain what findings the jury actually made. With only one answer blank per liability question, it is impossible to know whether the jury answered "yes" to one subpart, to multiple subparts, or to all subparts. Thus, there is no way to determine whether the jury answered "yes" to a subpart that is both: (a) based on a legally recognized and properly pleaded cause of action; and (b) supported by sufficient evidence.

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[170] *See* Tex.R.App.P. 80(b) (court of appeals can reform or render the judgment); Tex.R.App.P. 180 (supreme court can render judgment that the court of appeals should have rendered).

For example, the jury might have answered "yes" to Question 1.E. and "no" to the rest of Question 1. But given that Denise pleaded no basis for Question 1.E., and that Provident American properly objected to the submission of that subpart, the judgment cannot rest on the jury's answer.[171] As a second example, the jury might have answered "yes" to a subpart for which there is no evidentiary support -- such as Question 1.I. -- but answered "no" to the remaining subparts. Under either scenario, the jury's only true "yes" answer would mandate a judgment for the defendant (assuming that Questions 3 and 4 also do not support a plaintiff's judgment). But the verdict would give the false appearance of justifying a judgment for the plaintiff, because there is no way to tell that the jury answered "no" to the other subparts.

And these are only two scenarios. Given that Questions 1, 3, and 4 contain a combined total of 20 subparts, there are dozens of possible combinations of "yes" answers that the jury could have intended. With this mind-boggling array of possibilities, the court and parties can only speculate about which liability findings (if any) actually support the judgment.

The damage questions (Questions 6 and 8) suffer from the same infirmity, and the interplay between the liability questions and the damage questions further compounds the problem. For example, because Question 6 was conditioned on a "yes" answer to any liability finding, it is impossible to determine if the jury found actual damages for a liability theory that is legally recognized, properly pleaded, and supported by sufficient evidence. The treble-damage question presents the same problem, because the overall format of the charge allowed the jury to award treble damages based on a "yes" answer to any liability subpart.[172] There is at least a possibility, therefore, that the jury awarded treble damages based on a liability theory that is not legally recognized, was not pleaded, or has no evidentiary support. But under

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[171] Tr. 30-34; S.F. 837-838; *see, e.g., Millers Cas. Ins. Co. of Tex. v. Lyons*, 798 S.W.2d 339, 344 (Tex.App.--Eastland 1990) (reversing an affirmative finding to an unpleaded misrepresentation claim), *aff'd on other grounds*, 866 S.W.2d 597 (Tex. 1993).

[172] Tr. 89-94.

the charge as formatted, no one can tell what the jury found.

To draft a judgment, however, it is imperative to know what the jury found.[173] The Texas Supreme Court has dealt with this problem on several occasions, starting as far back as 1923 in *Lancaster v. Fitch*.[174] In *Lancaster*, the trial court submitted a general charge containing three theories of negligence, one of which was erroneous. This court held that this error was harmful, because it was impossible to determine if the jury answered "yes" to the improper theory or to the two proper theories.[175] More recently, this court held similarly in the *Scott* case, decided after the court began espousing the use of broadform jury charges.[176] In *Scott*, a negligence issue allowed the jury to find negligence that was neither pleaded nor proved. This, the court held, was harmful error requiring reversal and remand.[177] And courts of appeals have held similarly in other cases.[178]

Texas courts have also dealt with this problem in relation to damage questions. For example, in one case, this court upheld a reversal and remand, because the damage question failed to segregate between damages that the plaintiff could legally recover and damages that he

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[173] *See, e.g., Kendall v. Johnson*, 212 S.W.2d 232, 236 (Tex.Civ.App.--San Antonio 1948, no writ) (court must be able to "clearly ascertain" the jury's intended finding); *Texas & New Orleans R.R. Co. v. Young*, 148 S.W.2d 229, 232 (Tex.Civ.App.--Fort Worth 1941, orig. proceeding) (verdict must "apprise the court of what the jury intended to find the facts to be").

[174] 112 Tex. 293, 246 S.W. 1015, 1016-1017 (1923), *cert. denied*, 262 U.S. 754 (1923).

[175] *Id.*; *accord Tisdale v. Panhandle & Santa Fe Ry. Co.*, 228 S.W. 133, 137 (Tex. Comm'n App. 1921, holding approved).

[176] *Scott v. Atchison, Topeka & Santa Fe Ry. Co.*, 572 S.W.2d 273, 277 (Tex. 1978).

[177] *Id.*

[178] *See, e.g., Wm. H. McGee & Co. v. Schick*, 792 S.W.2d 513, 517 (Tex.App.--Eastland 1990) (a finding that an insurer engaged in "unfair and/or deceptive" acts did not support the judgment, because the jury might have found "unfair" acts, and the law does not recognize a cause of action for "unfair" acts under the DTPA), *writ dism'd pursuant to settlement*, 843 S.W.2d 473 (Tex. 1992).

could not.[179] In another case, a court of appeals reversed a punitive-damage award, because the format of the charge did not permit the court to determine whether the jury awarded punitive damages for tort or for breach of contract.[180] In still another case, the court reversed, because the charge did not segregate between damages for negligence and damages for DTPA violations.[181]

These cases were correctly decided, because courts are not permitted to speculate about what the jury found.[182] Furthermore, the inability to draft an accurate judgment based on such speculation is error that the appellant can preserve in post-verdict motions.[183] Because it is the plaintiff's burden to obtain jury findings that allow the court to draft an accurate judgment, the defendant need not have objected to the charge in order to preserve error.[184] In this case, therefore, Provident American properly preserved error in its post-verdict motions.[185]

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[179] *Wingate v. Hajdik*, 795 S.W.2d 717, 719-720 (Tex. 1990); *see, e.g., State v. Munday Enter.*, 868 S.W.2d 319, 320-321 (Tex. 1993) (judgment reversed where an unsegregated damage finding was based on both compensable and noncompensable injuries), *cert. denied*, 115 S.Ct. 64 (1994); *Dawson v. Garcia*, 666 S.W.2d 254, 261 (Tex.App.--Dallas 1984, no writ) (judgment reversed where an aggregated damage finding may have included a noncompensable element).

[180] *Lovelace v. Sabine Consol., Inc.*, 733 S.W.2d 648, 654-655 (Tex.App.--Houston [14th Dist.] 1987, writ denied).

[181] *Lucas v. Nesbitt*, 653 S.W.2d 883, 886-887 (Tex.App.--Corpus Christi 1983, writ ref'd n.r.e.); *see Johnson v. Holly Farms of Tex., Inc.*, 731 S.W.2d 641, 646 (Tex.App.--Amarillo 1987, no writ) (remanding where the damage issue did not permit the court to determine which damages belonged to which plaintiff).

[182] *See, e.g., Perez v. Weingarten Realty Investors*, 881 S.W.2d 490, 493-495 (Tex.App.--San Antonio 1994, writ denied); *Parker v. Keyser*, 540 S.W.2d 827, 830 (Tex.Civ.App.--Corpus Christi 1976, no writ); *Cactus Drilling Co. v. Williams*, 525 S.W.2d 902, 907 (Tex.Civ.App.--Amarillo 1975, writ ref'd n.r.e.).

[183] *J & C Drilling Co. v. Salaiz*, 866 S.W.2d 632, 640 (Tex.App.--San Antonio 1993, no writ); *Lovelace*, 733 S.W.2d at 655; *Lucas*, 653 S.W.2d at 887.

[184] *J & C Drilling*, 866 S.W.2d at 640; *Lovelace*, 733 S.W.2d at 655; *Lucas*, 653 S.W.2d at 887.

[185] Tr. 230, 237-238, 243-244, 250.

The court of appeals held, however, that any error in the charge was harmless.[186] The court explained: "While it is possible that the jury made an affirmative finding based on an improperly submitted theory of liability, possibility is not a sufficient showing [of harm] under Rule 81(b)(1)."[187] The court is partially correct: given that no one can tell what the jury found, Provident American cannot show more than a possibility that the jury relied on an improper, defective, or factually unsupported subpart.

In so holding, however, the court set up a test that no appellant in Provident American's position could ever pass. Because Provident American can never show a "probability," Provident American could never meet the court of appeals' harmful-error test. The court of appeals failed to realize that this impossibility creates the other type of harm recognized in the rules: that the appellant was probably prevented from making a proper presentation on appeal.[188] Other courts have found such harm where it was impossible for the appellant to determine what findings the trial court made in a nonjury setting.[189] Such harm is similarly present when it is impossible to determine what findings the jury made.[190] When the charge includes an improper element, the appellate court cannot "say that inclusion of [the improper] element in the charge was harmless because of the jury's findings on other elements, since it would be impossible to determine what the jury had found on other elements."[191] As Professor

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[186] 914 S.W.2d at 277-278.

[187] *Id.* at 277.

[188] Tex.R.App.P. 81(b)(1), 184(b).

[189] *E.g.*, *Zarsky v. Zurich Mgmt., Inc.*, 829 S.W.2d 398, 400 (Tex.App.--Houston [14th Dist.] 1992, no writ); *F.D.I.C. v. Morris*, 782 S.W.2d 521, 523-524 (Tex.App.--Dallas 1989, no writ); *Barnes v. Coffman*, 753 S.W.2d 823, 823-824 (Tex.App.--Houston [14th Dist.] 1988, writ denied).

[190] *Haney Elec. Co. v. Hurst*, 624 S.W.2d 602, 610 (Tex.Civ.App.--Dallas 1981, writ dism'd as moot).

[191] *Id.*

Dorsaneo has stated: "[T]he inclusion of invalid legal theories has a strong presumption of harm, especially when the flawed legal theory has support in the evidence."[192]

If the court of appeals' ruling stands, jury charges like the one in this case will be truly impenetrable. No matter what the jury found or intended to find, the judgment will be impervious to attack on appeal, because the appellant could never prove harm. Provident American therefore asks this court to recognize that harm is present, in the form of error rendering it impossible to make a proper appellate presentation. Based on that harm, Provident American asks the court to reverse and remand for a new trial.

Issue Six: Attorney's Fees as a Percentage of the "Recovery"

Fifteenth Point of Error (Restated)

The court of appeals erred in overruling Provident American's eleventh point of error, and in holding that Ms. Castaneda can recover attorney's fees, even though the attorney's-fee question required the jury to speculate about the amount of Ms. Castaneda's "recovery."

Arguments Germane to Point Fifteen

The attorney's-fees question (Question 9) asked the jury to award fees stated as a percentage of Denise's "recovery."[193] Although this submission followed the Texas Pattern Jury Charges, the Fourteenth Court of Appeals has disapproved of the Pattern Jury Charges' use of the word "recovery."[194] Without a definition of "recovery," both the court and the jury

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[192] William V. Dorsaneo, III, *Broad-Form Submission of Jury Questions and the Standard of Review*, 46 SMU Law Rev. 601, 636 (1992).

[193] Tr. 94.

[194] *Roberts v. Grande*, 868 S.W.2d 956, 960 n.1 (Tex.App.--Houston [14th Dist.] 1994, no writ); 4 State Bar of Texas, *Texas Pattern Jury Charges* PJC 110.16 (1990); *see Great Am. Ins. Co. v. North Austin Mun. Util. Dist. No. 1*, 908 S.W.2d 415, 428 n.12 (Tex. 1995) (refusing to rule on the propriety of the PJC attorney's-fees question).

must speculate.[195] The jury cannot accurately assess attorney's fees, because the jury will necessarily be unaware of what amounts are legally included in the "recovery."[196] And not knowing what the jury considered to be the "recovery," the court cannot evaluate the propriety of the award.[197] Texas law does not permit a jury finding to be based on speculation.[198] Moreover, Texas law recognizes that awarding a contingent fee as a percentage of the recovery results in an excessive fee.[199] Provident American therefore asks this court to delete the award of attorney's fees.[200]

CONCLUSION

For the reasons stated, Provident American asks the court to reverse and render a take-nothing judgment, or alternatively, to reverse and remand for a new trial, or alternatively, to reform the judgment to award only the recoverable medical expenses. Provident American further prays for general relief.

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[195] *See Roberts*, 868 S.W.2d at 960 n.1, 960-961.

[196] *See* Objections to the Charge, S.F. 847.

[197] *See Roberts*, 868 S.W.2d at 961 ("We do not know what items were intended to be included in the recovery . . . .").

[198] *See, e.g., Lakewood Pipe of Tex., Inc. v. Conveying Techniques, Inc.*, 814 S.W.2d 553, 556 (Tex.App.--Houston [1st Dist.] 1991, no writ) ("Recovery of damages cannot be based on pure speculation.").

[199] *See, e.g., Southland Life Ins. Co. v. Norton*, 5 S.W.2d 767, 768 (Tex. Comm'n App. 1928, holdings approved); *Community Life & Health Ins. Co. v. McCall*, 497 S.W.2d 358, 367 (Tex.Civ.App.--Amarillo 1973, writ ref'd n.r.e.); *General Life Ins. Co. v. Potter*, 124 S.W.2d 409, 410-411 (Tex.Civ.App.--Eastland 1939, no writ).

[200] *See Arthur Andersen & Co. v. Perry Equip. Corp.*, 898 S.W.2d 914 (Tex.App.--Houston [1st Dist.] 1995), *writ granted*, 39 Tex. Sup. Ct. J. 254 (Feb. 9, 1996) (granting writ on the issue whether percentage of "recovery" is a proper measure of attorney's fees under the DTPA).

Respectfully submitted,

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CERTIFICATE OF SERVICE

A copy of this brief was sent to Tim Patton, Esq., Pozza & Patton, 7979 Broadway, Suite 207, San Antonio, Texas 78209, and Ben Langford, Esq., 444 Executive Center, Suite 222, El Paso, Texas 79902, by certified mail, return receipt requested on March 26, 1996.

Scott P. Stolley
Scott Patrick Stolley

IN THE DISTRICT COURT OF EL PASO COUNTY, TEXAS

243RD JUDICIAL DISTRICT

Filed 25 Mar A.D. 19 94
at 2:20 o'clock P M
EDIE RUBALCAVA, Clerk, Dist. Courts
El Paso County, Texas
BY DEPUTY

DENISE CASTANEDA	§	
	§	
Plaintiff,	§	
	§	
v.	§	Cause No. 92-14245
	§	
PROVIDENT AMERICAN INSURANCE COMPANY,	§	
	§	
Defendant.	§	

Verdict Filed 26 Mar A.D. 19 94
For the Plaintiff at 7:40 o'clock A M
EDIE RUBALCAVA, Clerk, Dist. Courts
El Paso County, Texas
BY DEPUTY

CHARGE OF THE COURT

LADIES AND GENTLEMEN OF THE JURY:

This case is submitted to you by asking questions about the facts, which you must decide from the evidence you have heard in this trial. You are the sole judges of the credibility of the witnesses and the weight to be given their testimony, but in matters of law, you must be governed by the instructions in this charge. In discharging your responsibility on this jury, you will observe all the instructions which have previously been given you. I shall now give you additional instructions which you should carefully and strictly follow during your deliberations.

1. Do not let bias, prejudice or sympathy play any part in your deliberations.

2. In arriving at your answers, consider only the evidence introduced here under oath and such exhibits, if any, as have been introduced for your consideration under the rulings of the court, that is, what you have seen and heard in this courtroom, together with the law as given you by the court. In your

deliberations, you will not consider or discuss anything that is not represented by the evidence in this case.

3. Since every answer that is required by the charge is important, no juror should state or consider that any required answer is not important.

4. You must not decide who you think should win, and then try to answer the questions accordingly. Simply answer the questions, and do not discuss nor concern yourselves with the effect of your answers.

5. You will not decide the answer to a question by lot or by drawing straws, or by any other method of chance. Do not return a quotient verdict. A quotient verdict means that the jurors agree to abide by the result to be reached by adding together each juror's figures and dividing by the number of jurors to get an average. Do not do any trading on your answers; that is, one juror should not agree to answer a certain question one way if others will agree to answer another question another way.

6. You may render your verdict upon the vote of ten or more members of the jury. The same ten or more of you must agree upon all of the answers made and to the entire verdict. You will not, therefore, enter into an agreement to be bound by a majority or any other vote of less than ten jurors. If the verdict and all of the answers therein are reached by unanimous agreement, the presiding juror shall sign the verdict for the entire jury. If any juror disagrees as to any answer made by the verdict, those jurors who agree to all findings shall each sign the verdict.

These instructions are given you because your conduct is subject to review the same as that of the witnesses, parties, attorneys and the judge. If it should be found that you have disregarded any of these instructions, it will be jury misconduct and it may require another trial by another jury; then all of our time will have been wasted.

The presiding juror or any other who observes a violation of the court's instructions shall immediately warn the one who is violating the same and caution the juror not to do so again.

When words are used in this charge in a sense that varies from the meaning commonly understood, you are given a proper legal definition, which you are bound to accept in place of any other definition or meaning.

Answer "Yes" or "No" to all questions unless otherwise instructed. A "Yes" answer must be based on a preponderance of the evidence. If you do not find that a preponderance of the evidence supports a "Yes" answer, then answer "No". The term "preponderance of the evidence" means the greater weight and degree of credible testimony or evidence introduced before you and admitted in this case. Whenever a question requires other than a "Yes" or "No" answer, your answer must be based on a preponderance of the evidence.

A fact may be established by direct evidence or by circumstantial evidence or both. A fact is established by direct evidence when proved by documentary evidence or by witnesses who saw the act done or heard the words spoken. A fact is established by circumstantial evidence when it may be fairly and reasonably inferred from other facts proved.

An insurance company acts through its agents and employees and is considered as having knowledge acquired by its employees and agents. An insurance company has a duty to act in good faith toward its insures and a duty to deal fairly with them. Whether there is a reasonable basis for PROVIDENT AMERICAN INSURANCE COMPANY's conduct must be judged by the facts before PROVIDENT AMERICAN INSURANCE COMPANY at the time the claim was denied.

"PRODUCING CAUSE" means an efficient, exciting, or contributing cause, which in a natural sequence, produce the damages, if any. There may be more than one producing cause of an event.

You are instructed that the Plaintiff has presented her claim for damages upon more than one cause of action. A "cause of action" is a term used in law which means the legal basis for liability and assessment of damages. Under the American system of justice, one incident, accident, or set of facts ~~given~~ rights to the lawsuit may be presented to the Court and jury upon more than one cause of action.

The Court is submitting each of the causes of action to you in a series of questions. If the Plaintiff is entitled to recover, she will recover only under one cause of action and not all of them. Should you be required to answer any damage question under one cause of action and are likewise require to answer a damage question under another cause of action, you are not to deduct from either any amount you have found in the other.

You are instructed that a corporation is not a person and thus can only act through its agents, servants, employees and representatives.

QUESTION NO. 1:

Did PROVIDENT AMERICAN INSURANCE COMPANY engage in any unfair or deceptive act or practice that was a producing cause of damages to DENISE CASTANEDA?

"Unfair or deceptive act or practice" means any of the following:

A. Engaging in any false, misleading, or deceptive act 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; or

[Source: DTPA §17.46(a)]

B. Making or causing to be made any statement misrepresenting the terms, benefits, or advantages of an insurance policy; or

[Source: art. 21.21, § 4(1)]

C. Making, or directly or indirectly causing to be made, any assertion, representation, or statement with respect to insurance that was untrue, deceptive, or misleading; or

[Source: art. 21.21, §4(2)]

D. 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; or

[Source: unknown]

E. Making any misrepresentation relating to insurance.

"Misrepresentation" means any of the following:

1. any untrue statement of a material fact; or
[Source: 28 TAC § 21.4(1)]
2. any failure to state a material fact that is necessary to prevent the statements from being misleading, when these statements are considered in the light of the circumstances under which they are made; or
[Source: 28 TAC § 21.4(2)]
3. the making of any statement in such manner or order as to mislead a reasonably prudent person to a false

conclusion of a material fact; or

[Source: 28 TAC § 21.4(3)]

4. any material misstatement of law; or

[Source: 28 TAC § 21.4(4)]

5. the failure to disclose any matter required by law to be disclosed.

[Source: 28 TAC § 21.4(5)]

F. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue; or

***[Sources: art. 21.21-2, § 2(b)(1); 28 TAC § 21.203(1)]**

G. Denying a claim or delaying payment on a claim without a reasonable basis or failing to determine whether there is any reasonable basis for the denial or delay; or

[Source: common-law bad faith]

H. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies; or

***[Sources: art. 21.21-2, § 2(b)(2); 28 TAC § 21.203(2)]**

I. Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies; or

***[Sources: art. 21.21-2, § 2(b)(3); 28 TAC § 21.203(3)]**

J. Not attempting in good faith to effectuate a prompt, fair, and equitable settlement of a claim when liability has become reasonably clear; or

[Sources: art. 21.21-2, § 2(b)(4); 28 TAC § 21.203(4)]

K. Compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less in the amounts ultimately recovered and suits brought by them.

[Sources: art. 21.21-2, § 2(b)(5); 28 TAC § 21.203(5)]

Answer "Yes" or "No".

Answer: Yes

If your answer to Question Number 1 is "Yes," then answer the following Question.

Otherwise, do not answer the following Question.

QUESTION NO. 2:

Did PROVIDENT AMERICAN INSURANCE COMPANY engage in any such conduct knowingly?

"Knowingly" means actual awareness of the falsity, deception, or unfairness of the conduct in question ~~for~~ Actual awareness may be inferred where objective manifestations indicate that a person acted with actual awareness.

In answering this question, consider only the conduct that you have found was a producing cause of damages to DENISE CASTANEDA.

Answer "Yes" or "No".

Answer: YES

QUESTION NO. 3:

Did PROVIDENT AMERICAN INSURANCE COMPANY engage in any unconscionable action or course of action that was a producing cause of damages to DENISE CASTANEDA? ***[Source: DTPA § 17.50(a)(3)]***

An "unconscionable action or course of action" is an act or practice that, to a person's detriment, either -

a. takes advantage of the lack of knowledge, ability, experience, or capacity of a person to a grossly unfair degree or

b. results in a gross disparity between value received and consideration paid in a transaction involving transfer of consideration.

Answer "Yes" or "No."

Answer: YES

QUESTION NO. 4:

Did PROVIDENT AMERICAN INSURANCE COMPANY engage in any false, misleading, or deceptive act or practice that was a producing cause of damages to DENISE CASTANEDA?

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

a. Representing that goods or services had or would have characteristics that they did not have; or
[Source: DTPA § 17.46(b)(5)]

b. Representing that goods or services are or will be of a particular quality if they were of another; or
[Source: DTPA § 17.46(b)(7)]

c. Representing that an agreement confers or involves rights that it did not have or involve.
[Source: DTPA § 17.46(b)12)]

Answer "Yes" or "No."

Answer: Yes

If your answer to Question Number 4 is "Yes," then answer Question 5. Otherwise, do not answer Question 5.

QUESTION NO. 5:

Did PROVIDENT AMERICAN INSURANCE COMPANY engage in any such conduct knowingly?

"Knowingly" means actual awareness of the falsity, deception, or unfairness of the conduct in question, ~~for~~. Actual awareness may be inferred where objective manifestations indicate that a person acted with actual awareness.

In answering this question, consider only the conduct that you have found was a producing cause of damages to DENISE CASTANEDA.

Answer "Yes" or "No".

Answer: Yes

If your answer to Question Number 1, 3, or 4 is "Yes," then answer the following Question. Otherwise, do not answer the following Question.

QUESTION NO. 6:

What sum of money, if paid now in cash, would fairly and reasonably compensate DENISE CASTANEDA for the damages, if any, that you have found or caused by PROVIDENT AMERICAN INSURANCE COMPANY in your answers to Questions 1, 3, or 4?

Consider the elements of damage listed below and none other. Consider each element separately. Do not include damages for one element in any other element.

a. Loss of credit reputation. "Credit" means the ability of an individual to borrow on the opinion conceived by the lender that he will be repaid.

b. Loss of benefits. "Loss of benefits" means the amount of benefits due under the policy.

Answer, with respect to the elements listed above, in dollars and cents for damages, if any, that -

were sustained in the past; Answer: $50,000.00

in reasonable probability

will be sustained in the future. Answer: 0

If your answer to Question Number 3 or Question Number 5 is "Yes," then answer the following Question. Otherwise, do not answer the following Question.

QUESTION NO. 7:

What sum of money, if paid, now in cash, would fairly and reasonably compensate DENISE CASTANEDA for the mental anguish, if any, that you have found or caused by PROVIDENT AMERICAN INSURANCE COMPANY in your answers to Questions 1,3, or 4?

"Mental anguish" means the emotional pain, torment, and suffering experience by DENISE CASTANEDA.

Answer in dollars and cents for damages, if any, that -

sustained in the past Answer: _____

and reasonable probability will be sustained in the future Answer: _____

If your answer to Question Number 3 or Question Number 5 is "Yes," then answer the following Question. Otherwise, do not answer the following Question.

QUESTION NO. 8:

What sum of money, if any, should be assessed against PROVIDENT AMERICAN INSURANCE COMPANY as additional damages?

"Additional damages" means an amount that you may in your discretion award as an example to others and as a penalty or by way of punishment in addition to any amount which may have been found by you as actual damages.

Answer in dollars and cents, if any.

Answer: $ [illegible]

QUESTION NO. 9:

What is a reasonable fee for the necessary services of DENISE CASTANEDA's attorney in this case, stated as a percentage of DENISE CASTANEDA's recovery? Answer by stating a percentage.

Answer: 22 %

QUESTION NO. 10:

Do you find from a preponderance of the evidence the HEMOLYTIC SPHEROCYTOSIS of Plaintiff, DENISE CASTANEDA, first manifested itself prior to July 17, 1991?

You are instructed that under the policy a covered "sickness" is an illness or a disease of a member of the family group which first manifests itself more than thirty (30) days after the policy date.

You are further instructed that "Manifestation" does not necessarily mean the time at which a covered sickness is medically diagnosed.

Answer: "Yes" or "No"

Answer: NO

QUESTION NO. 11:

Do you find from a preponderance of the evidence the sickness or disorder of the Plaintiff, DENISE CASTANEDA, involved her gall bladder?

Answer: "Yes" or "No"

Answer: No

After you retire to the jury room, you will select your presiding juror. The first thing the presiding juror will do is to have this complete charge read aloud and then you will deliberate upon your answers to the questions asked.

IT IS THE DUTY OF THE PRESIDING JUROR:

1. to preside during your deliberations;
2. to see that your deliberations are conducted in an orderly manner and in accordance with the instructions in this charge;
3. to write out and hand to the bailiff any communication concerning the case which you desire to have delivered to the judge;
4. to vote on the questions;
5. to write your answers to the questions in the spaces provided, and;
6. to certify to your verdict in the space provided for the presiding juror's signature or to obtain the signatures of all the jurors who agree with the verdict if your verdict is less than unanimous.

You should not discuss the case with anyone, not even with other members of the jury, unless all of you are present and assembled in the jury room. Should anyone attempt

to talk to you about the case before the verdict is returned, whether at the courthouse, at your home, or elsewhere, please inform the judge of this fact.

When you have answered all of the questions which you are required to answer under the instructions of the judge, and your presiding juror has placed your answers in the spaces provided, and signed the verdict as presiding juror or obtained the signatures, you will advise the bailiff at the door of the jury room that you reached a verdict, and then you will return into the court with your verdict.

Hal Marl

JUDGE PRESIDING

CERTIFICATE

WE, THE JURY, HAVE ANSWERED THE ABOVE AND FOREGOING QUESTIONS AS HEREIN INDICATED, AND HEREWITH RETURN SAME INTO COURT AS OUR VERDICT.

(TO BE SIGNED BY THE PRESIDING JUROR IF UNANIMOUS)

_____
PRESIDING JUROR'S SIGNATURE

_____
PRESIDING JUROR'S PRINTED NAME & NUMBER

(TO BE SIGNED BY THOSE RENDERING THE VERDICT IF NOT UNANIMOUS)

	(SIGNATURE)	(PRINT NAME & JUROR NUMBER)	
1.	[illegible]	[illegible]	10
2.	[illegible]	[illegible]	7
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Texas Insurance Law Journal

Butterworth Legal Publishers

RICHARD S. GEIGER, EDITOR IN CHIEF
LEO JOHN JORDAN, ASSOCIATE EDITOR

Volume 3, Number 3 March 1994

CONTENTS

Reasoning Through The Reasonable-Basis Defense

By Scott Patrick Stolley *

I. INTRODUCTION

Following the birth of first-party bad-faith law, Texas courts have struggled—predictably so—with a new set of questions. But no question has been more pressing than this: Can insurers deny questionable claims without being liable for bad faith?[1] As presented to appellate courts, that question usually involves a no-evidence review: Is there evidence to support a bad-faith finding? In two recent decisions finding no evidence to support bad-faith findings, the Texas Supreme Court demonstrated that it is serious about preserving the right to deny questionable claims.[2] The Court further clarified how a reviewing court should conduct a no-evidence review in a bad-faith case.

II. THE *ARANDA* PROMISE

In the *Arnold* decision,[3] the Texas Supreme Court first recognized the cause of action for breach of the duty of good faith and fair dealing, commonly known as bad faith.[4] In extending the bad-faith cause of action to worker's compensation claims, the court in *Aranda*[5] reformulated the bad-faith test to require the insured to prove: (1) the absence of a reasonable basis for denying or delaying payment of the benefits of the policy *and* (2) that the carrier knew or should have known that there was not a reasonable basis for denying

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EDITOR'S NOTE: In *Transportation Ins. Co. v. Moriel*, No. D-1507, Tex. S. Ct. (Feb. 2, 1994), The Texas Supreme Court determined that in bad faith insurance disputes the determination of the amount of punitive damages should be bifurcated from the remaining issues (liability for actual damages, amount of actual damages, and liability for punitive damages). The significance of this case will be addressed in the next issue of the Texas Insurance Law Journal.

ISSN 0964-2471

The *Texas Insurance Law Journal* is published four times a year by Butterworth Legal Publishers, 2283 Cosmos Court, Carlsbad California 92009, telephone 800-452-9873. Subscription price is $108.00 per year.

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The editors welcome suggestions for making this *Journal* more useful to Texas lawyers.

This *Journal* may be cited as 3 Tex. Ins. L. J. xx (1993). The following citation form is used for court of appeals cases not yet appearing in *South Western Reporter 2d: Smith v. Jones*, No. 40,000, Op. Serv.—Civil, T6-89-23-146 (Beaumont, May 12, 1993). This form does not include a writ history because in many instances the time for filing an application may not have expired.

or delaying payment of the benefits of the policy *and* (2) that the carrier knew or should have known that there was not a reasonable basis for denying the claim or delaying payment of the claim. The Court then explained its test:

> 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. The second element balances the right of an insurer to reject an invalid claim and the duty of the carrier to investigate and pay compensable claims. This element will be met by establishing that the carrier actually knew there was no reasonable basis to deny the claim or delay payment, or, by establishing that the carrier, based on its duty to investigate, should have known that there was no reasonable basis for denial or delay.[6]

Finally, the Court promised: "Under the test, carriers will maintain the right to deny invalid or questionable claims and will not be subject to liability for an erroneous denial of a claim."[7]

With this promise, the Court acknowledged that bad-faith law must allow insurers the latitude to deny questionable claims. But the unanswered question was: How far does that latitude extend? Relying on the Court's language, many people have logically concluded that a reasonable basis to deny a claim exists if reasonable minds can disagree about the coverage question.[8] In other words, if reasonable minds can disagree about the coverage evidence, then a fact question exists.[9] Given the presence of a fact question on coverage, an insurer should have the latitude to litigate coverage without exposure to bad-faith liability.[10] Hence, the *Aranda* promise appeared to foreshadow the existence of a "reasonable-basis" defense.[11]

But until recently, the *Aranda* promise has gone largely unfulfilled. Fueled by dislike of insurance companies or sympathy for the claimants, Texas juries have routinely found bad faith, even when a claim is clearly questionable.[12] And many appellate courts have affirmed those bad-faith findings, with little regard for the *Aranda* promise.[13] Caught in the tension between competing public policies, the *Aranda* promise got waylaid.

III. THE INHERENT TENSIONS BETWEEN PUBLIC POLICIES

Although the Texas Supreme Court announced that the duty of good faith and fair dealing arises out of a "special

relationship" between the insurer and the insured, the Court's real concern was that "unscrupulous insurers" can use their bargaining leverage to take advantage of trouble-stricken insureds during the claims-handling process.[14] In essence, the Court seized on two acknowledged virtues: honoring one's commitments and helping one's neighbors in need. Bad-faith law is designed to coerce recalcitrant insurers into conforming their conduct to those virtues. Put more simply, the public-policy aim is to force insurers to pay claims.

That public policy, however, clashes with another public goal: ensuring that insurance is universally available. As put by one court:

> [An] insurer is permitted to dispute its liability in good faith because of the prohibitive social costs of a rule that would make claims nondisputable. Insurance companies burdened with such liability would either close their doors or increase premium rates to the point where only the rich could afford insurance.[15]

Not only are the social costs prohibitive, but forcing insurers to pay all claims also undermines another public policy: promoting honesty on the part of insureds. Thus, one set of policy concerns promotes payment of claims, while another set promotes denial of claims.

The clash of these public policies (pro-payment vs. pro-denial) provokes another clash. Inevitably, human affairs lead to disputes, including disputes over the payment of insurance claims. To peaceably resolve these disputes, our society has developed a judicial system in which the right to a jury trial is inviolate.[16] Even corporations are constitutionally entitled to submit their disputes to a jury.[17] But when unconstrained, bad-faith law penalizes insurers for exercising this constitutionally-guaranteed right. Even though an insurer has enough evidence to create a jury question, the act of submitting that question to a jury (instead of paying the claim) could put the insurer at grave risk. In short, unconstrained bad-faith law produces a chilling effect on the exercise of the right to a jury trial.

So, as manifested in our judicial system, the basic tension is this: How do courts curb the potential for insurers to abuse insureds, while at the same time preserving insurers' rights to fairly contest claims before a jury? If an insurer has enough evidence to get to a jury on the coverage question, can it nevertheless be unfair for the insurer to deny the claim? How does society then draw the line between a legitimate denial and an abusive denial? And after a jury finds bad faith, how does an appellate court conduct a no-evidence review, which is essentially an exercise in double negatives? When is there *no* evidence of *no* reasonable basis?

Although in making the *Aranda* promise, the Texas Supreme Court recognized these tensions, it was left to the courts of appeal to resolve those tensions consistent with that promise. Characteristically, those courts split along ideological lines, a split that is best exemplified by two cases involving State Farm, both of which are discussed below.

IV. THE *ARANDA* AFTERMATH

A. The *Polasek* Case

Taking the *Aranda* promise seriously, the San Antonio Court of Appeals reversed and rendered a bad-faith finding in *State Farm Lloyds, Inc. v. Polasek*.[18] Focusing on the undisputed evidence before State Farm at the time of denial, the court held that State Farm had a reasonable basis to deny the claim as a matter of law, "even though the jury later decided that State Farm should have believed contrary evidence and paid the claim."[19] The court rejected the notion that a jury can find bad faith by weighing the coverage evidence and disagreeing with the insurer's evaluation:

> If the factfinder could simply disagree with the insurer's assessment of such evidence in the bad faith action, the insurer would be held liable *in tort* for its erroneous denial of the claim. The supreme court in *Aranda* assured us that this would not happen.[20]

Polasek involved a claim for fire damage to the insured's video store, a claim that State Farm denied, based on arson. The evidence strongly suggested an incendiary fire: burn patterns indicated that accelerants had been poured in two places; lab tests confirmed the presence of kerosene in the carpet; no accidental cause was apparent; and the fire was concentrated in two areas, where it burned from the floor up even though there were no heat sources on the floor. At trial, although the Polaseks apparently did not dispute that the fire was incendiary, they claimed that they had nothing to do with the fire. State Farm, however, had evidence of both opportunity and motive. Mrs. Pola-

sek, who was the last person to leave the video store, turned all the lights off, contrary to usual practice. The Polaseks lived just a short distance from the store, and only they possessed a key, but there was no sign of forced entry. Regarding motive, their video business was, at best, marginally profitable. Although the Polaseks had a $6,500 note due five days after the fire, the business bank account contained only $365. Cash flow was so poor that the family had been paying operating expenses out of personal funds. They had also borrowed other money and had been late paying rent. Finally, the evidence showed that on the day of the fire, Mr. Polasek removed an uninsured air compressor from the store.

The jury exonerated the Polaseks of arson, apparently believing the Polaseks' contrary evidence regarding motive. Although this evidence was marginal, the court of appeals held it constituted some evidence to support the jury finding.[21] Thus, the court affirmed the judgment for the Polaseks on the contract claim.

Turning to the jury's bad-faith finding, the court noted that the analysis differed from the analysis of the contract claim.[22] Under the bad-faith test, it was the Polaseks' burden to prove a negative: that State Farm had *no* reasonable basis to deny the claim.[23] The insured could not satisfy this burden by introducing some evidence of unreasonableness.[24]

> [I]t is not enough for the insured to show that the insurer should have known to pay the claim, or that there were other facts suggesting the claim was valid. . . . [T]he insured must prove that there were no facts before the insurer which, if believed, would justify denial of the claim.[25]

Some evidence of unreasonableness does not fulfill the insured's *Aranda* burden to prove *no* reasonable basis. Thus, the *Polasek* court couched the test in this way:

> In deciding whether a reasonable basis existed for denying an insurance claim, the trier does not weigh conflicting evidence; it decides whether the evidence existed and whether, standing alone, it constituted a reasonable ground for denying the claim.[26]

In other words, the court and jury must examine the insurer's reason for denial and decide if the insurer possessed evidence that, if believed, supports the denial. It is immaterial that the insured can introduce some evidence on the other side of the scale to show that it was also reasonable to pay the claim. The jury does not weigh the evidence supporting payment versus the evidence supporting denial. Instead, bad faith is a lack of evidence on one side of the scale, namely, on the side supporting denial. The insured must show that the insurer possessed no reasonable evidence to place on the insurer's side of the scale. Given the language chosen by the Texas Supreme Court to define bad faith—"absence of a reasonable basis"—this analysis seems mandated.

The *Polasek* court recognized, under this analysis, that a fact question arises in a bad-faith case when "it is disputed whether there was any reasonable basis in existence to support denial of the claim. . . ."[27] In essence, this means that two questions can arise: (1) what evidence did the insurer possess? and (2) does that evidence reasonably support the denial? The first question is a fact question, but as the *Polasek* court held, when the evidence is undisputed, there is no fact question.[28] And here is where the *Polasek* court found a flaw in the no-evidence review applied by other courts of appeals in bad-faith cases.

The traditional no-evidence review requires the court to "consider only the evidence supporting the verdict and disregard evidence and inferences to the contrary."[29] But as the *Polasek* court noted: "When evidence concerning a vital fact is uncontroverted and proven conclusively, its effect is a question of law and there is no issue for the jury."[30] Thus, in conducting a no-evidence review, the appellate court does not disregard undisputed evidence.[31] The *Polasek* court therefore rejected the insureds' suggestion that the court must disregard all evidence supporting State Farm's denial.[32] To ask a jury whether such evidence existed, and then to presumptively ignore that evidence on appeal, would put an insurer in a hopeless situation. Because there was no dispute in *Polasek* as to what evidence State Farm possessed, the Polaseks failed to create a fact question.[33] Further, because State Farm's reliance on the undisputed evidence was reasonable as a matter of law, the Polaseks failed to carry their burden to prove the negative—that State Farm had no reasonable basis.[34] Thus, the court sustained State Farm's no-evidence point.

The *Polasek* decision demonstrates the proper approach to no-evidence review in bad-faith cases. The first step is

to determine what evidence the insurer possessed. If there is no dispute as to what evidence was before the insurer, then no fact question exists.[35] The next step is to ask whether that evidence reasonably supports the denial. That is a question of law—whether reasonable minds could accept the insurer's evidence and find for the insurer on the contract claim. Although "reasonableness" is ordinarily a question of fact, it is a question of law in this instance, just as it is when a trial court is deciding whether the evidence is sufficient to submit a jury question.[36] When preparing a jury charge, the trial court must decide whether reasonable minds could differ about the evidence, and only in that event submit the issue to the jury.[37] A court should perform the same analysis when deciding whether the insurer's evidence reasonably supports the denial: Could reasonable people differ on the coverage issue? If they could, then as a matter of law, the insurer had a reasonable basis. In *Polasek*, because there was no question about what evidence was before State Farm, and because that evidence was more than sufficient to create a jury question about arson, State Farm (as a matter of law) was not guilty of bad faith.

Critics commonly argue that this analysis runs afoul of what could be called the *Burk Royalty* problem. In *Burk Royalty Company v. Walls*,[38] the Texas Supreme Court held that a finding of gross negligence is not defeated on appeal by evidence of some care. As the Court reasoned, the jury does not have to believe the evidence that the defendant exercised some care, so courts should properly disregard such evidence when conducting a no-evidence review.[39] Applying this rule to bad-faith claims, some people argue that the reviewing court should ignore the insurer's evidence of a reasonable basis, because a jury could disbelieve that evidence. But *Burk Royalty* does not, in actuality, address the question raised in bad faith appeals—namely, how do courts properly analyze the double negative (*no* evidence of *no* reasonable basis)?

In reaching its result, the *Burk Royalty* Court misdirected its focus on the phrase "entire want of care." The true essence of gross negligence is not "entire want of care"—which requires a negative finding—but rather, is "conscious indifference" to another's rights, which requires a positive finding.[40] What the language in *Burk Royalty* purports to say is that a defendant cannot defeat a finding of "no care" by showing that the record contains evidence of "some care." But if one ignores the Court's misfocus on "entire want of care," the true point of *Burk Royalty* is that a defendant cannot defeat a finding of "conscious indifference" by showing "some care."[41] A party cannot defeat a positive finding (conscious indifference) with positive evidence of the opposite (evidence of some care). With the true point of *Burk Royalty* thus in focus, it is apparent that the *Burk Royalty* Court did not address whether a party can defeat a negative finding ("entire want of care") with undisputed evidence of the positive (exercise of "some care").

The corresponding question in a bad-faith case is: Does *some* evidence of a reasonable basis equal *no* evidence of *no* reasonable basis? As in algebra, does the double negative equal a positive? Though the *Polasek* court did not articulate the question in this way, the court answered the question by holding that a reviewing court should not ignore *undisputed* evidence that a reasonable basis existed.[42] Therefore, once the court acknowledges the existence of undisputed evidence of a reasonable basis, it follows that the insured has failed to carry the burden of proving that the insurer had no reasonable basis. Under the *Polasek* reasoning, undisputed evidence of the positive sustains the insurer's appellate burden to prove the double negative.

The *Polasek* court closed with the observation that, contrary to the Supreme Court's intent, bad-faith counts have become all too common. Creation of the bad-faith cause of action

> simply gave a tort remedy for the exceptional case in which the insurer denies or delays payment even though no reasonable basis for that decision exists. Courts should be careful to ensure that the bad faith action is reserved for cases of flagrant denial or delay of payment where no reasonable basis existed, and not for mere unreasonable denial or delay.[43]

Subscribing to a contrary view, the Beaumont Court of Appeals rebuked the *Polasek* court in the second case involving State Farm.

B. The *Simmons* Case

Viewing *Polasek* as a "virtual abrogation" of bad-faith law, the Beaumont Court of Appeals overruled the insurer's no-evidence point in *State Farm Fire & Casualty Company v. Simmons*.[44] In juxtaposition, *Polasek* and *Simmons* vividly

demonstrate how the inherent tensions between the conflicting public policies can affect the shape of bad-faith law. While the *Polasek* court showed concern for the *Aranda* promise, the *Simmons* court showed none. Instead, the *Simmons* court focused on the public policy favoring payment of claims, describing bad-faith law as a "stop-gap" to prevent abuse by insurers.[45] Calling the Simmons family "our insured,"[46] the court emphasized that State Farm had a duty to fulfill its contractual obligations and to help the Simmons recover from their fire loss.[47] The court even went so far as to say that State Farm had an affirmative duty to establish coverage.[48] The court found, however, that State Farm did in fact just the opposite by investigating with an eye toward establishing non-coverage.

Like *Polasek*, *Simmons* was an arson case. The Simmons left their home around two o'clock one morning to drive their children to Louisiana to stay with relatives for the summer. Shortly thereafter, a newspaper carrier noticed a fire in the Simmons' home. By the time the volunteer fire department arrived, it was too late to save the house.

The first entry in State Farm's activity log noted the agent's belief that the fire was suspicious because the Simmons had just suffered a large theft loss. State Farm had considered the theft loss suspicious, because the policy had just been incepted and Mr. Simmons had given an unusual description of how the theft occurred. Nevertheless, State Farm paid the theft claim. During the initial stages of the fire claim investigation, Mr. Simmons identified the suspected burglars (several neighborhood boys) as enemies and possible suspects in the fire. Six weeks after the fire, State Farm learned that two of the boys had confessed to the burglary, yet State Farm never reviewed the police files. State Farm also never tried to interview the suspects, providing as excuses that it was not important to do so, and that they did not know where to locate the boys. State Farm never learned until just before trial that the primary suspect, who had an angry confrontation with Mr. Simmons after the burglary, was released from jail two weeks before the fire.

The court found State Farm's investigation deficient in other respects. State Farm did not interview the newspaper carrier until shortly before the trial, which was five years after the fire. State Farm never interviewed the first fireman on the scene, never obtained a detailed statement from the fire marshal, and never tried to determine when the fire started in relation to the Simmons' departure or the discovery of the fire. State Farm additionally failed to determine the suspects' whereabouts at the time of the fire and neither interviewed two additional suspects nor Mr. Simmons' employer. Further, according to the court, State Farm and its lawyer engaged in unfair tactics when examining the Simmons under oath.

As support for its denial, State Farm cited the opinion of its private arson investigator that the fire was incendiary. However, although the investigator testified that he had eliminated faulty wiring as a cause, he failed to document unrepaired electrical problems that Mr. Simmons had mentioned to State Farm. The investigator also showed little or no knowledge of wiring in the den where there was heavy burning behind one wall. The fire chief, who disagreed with the investigator's opinion of incendiary origin, believed that the fire was consistent with a slow-burning, accidental fire. The fire marshal also testified about the prevalence of revenge and spite fires in that county. Finally, although State Farm concluded that the house was secure at the time of the fire, its investigator admitted that the house was too badly damaged to draw that conclusion.

As for motive, State Farm relied on incorrect information from the V.A. that the Simmons' mortgage payment was $1,343 per month, which was more than the Simmons' monthly income. Although the Simmons were in fact behind on their mortgage (though not as far behind as State Farm thought), State Farm ignored evidence that the Simmons' true payment was $185 per week, along with other evidence that there would have been a balance remaining even if all policy proceeds had been applied to the mortgage. At the time of trial, State Farm had still not paid the V.A., which had foreclosed on the property after the fire, leaving the Simmons with a $62,000 deficiency.

Finally, the court believed that State Farm's claim file compelled a conclusion that State Farm's investigation was slanted.[49] State Farm's claim committee decided that the claim was defensible based on factors unrelated to the merits of the arson defense. Although the committee report did not allege that the Simmons set the fire, it nevertheless decided that the Simmons would have to fight for the policy benefits. State Farm's in-house investigator even admitted that early in the investigation it was his intent to establish that the Simmons had a financial motive. Thus,

the Beaumont Court of Appeals concluded that "State Farm viewed and treated their insureds . . . as adversaries as opposed to policyholders to whom State Farm owed a duty of loyalty and special trust."[50]

Horrified at State Farm's "outcome-oriented" investigation, the court affirmed the judgment in the Simmons' favor, not only on the contract claim, but also on the bad-faith, DTPA, and gross-negligence claims. In the process of affirming, the court went to great lengths to criticize *Polasek*, viewing *Polasek* as an "abrupt substantive departure" that makes the insured's burden impossible.[51] According to the *Simmons* court, "*Polasek* so deteriorates the degree of care and diligence required of an insurer toward its insured as to make that requirement nonexistent."[52] The *Simmons* court predicted that *Polasek* is "the beginning of the end" of the bad-faith cause of action.[53]

Mainly, the court disagreed with the *Polasek* court's focus on the evidence before the insurer. This, the *Simmons* court believed, would allow an insurer to conduct an outcome-oriented investigation designed to generate selective evidence justifying a denial.[54] If a denial is judged solely against evidence in the insurer's possession, the court feared that an insurer could manipulate the investigation to reflect only evidence of non-coverage.[55] If the bad-faith analysis focuses only on this evidence, then the insurer could dodge bad-faith liability, even though the investigation was deficient.[56] Thus, the court criticized *Polasek* for eliminating the second element of the *Aranda* test ("knew or should have known"), by absolving insurers of the duty to investigate.[57] The *Simmons* court also criticized *Polasek* for cutting the jury out of the process.[58] To preserve the duty to investigate, and to maintain the jury's role, the *Simmons* court espoused that the jury should be allowed to weigh all evidence and judge the reasonableness of the insurer's conduct. Otherwise, the *Simmons* court feared that *Polasek* would convert bad faith into a question of law that the insurer will always win.[59]

The court even proposed its own bad-faith test: "Did the insurer fulfill its duty to its insured by pursuing a thorough, systematic, objective, fair, and honest investigation of the claim prior to denying such claim?"[60] Applied to the *Simmons* facts, the answer to this question is "no;" State Farm did not conduct an investigation meeting that standard, so the bad-faith finding had support in the record.[61] But according to the *Simmons* court, application of the *Polasek* rule would require a reversal of the bad-faith finding, because State Farm did possess some evidence constituting a reasonable basis for denial.[62] Naturally, the *Simmons* court could not abide such a result.

To the *Simmons* court, *Polasek* holds that the question of reasonableness must be determined based solely on the insurer's mindset.[63] Closing with a bit of sarcasm, the *Simmons* court asked whether it would be absurd to reverse that logic and judge reasonableness based solely on the insured's mindset.[64] Calling its own suggestion ludicrous, the *Simmons* court essentially accused the *Polasek* court of hypocrisy for not following the axiom that "what's sauce for the goose is sauce for the gander."[65]

With its preferred public policy thus at risk, the *Simmons* court launched a barrage at *Polasek*. While not the first salvo in the battle over the meaning of the *Aranda* promise, *Simmons* was certainly the loudest. *Polasek* and *Simmons* seemingly presented the Texas Supreme Court with the perfect opportunity to impose peace.[66] But surprisingly, the Court denied writ in both *Polasek* and *Simmons*, using two other cases to resolve the dispute.

C. The *Lyons* Case

On the same day that it denied writ in *Polasek*, the Texas Supreme Court decided *Lyons v. Millers Casualty Insurance Company of Texas*.[67] In its opening sentence, the Court stated that *Lyons* presented the opportunity to clarify the proper way to conduct no-evidence reviews of bad-faith findings.[68] Citing *Polasek*, the Court noted that the courts of appeals have "struggled to reconcile the insurer's substantive rights under the *Aranda* test and the traditional statement of the no evidence standard of review."[69] The Court noted that this question presents unusual problems, primarily due to the double negative—no evidence of no reasonable basis.[70] Reaffirming the *Aranda* promise, a 6-to-3 majority held that there was no evidence that Millers acted in bad faith.[71]

The case arose out of a windstorm claim submitted by Golda Lyons. After the storm, Mrs. Lyons found that a hackberry tree had blown down and was laying in her backyard. She alleged that the storm had damaged the brick veneer and an outside staircase at the back of her house. She and two neighbors claimed at trial that this damage did not exist before the storm. Mrs. Lyons theo-

rized that the tree, which had stood adjacent to the staircase, must have hit the house and bounced into the backyard.

Two weeks after the storm, Millers' adjuster inspected the house, along with a reconstruction expert. They found that the staircase was deteriorated and rotten. They further found that the brick veneer was cracked extensively, with large panels of brick separating from the house. Based on this and other evidence of foundation problems, the expert concluded that the damage was due to foundation shifting and settling, and not due to the storm. The expert also found no indication of contact between the tree and the house. Because foundation movement of this type was excluded from coverage, Millers denied the claim promptly, less than one month after the storm.

After Mrs. Lyons protested the denial, Millers hired an engineer, who inspected the house about four months after the storm. He found the same foundation problems and the same absence of contact between the tree and the house. Based on his report, Millers once again denied the claim.

Sixteen months after the storm, Mrs. Lyons hired an unlicensed architect (who had no experience with residential foundations) to inspect her home. By this time, the stairway had collapsed, allegedly because of a second storm. This expert concluded that the brick damage was storm-induced. He theorized that the fallen tree, which had stood in a clump of trees that was only inches from the staircase, had caused one of the remaining trees to whipsaw into the staircase, thereby transferring a force through the staircase and into the brick veneer. His report stated that the force imposed on the brick was approximately 24,000 pounds per square foot, which he admitted at trial would flatten the house.

Before trial, Millers hired a meteorologist, who, among other things, conducted a neighborhood survey. As it turned out, one of the interviewed neighbors was one of Mrs. Lyons' trial witnesses who testified that the damage was not there before the storm.

The jury found that 25 percent of the damage was caused by the windstorm. The jury also found bad faith and a DTPA violation. The Eastland Court of Appeals reversed and rendered the bad-faith and DTPA claims, because there was no evidence to support either jury finding.[72] The court also reversed and remanded the coverage issue, finding error in the charge.[73] Mrs. Lyons complained in the Texas Supreme Court about the reversal of her bad-faith and DTPA claims, but did not complain about the reversal of her contract claim.

Writing for the majority, Justice Cornyn first stated that the focus of a no-evidence review "should be on the relationship of the evidence arguably supporting the bad faith finding to the elements of bad faith."[74] The evidence "must be such as to permit the logical inference that the insurer had no reasonable basis . . . and that it knew or should have known that it had no reasonable basis . . . ."[75] That evidence must relate to the elements of the bad-faith test, "not just to the contract issue of coverage."[76] Seemingly, this means that if the evidence relates only to the contract claim, then in most cases that evidence is not considered in the no-evidence review.[77] Justice Cornyn stated that this focus on the evidence relating to bad-faith is necessary to maintain the distinction between the contract claim and the bad-faith claim.[78] The Court then held that there was no evidence to support the bad-faith finding:

> 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 from which a factfinder could infer that Millers acted without a reasonable basis and that it knew or should have known that it lacked a reasonable basis for its actions.[79]

Justice Doggett dissented, accusing the majority of discarding the Texas Constitution and surreptitiously engaging in a factual-sufficiency review.[80] He first challenged the majority's statement that the appellate court should focus on the evidence that relates to the elements of the bad-faith claim.[81] Arguing that this rule has never been employed in a no-evidence review, Justice Doggett actually appeared to take issue with the majority's holding that evidence relating only to the contract claim is usually irrelevant in a no-evidence review of a bad-faith finding.[82] He hinted that he saw no need to maintain a distinction between the bad-faith and contract claims.[83]

Justice Doggett next argued that reasonableness is a question of fact, and that evidentiary conflicts about reasonableness must be resolved in favor of the verdict.[84] However, the question whether reasonable minds can differ about the evidence is a question of law.[85] Applying his

view that reasonableness is a question of fact, he next stated: "The effect [of a no-evidence review] is that an appealing insurer must demonstrate that a reasonable basis for delay or denial is conclusively established in the record."[86] If applied in the trial court, this test would reverse the burden of proof by obligating the insurer to prove a reasonable basis, rather than obligating the insured to prove no reasonable basis. But Justice Doggett's comment appears to endorse the *Polasek* approach—that an insurer can prevail on a no-evidence point when the undisputed evidence demonstrates a reasonable basis. Where Justice Doggett appears to diverge from the *Polasek* approach is his view of what evidence is relevant to bad faith. Under his view, unlike the majority's view, evidence of coverage (for example) would be some evidence of unreasonableness. Thus, the insurer's evidence would be disputed, and the insurer's no-evidence point would be overruled on appeal.

Justice Doggett then implicitly acknowledged what he had disclaimed just a few sentences earlier—that some reasonableness questions are questions of law. "If, upon reviewing the evidence in the light most favorable to the verdict, reasonable minds could differ as to the reasonableness of the claim's denial, the no-evidence challenge fails."[87] The author questions, however, how an appellate court could perform this analysis without treating reasonableness as a question of law. If reasonable minds could differ on the coverage question, then the no-evidence challenge should succeed, and not fail as Justice Doggett would have it.[88]

Citing *Simmons* for the proposition that an insurer should "turn over every leaf," Justice Doggett closed with some criticisms of Millers' investigation.[89] For example, he complained that Millers limited the scope of its investigation by never considering the theory that Mrs. Lyons' expert developed sixteen months after the storm.[90] According to Doggett, this is some evidence of bad-faith, as is the fact that Millers still refused payment after being informed of this theory.[91] Query: how does this square with Justice Doggett's comment in *Viles* that bad faith is measured by what the insurer knew at the time of denial?[92] Justice Doggett also criticized Millers for not initially interviewing the two neighbors who testified at trial.[93] Yet, as the majority pointed out, the neighbors' testimony was merely cumulative of Mrs. Lyons' testimony.[94] Given that two experts found the damage to be excluded, Millers' denial would have been no less reasonable had Millers known about the neighbors' testimony.

Thus, with barely a mention of *Polasek* or *Simmons*, the Texas Supreme Court took up the debate. Recognizing the tensions, the Court fulfilled its own promise by refusing to let an insurer be penalized for exercising the right to contest a questionable claim. Shortly thereafter, in the *Dominguez* case, the Court reenacted the debate, with the same result.

D. The *Dominguez* Case*

One month after *Lyons*, and on the same day that it denied writ in *Simmons*, the Court decided *National Union Fire Insurance Company v. Dominguez*.[95] Citing *Lyons*, a 7-to-2 majority held that there was no evidence that National Union had acted in bad faith.[96] The Court declined, however, to address another important question—whether the agreement settling the underlying claim barred the bad-faith claim.[97]

National Union was the workers' compensation carrier for Justo Dominguez' employer. Unable to work because of a sore back, Dominguez applied for and received disability benefits under his employer's group health policy, which covered only non-work-related conditions. Dominguez signed a number of forms attesting that his condition was not work-related. About five months later, after a new doctor pronounced Dominguez fit for work, the company terminated the disability payments.

About six months later, Dominguez was fired for missing work without informing his supervisor. As it turns out, Dominguez had to attend a family funeral, and he had been unable to reach his supervisor. Believing he had actually been terminated because of his back condition, Dominguez filed a claim with the Industrial Accident Board (I.A.B.). During National Union's investigation, the employer told National Union that Dominguez had never reported a work-related injury. Even after filing the compensation claim, Dominguez represented in forms filed with the disability carrier that his injury was unrelated to work. National Union controverted the compensation claim for two reasons: (1) failure to file the claim within thirty days, and (2) failure to report the injury as an on-the-job injury.

*A synopsis of this case likewise appears in the case notes following the conclusion of this article.

The I.A.B. awarded Dominguez about $6,500, plus lifetime medical benefits. Both parties appealed, but on the morning of trial, they settled for $28,000. On the same day, Dominguez sued National Union for bad faith. The settlement agreement for the underlying claim contained the usual recitations to the effect that liability was uncertain. At the bad-faith trial, Dominguez agreed that those recitations were truthful.

Ruling on National Union's appeal from an adverse verdict in the bad-faith case, the El Paso Court of Appeals reversed the award for future mental anguish, finding that there was no evidence to support this award.[98] The court similarly reversed the punitive-damage award, finding no evidence of conscious indifference.[99] Overruling National Union's arguments that there was no evidence of bad faith and that the settlement agreement barred the bad-faith claim, the court affirmed the remainder of the bad-faith award.[100]

In reversing the court of appeals' failure to find no evidence of bad faith, the Texas Supreme Court reiterated that the insured's burden is to prove a negative.[101] The Court further reiterated that courts have had difficulty conducting no-evidence reviews, primarily because of the rule requiring the court to disregard evidence contrary to the finding.[102] The Court also confirmed its *Lyons* holdings that (1) the insured's bad-faith evidence "must be such as to permit the logical inference" that the insurer had no reasonable basis, and (2) that evidence of coverage alone does not go to the bad-faith issue.[103] The Court then restated a well-established rule of no-evidence review: "Unless the evidence furnishes some reasonable basis for the conclusion by reasonable minds as to the existence of the vital fact [namely, no reasonable basis], it is no more than a scintilla, the legal equivalent of no evidence."[104] While the Court acknowledged that a no-evidence review requires the court to reject evidence contrary to the finding, the Court then made this important statement:

> However, only after an appellate court has determined what potential basis an insurance company may have had for denying a claim can the court conduct a meaningful review of whether the insured has presented evidence that the insurer lacked a reasonable basis for denying or delaying a claim.[105]

In other words, to conduct a meaningful review of a bad-faith finding, the court does not examine all evidence in the case, but only the evidence relevant to the bad-faith elements.[106] To do that, the court must know why the insurer denied the claim. If the insurer had no reasonable evidence to support that denial, then the insured proved bad faith. But evidence that the insurer made the wrong decision or acted inappropriately (for example, by treating the insured rudely) is not enough to establish bad faith. The court must focus only on the bad-faith evidence, just as the court must focus only on the damage evidence when performing a no-evidence review of a damage finding. By itself, rude behavior by an insurance company no more proves bad faith than it proves what the insured's repair costs are. Evidence of rudeness fails to support a reasonable inference of bad faith or of the amount of repair costs; it is the legal equivalent of no evidence.

Thus, the Court held that the only bad-faith evidence offered by Dominguez (a letter to Dominguez' lawyer from a doctor, stating that the injury was work related) was only evidence of coverage, and not evidence that the denial lacked a reasonable basis.[107] Moreover, echoing its statement in *Lyons* that the insurer could reasonably rely on experts, the Court found that Dominguez presented no evidence casting doubt on National Union's reliance on the doctors who found only a degenerative disease.[108] Similarly, Dominguez' evidence cast no doubt on National Union's reliance on the disability insurance forms attesting that the injury was not work-related.[109]

Justice Doggett dissented, one among his criticisms that the majority disregarded Dominguez' testimony that he had almost immediately informed his supervisor that his injury was work-related.[110] Dominguez' attorney refused to allow National Union to interview Dominguez, and there was nothing in the record indicating that the supervisor would have supported Dominguez' position.[111] In fact, the supervisor testified via deposition that Dominguez said his injury was not work-related.[112] Moreover, even if Dominguez had told his supervisor, that would not have proven that National Union had *no* reasonable basis to contest the claim.

Justice Doggett also complained about National Union's investigation. Besides failing to interview the supervisor, the investigator wrote a report containing inaccuracies about Dominguez' post-injury health care.[113] "Taken in the light most favorable to the judgment, the inaccuracies in this report regarding crucial elements of the claim, in

addition to the investigator's failure to consult the supervisor constitute evidence of bad faith."[114] In short, "[r]ejecting [a] claim without even conducting a proper investigation of the basis for the denial certainly constitutes evidence of bad faith."[115] The author concludes however, that in addition to his failure to explain exactly how the inaccuracies showed *no* reasonable basis, Justice Doggett overlooked the fact that an insurer can do a poor investigation and still have a reasonable basis to deny, or even be correct in denying.[116]

Finally, Justice Doggett criticized the majority's observation that Dominguez failed to present evidence casting doubt on National Union's reliance on the doctors' opinions and on Dominguez' insurance forms. He found this failure to be irrelevant, because a legal-sufficiency review must focus on facts supporting the judgment and ignore facts opposing the judgment.[117] Thus, according to Justice Doggett, the Court should ignore the evidence National Union relied on, even if that evidence is unchallenged. But Justice Doggett's analysis fails to appreciate that evidence casting doubt on the insurer's evidence is precisely what the insured must produce to create a fact issue on the bad-faith test, or otherwise, the insurer's evidence of a reasonable basis would be undisputed and conclusive of no bad faith.

Rejecting Justice Doggett's views, the Lyons and *Dominguez* majorities have given the *Aranda* promise new life. The form that life will take, especially in view of the denial of writs in *Polasek* and *Simmons*, is questionable.

V. THE *LYONS* AND *DOMINGUEZ* LESSONS

The promise in *Aranda* resulted from the Texas Supreme Court's attempt to maintain a balance between the inherent tensions that underlie bad-faith law. In *Lyons* and *Dominguez*, the Court backed up this promise by serving emphatic notice that insurers should not be penalized for exercising the right to contest contestable claims.[118] That is the first lesson of *Lyons* and *Dominguez*.

Other lessons are also apparent. First, a no-evidence review is an appropriate vehicle for challenging a bad-faith finding and thereby preserving the right to contest claims. Because the bad-faith test is expressed as a negative, the reviewing court must look for evidence of the absence of a reasonable basis, not for some evidence of unreasonableness. In conducting a no-evidence review, the court must focus on the evidence relevant to the bad-faith elements and ignore evidence irrelevant to bad-faith. Evidence of coverage alone does not establish the absence of a reasonable basis. The court should determine the insurer's basis for denial and then examine whether the insured presented evidence that the insurer lacked a reasonable basis.

Second, reliance on an expert's opinion can absolve an insurer of bad faith.[119] The court did, however, leave open the possibility that an insured could create a fact question with evidence that the insurer's reliance on an expert was unreasonable and that the insurer knew or should have known that such reliance was unreasonable.[120]

Third, deficiencies in an insurer's investigation are not fatal to the insurer's position. In both *Lyons* and *Dominguez*, the court rejected Justice Doggett's criticisms of the insurer's investigations. In neither case did those alleged deficiencies prove that the insurer lacked a reasonable basis. To avoid bad faith, an insurer, therefore, does not have to "turn over every stone." If investigative deficiencies proved bad faith, then almost no claim could be denied.[121]

Aside from these obvious lessons, however, there is a deeper lesson arising from *Lyons* and *Dominguez*, one bound up in the denial of writ in *Polasek* and *Simmons*. The designation "writ denied" means that the Supreme Court "is not satisfied that the opinion of the court of appeals in all respects has correctly declared the law, but is of the opinion that the application presents no error which requires reversal, or which is of such importance to the jurisprudence of the State as to require correction . . . ."[122] Because *Polasek* and *Simmons* espouse such diametrically opposed views of bad-faith law, it defies logic to believe that neither case contained an error of law important enough to require correction. If both cases correctly state the law, then trial courts would be left in a quandary. Thus, it is more likely that the Supreme Court denied writ because neither case contained reversible error—in *Polasek*, the court of appeals did not err in finding no evidence of bad faith; and in *Simmons*, the court of appeals did not err in finding some evidence of bad faith. But again, how can that be when those holdings are so contrary?

Simmons interpreted *Polasek* to mean that the mindset of the insurer controls the issue of reasonableness—that the insurer is the sole judge of whether its denial was reasonable.[123] Yet under *Polasek*, reasonableness is actually judged by the jury (in resolving fact questions about what evidence the insurer possessed) and by the court (in deciding whether reasonable minds could differ about coverage). Based on its misapprehension of *Polasek*, the *Simmons* court concluded that the *Polasek* analysis would absolve State Farm of bad faith.[124] Thus, to avoid this result, the *Simmons* court forged its own test, one that State Farm failed.

Even under *Polasek*, however, State Farm would have lost the *Simmons* appeal. Despite its earlier protestations, the *Simmons* court recognized this when it said:

> Suffice it to say that State Farm never presented direct evidence that the Simmons set fire to their home. Its proof was circumstantial in nature. Even though circumstantial evidence may sufficiently support a burden of proof, State Farm failed in that burden. Even if this circumstantial evidence clearly supported the fact of arson, such evidence was insufficient to connect the Simmons with the arson case.[125]

In short, State Farm failed to create a fact question on the arson issue. As with nearly every case of arson, State Farm's denial depended on circumstantial evidence. Proof of arson had to be inferred from direct evidence.[126] But the law does not recognize all inferences as proof. Some inferences are so unreasonable that, as a matter of law, they constitute no evidence.[127] Here, the *Simmons* court found, as a matter of law, that State Farm's circumstantial inferences were so unreasonable that State Farm had no evidence of arson.[128] Thus, the Simmons proved that State Farm had no reasonable basis to deny, and State Farm's no-evidence point failed.

This, in the author's opinion, is the most logical explanation for the Supreme Court's denial of writ in *Simmons*. Although the court did not endorse the *Simmons* court's explanation of bad-faith law, it saw no error in the result, because the circumstantial evidence in State Farm's possession failed to constitute a reasonable basis to deny.

Similarly, the Supreme Court found no error in the *Polasek* result. But it goes too far to say that the Court has not endorsed the *Polasek* court's exposition of bad-faith law. By its analysis in *Lyons* and *Dominguez*, the Supreme Court has at least tacitly approved the *Polasek* approach to no-evidence review. All three opinions (*Polasek*, *Lyons*, and *Dominguez*) recognize that the insured must prove a negative—the absence of a reasonable basis. The insured cannot prove this negative with some evidence of the positive—that is, with some evidence of unreasonableness. All three opinions recognize that, in searching for evidence of the negative, the court must focus on evidence that goes to the elements of the bad-faith test. *Polasek* put this in a slightly stronger way (that the court should focus on the evidence before the insurer) but the idea is essentially the same. Only certain evidence is relevant to bad faith. Although other evidence may prove that the insurer is a corporate scoundrel, such evidence does not prove that the insurer had no reasonable basis to deny.[129] Finally, by finding no evidence in *Lyons* and *Dominguez*, the Supreme Court did basically what the *Polasek* court did—acknowledge that the reviewing court does not ignore undisputed evidence. Just as State Farm did in *Polasek*, the insurers in *Lyons* and *Dominguez* carried their appellate burdens by showing that the undisputed evidence demonstrated a reasonable basis to deny. Thus, while not overtly agreeing with the *Polasek* reasoning, the Supreme Court in *Lyons* and *Dominguez* employed an analysis akin to that espoused in *Polasek*.

VI. CONCLUSION

In interpreting *Polasek*, *Lyons*, and *Dominguez*, it is necessary to understand the import of the negative finding required by the bad-faith test. Construed most logically, the phrase "no reasonable basis to deny" must mean: (1) that there was no fact question about coverage (as the court found in *Simmons*); or (2) that there was no legitimate question of contract interpretation (in cases where denial is based on a coverage interpretation). If reasonable minds can disagree about the coverage evidence, or if there is a legitimate question of contract interpretation, then the insurer has a contractual and constitutional right to contest the claim, and the insurer should not be punished for exercising that right.[130] *Lyons* and *Dominguez* demonstrate that this is what the Texas Supreme Court intended when it fashioned the bad-faith test, and moreover, that the Court is committed to fulfilling the *Aranda* promise.

NOTES

1. *See generally* Ashley, "The Bona Fide Dispute Defense and the Difference Between an Unreasonable Denial and a Denial With No Reasonable Basis," 9 Bad Faith Law Report 49 (1993).

2. *Lyons v. Millers Casualty Insurance Company of Texas*, 37 Tex. Sup. Ct.J. 241 (Dec. 8, 1993), *aff'g*, 798 S.W.2d 339 (Tex. App.—Eastland 1990); *National Union Fire Insurance Company v. Dominguez*, 37 Tex. Sup. Ct.J. 316 (Jan. 5, 1994); *rev'g*, 793 S.W.2d 66 (Tex. App.—El Paso 1990). As this article was in the final stages of preparation, the court issued an important decision concerning punitive damages. *Transportation Insurance Company v. Moriel*, 37 Tex. Sup. Ct.J. 450 (Feb. 2, 1994). By allowing punitive damages in bad-faith cases only when the "bad faith is accompanied by aggravated conduct by the insurer," *Moriel* further demonstrates the court's resolve to preserve insurers' rights to contest claims. *Id.* at 456.

3. *Arnold v. National County Mutual Fire Insurance Company*, 725 S.W.2d 165, 167 (Tex. 1987).

4. For economy of words, the term "bad faith" will be used throughout this article. This is not meant to imply that the insured must prove "bad faith," as opposed to an absence of "good faith."

5. *Aranda v. Insurance Company of North America*, 748 S.W.2d 210 (Tex. 1988) (emphasis in original). The variance between the *Arnold* test and the *Aranda* test has caused some confusion among the courts of appeals. *See generally* Ashley, "Confusion, Texas Style," 7 Bad Faith Law Report 103, 107 (1991). According to Ashley, the *Aranda* test requires the insured to prove a "knowing refusal to pay an indisputable claim." *Id.*

6. *Aranda*, 748 S.W.2d at 213.

7. *Id.*

8. *See* Stephen S. Ashley, *Bad Faith Actions - Liability and Damages* § 5:04 (1993); Hauser, "Good Faith as a Matter of Law: The Insurance Company's Right to Be Wrong," 27 Tort & Ins. Law J. 665, 667-668 (1992); Schubert, "Insurer's Duty of Good Faith and Fair Dealing: Is There a 'Bona Fide Dispute' Defense?" at 6, Second Annual Ultimate Insurance Seminar (State Bar of Texas 1993).

9. *See, e.g., Henderson v. Travelers Insurance Company*, 544 S.W.2d 649, 650 (Tex. 1976) ("When reasonable men may differ as to the truth of controlling facts, a jury issue is present.")

10. *See* authorities cited *supra* in note 8. This is often called the "directed-verdict rule," which was first recognized in *National Savings Life Insurance Company v. Dutton*, 419 So.2d 1357 (Ala. 1982). *See* Ashley, *supra* note 8, at § 5:04. Under the directed verdict rule, the insurer is entitled to a directed verdict on the bad-faith claim if there is a fact question on the contract claim. *Id.* The same type of analysis should be applied in cases where there is no fact question, but the insurer has a reasonable basis to deny because there is a legal question regarding contract interpretation. In those cases, too, the insurer should be absolved of bad faith. *See National Union Fire Insurance Company v. Hudson Energy Company, Inc.*, 780 S.W.2d 417, 427 (Tex. App.—Texarkana 1989), *aff'd on other grounds*, 811 S.W.2d 552 (Tex. 1991) (in part finding no bad faith because there was a "legitimate question of policy construction"). In *Moriel*, the court recognized that an insurer could dispute coverage in good faith when there is a question of policy interpretation. *Moriel*, *supra* note 2, at 455 n.8.

11. This is not actually an affirmative defense, but rather, is a method of asserting that the insured has failed to carry his or her burden of proof. *See* Ashley, *supra* note 1, at 49. Others have called this the "bona-fide dispute" defense. *See, e.g., id.*; Schubert, *supra* note 8, at 4; *Hudson Energy*, *supra* note 10, at 426 (stating that a "bona-fide controversy" can absolve an insurer of bad faith). In *Moriel*, the court described the bona-fide dispute defense as "nothing more than a shorthand notation for the observation that the parties to an insurance contract will sometimes have a good faith disagreement about coverage." *Moriel*, *supra* note 2, at 455 n.8. The term "reasonable-basis defense" may not be as descriptive, but it coincides with the bad-faith definition applicable in Texas.

12. Even a casual review of Texas bad-faith opinions reveals that the vast majority involve bad-faith findings for the insured, rather than for the insurer.

13. *See, e.g., Commonwealth Lloyd's Insurance Company v. Thomas*, 825 S.W.2d 135 (Tex. App.—Dallas 1992), *judgment set aside pursuant to settlement agreement*, 843 S.W.2d 486 (Tex. 1993) (finding some evidence of bad faith, even though there was a fact issue on arson).

14. *Arnold*, *supra* note 3, at 167.

15. *Vernon Fire & Casualty Insurance Company v. Sharp*, 264 Ind. 599, 349 N.E.2d 173, 181 (1976).

16. U.S.Const. amend. VI ("[T]he right of trial by jury shall be preserved . . . ."); Tex. Const. art. I, § 15 ("The right of trial by jury shall remain inviolate.")

17. *See St. Paul Guardian Insurance Company v. Luker*, 801 S.W.2d 614, 621-622 (Tex. App.—Texarkana 1990, no writ) ("When there is a bona fide controversy, the insurer has a right to have its day in court and let the jury determine each witness's [sic] truthfulness.").

18. 847 S.W.2d 279 (Tex. App.—San Antonio 1992, writ denied).

19. *Id.* at 288. Among the other cases finding no bad faith as a matter of law are: *Thrash v. State Farm Fire & Casualty Company*, 992 F.2d 1354, 1358 (5th Cir. 1993) (no reasonable jury could have found bad faith); *Plattenburg v. Allstate Insurance Company*, 918 F.2d 562, 563-564 (5th Cir. 1990) (summary judgment for insurer on bad faith claim); *Dixon v. State Farm Fire & Casualty Company*, 799 F.Supp. 691, 695 (S.D.Tex. 1992) (summary judgment for insurer on bad faith claim); *Employers National Insurance Company v. Dalros*, No. 04-92-00078-CV (Tex. App.—San Antonio, March 31, 1993, n.w.h.) (insurer had reasonable basis to deny as a matter of law); *Charter Roofing Company, Inc. v. Tri-State Insurance Company*, 841 S.W.2d 903, 906 (Tex. App.—Houston [14th Dist.] 1992, writ denied) (summary judgment for insurer on bad faith claim); *St. Paul Lloyd's Insurance Company v. Fong Chun Huang*, 808 S.W.2d 524, 526 (Tex. App.—Houston [14th Dist.] 1991, writ denied) (no

evidence of bad faith); *National Union Fire Insurance Company v. Hudson Energy Company, Inc.*, 780 S.W.2d 417, 427 (Tex. App.—Texarkana 1989), *aff'd on other grounds*, 811 S.W.2d 552 (Tex. 1991) (no evidence of bad faith).

20. *Polasek, supra* note 18, at 287 (emphasis in original).

21. *Id.* at 283.

22. *Id.*

23. *Id.*

24. *Id.* at 283, 285.

25. *Id.* at 284.

26. *Id.*

27. *Id.* at 287. As the court said: "A scintilla of evidence suggesting arson would not be enough [to constitute a reasonable basis]." *Id.*

28. *Id.* at 283-284.

29. *Id.* at 283.

30. *Id.* at 284.

31. *Id.* at 283.

32. *Id.* at 285.

33. *Id.* at 287. *See, e.g., Dixon v. Southwestern Bell Telephone Company*, 607 S.W.2d 240, 242 (Tex. 1980) ("It is fundamental that an issue, which is normally a question of fact, can be proved so conclusively by the evidence at trial that it becomes a question of law, rather than a question of fact."); *Schultz v. Shatto*, 150 Tex. 130, 237 S.W.2d 609, 615 (1951) (holding that the effect of uncontradicted evidence is a matter of law).

34. *Polasek, supra* note 18, at 288. "The undisputed evidence before State Farm when it considered and denied the Polasek's claim was more than sufficient to make out a circumstantial case of arson." *Id.*

35. *See, e.g., Employers Casualty Company v. Block*, 744 S.W.2d 940, 944 (Tex. 1988) ("Only disputed issues must be submitted for the jury's determination.")

36. *See Polasek, supra* note 18, at 284 ("When reasonable minds can draw only one conclusion about the vital fact, there is no jury issue and an instructed verdict is proper.")

37. *E.g., Collora v. Navarro*, 574 S.W.2d 65, 68 (Tex. 1978).

38. 616 S.W.2d 911, 921 (Tex. 1981).

39. *Id.*

40. *See Moriel, supra* note 2, at 458 (in which the court clarified that gross negligence has two elements: conscious indifference and conduct creating an extreme degree of risk).

41. *See id.* at 457 (stating that *Burk Royalty* "correctly instructed reviewing courts to look for evidence of the defendant's subjective mental state rather than the defendant's exercise of care."). In *Moriel*, the supreme court also abandoned the *Burk Royalty* approach altogether, criticizing *Burk Royalty* for permitting "an inference of gross negligence from evidence of 'some carelessness'." *Id.* at 458. "In this way, *Burk Royalty* established a 'some carelessness' standard of legal sufficiency review that was as favorable to punitive damages as the earlier 'some care' test had been hostile to them." *Id.* at 458.

42. *Polasek, supra* note 18, at 285.

43. *Id.* at 287. *Lyons, Dominguez*, and *Moriel* confirm that the *Polasek* court correctly read the Supreme Court's intent.

44. 857 S.W.2d 126 (Tex. App.—Beaumont 1993, writ denied). Among the other cases overruling points of error asserting no evidence of bad faith are: *St. Paul Insurance Company v. Rakkar*, 838 S.W.2d 622, 626-627, 631 (Tex. App.—Dallas 1992, writ denied); *Commonwealth Lloyd's Insurance Company v. Thomas*, 825 S.W.2d 135, 144 (Tex. App.—Dallas 1992), *judgment set aside pursuant to settlement agreement*, 843 S.W.2d 486 (Tex. 1993); *Automobile Insurance Company of Hartford v. Davila*, 805 S.W.2d 897, 903-906 (Tex. App.—Corpus Christi 1991, writ denied); *State Farm Mutual Automobile Insurance Company v. Zubiate*, 808 S.W.2d 590, 596-598 (Tex. App.—El Paso 1991, writ denied); *Wm. H. McGee & Company, Inc. v. Schick*, 792 S.W.2d 513, 521-522 (Tex. App.—Eastland 1990), *judgment set aside pursuant to settlement agreement*, 843 S.W.2d 473 (Tex. 1992); *Allied General Agency, Inc. v. Moody*, 788 S.W.2d 601, 607 (Tex. App.—Dallas 1990, writ denied).

45. *Simmons*, 857 S.W.2d 126, 132, 136.

46. *Id.* at 135.

47. *Id.* at 132-133.

48. *Id.* at 132-133, 135.

49. *Id.* at 139-140.

50. *Id.* at 140.

51. *Id.* at 134.

52. *Id.* at 135. The 14th Court of Appeals also criticized *Polasek* in *Nationwide Mutual Insurance Company v. Crowe*, 857 S.W.2d 644, 649 n.1 (Tex. App.—Houston [14th Dist.] 1993, *judgment set aside pursuant to settlement agreement*, 863 S.W.2d 462 (Tex. 1993).

53. *Simmons*, 857 S.W.2d at 142.

54. *Id.* at 135, 142.

55. *Id.* at 134.

56. *Id.* at 134, 140.

57. *Id.* at 134, 136.

58. *Id.* at 134-135, 143.

59. *Id.* at 134-135, 136.

60. *Id.* at 136.

61. *Id.* at 133, 135, 140.

62. *Id.* at 135, 136, 140.

63. *Id.* at 134, 135, 142-143.

64. *Id.* at 143.

65. *Id.*

66. One commentator stated that *Polasek* and *Simmons* created an intolerable conflict that the Texas Supreme Court had no choice but to address in one of those cases. Ashley, 9 Bad Faith Law Report 159 (1993).

67. 37 Tex. Sup. Ct. J. 241 (Dec. 8, 1993).

68. *Id.* at 241.

69. *Id.* at 242-243.

70. *Id.* at 242.

71. *Id.* at 243. Justice Cornyn wrote the majority opinion. Justice Doggett dissented, joined by Justices Hightower and Gammage.

72. 798 S.W.2d 339, 343-345 (Tex. App.—Texarkana 1990), *aff'd*, 37 Tex. Sup. Ct. J. 241 (Dec. 8, 1993).

73. *Id.* at 345.

74. *Lyons*, *supra* note 67, at 243.

75. *Id.* The court quoted this statement in *Moriel*, *supra* note 2, at 461.

76. *Lyons*, *supra* note 67, at 243.

77. As the Supreme Court said in *Moriel*, "There must necessarily be a logical connection, direct or inferential, between the evidence offered and the fact to be proved." *Moriel*, *supra* note 2, at 461.

78. *Lyons*, *supra* note 67, at 243.

79. *Id.*

80. *Id.* at 244-247 (Doggett, J., dissenting).

81. *Id.* at 245 (Doggett, J., dissenting).

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

83. *Id.* (Doggett, J., dissenting). He then said in *Moriel* that the contract claim is distinct from the bad-faith claim and that "resolution of one does not determine the other." *Moriel*, *supra* note 2, at 474 (Doggett, J., concurring).

84. *Lyons*, *supra* note 67, at 245. (Doggett, J., dissenting).

85. *See* notes 33 through 37, *supra*, and accompanying text.

86. *Lyons*, *supra* note 67, at 245 (Doggett, J., dissenting).

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

88. Justice Doggett's view suffers from the same infirmity that the *Moriel* court found with the *Burk Royalty* "some carelessness" approach to gross negligence. Under Justice Doggett's approach, the court would presumptively (1) ignore all of the insurer's evidence, thereby eliminating any evidence of a reasonable basis, and (2) construe the insured's evidence favorably. Because an insured can nearly always find some way to creatively complain about the insurer's conduct, the record would almost always support a bad-faith finding, even if the evidence showed a bona-fide coverage question.

89. *Lyons*, *supra* note 67, at 247 (Doggett, J., dissenting). In *Polasek*, the court rejected the insureds' argument that the insurer must "leave no stone unturned." *Polasek*, *supra* note 18, at 288.

90. *Lyons*, *supra* note 67, at 247 (Doggett, J., dissenting).

91. *Id.* at 246-247 (Doggett, J., dissenting).

92. *Viles v. Security National Insurance Company*, 788 S.W.2d 566, 567 (Tex. 1990).

93. *Lyons*, *supra* note 67, at 246 (Doggett, J., dissenting).

94. *Id.* at 243 n.3.

95. 37 Tex. Sup. Ct.J. 316 (Jan. 5, 1994).

96. *Id.* at 319. Justice Gonzalez wrote for the majority. Only Justices Doggett and Gammage dissented. Interestingly, Justice Hightower did not dissent, as he did in *Lyons*.

97. *Id.* at 316 n.1.

98. *National Union Fire Insurance Company v. Dominguez*, 793 S.W.2d 66, 73 (Tex. App.—El Paso 1990), *rev'd*, 37 Tex. Sup. Ct.J. 316 (Jan. 5, 1994).

99. *National Union Fire Insurance Company v. Dominguez*, 793 S.W.2d 66, 74 (Tex. App.—El Paso 1990).

100. *Id.* at 71-72.

101. *National Union Fire Insurance Company v. Dominguez*, 37 Tex. Sup. Ct.J. 316, 318 (Jan. 5, 1994).

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. Regarding no-evidence review, the Supreme Court recently stated: "[W]e are not simply directed to determine whether evidence exists that has some remote relation to the verdict. We must also determine whether the evidence is *legally sufficient*." *Moriel*, *supra* note 2, at 461. To be legally sufficient, "[t]here must necessarily be a logical connection, direct or inferential, between the evidence offered and the fact to be proved." *Id.*

107. *Dominguez*, *supra* note 101, at 318-319.

108. *Id.* at 319.

109. *Id.*

110. *Id.* at 320 (Doggett, J., dissenting).

111. *Id.* at 318 n.3.

112. *Id.*

113. *Id.* at 320 (Doggett, J., dissenting).

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

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

116. The question is whether the insured can prove that the deficient investigation caused any damage. If the insurer had a reasonable, or even an airtight, basis to deny, how has the insured been harmed by a poor investigation? *See, e.g.*, *Pace v. Insurance Company of North America*, 838 F.2d 572, 584 (1st. Cir. 1988) ("Although an insurer's subjective bad faith may be inferred from a flawed investigation, an improper investigation, standing alone, is not a sufficient cause for recovery if the insurer in fact had an objectively reasonable basis to deny the claim."); *see generally* Ashley, *supra* note 8 at § 5:08; *cf. Koral Industries v. Security Connecticut Life Insurance Company*, 802 S.W.2d 650, 651 (Tex. 1990) (per curiam) (valid contract defense negated the insured's bad-faith claim).

117. *Dominguez*, *supra* note 101, at 320 (Doggett, J., dissenting).

118. The court reinforced that notice in *Moriel*. "Evidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad faith. [citations omitted] Nor is bad faith established when the jury, with the benefit of hindsight, decides the insurer was simply wrong about the factual basis for its denial of the claim, or about the proper construction of the policy." *Moriel*, *supra* note 2, at 455.

119. The court also reinforced this point in *Moriel*. "A simple disagreement among experts about whether the cause of the loss is one covered by the policy will not support a judgment for bad faith." *Id.*

120. *See St. Paul Insurance Company v. Rakkar*, 838 S.W.2d 622, 626-627 (Tex. App.—Dallas 1992, writ denied) (fact question whether the insurer relied on expert reports and if it did, whether the reliance was reasonable).

121. "[I]t is almost impossible to conduct an investigation as to which some question of its adequacy, sufficient to get to the jury, cannot, in hindsight, be raised." *Pace v. Insurance Company of North America*, 838 F.2d 572, 584 (1st Cir. 1988). In rejecting the insureds' contention that State Farm had a duty to "leave no stone unturned," the *Polasek* court stated: "Even the most thorough investigation must stop somewhere; there is always something else the investigators could have done." *Polasek, supra* note, 18 at 288.

122. Tex. R. App. P. 133(a).

123. *Simmons, supra* note 44, at 134, 135, 142, 143.

124. *Id.* at 135, 136, 140.

125. *Id.* at 138. The court also stated: "State Farm presented nothing more than suspicions that the Simmons may have been responsible for their own loss." *Id.* at 136.

126. *See Polasek, supra* note 18, at 282 (noting that arson may be proved by circumstantial evidence.)

127. *E.g., Moriel, supra* note 2, at 461 ("In evaluating legal sufficiency, we are required to determine whether the proferred evidence as a whole rises to a level that would enable reasonable and fair-minded people to differ in their conclusions."); *Kindred v. Con/Chem, Inc.*, 650 S.W.2d 61, 63 (Tex. 1983) ("When the evidence offered to prove a vital fact is so weak as to do no more than create a mere surmise or suspicion of its existence, the evidence is no more than a scintilla and in legal effect, is no evidence."); *see* Calvert, "'No Evidence' and 'Insufficient Evidence' Points of Error," 38 Tex. L. Rev. 361, 363 (1960); Powers & Ratliff, "Another Look at 'No Evidence' and 'Insufficient Evidence'," 69 Tex.L.Rev. 515, 521 (1991) ("[T]he 'scintilla rule' applies only to cases in which the proponent attempts to establish a critical fact through an inference from other proof and the reviewing court finds the inference unreasonable.").

128. *See supra*, note 125 and accompanying text.

129. As recognized in *Moriel*, to be legally sufficient, the evidence must have more than a remote relation to the fact issue. "There must necessarily be a logical connection, direct or inferential, between the evidence offered and the fact to be proved." *Moriel, supra* note 2, at 461.

130. As put in *Moriel*: "Evidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad faith." *Moriel, supra* note 2, at 455.

Case Notes

BAD FAITH ACTIONS—MANNER OF PROOF HOMEOWNER'S INSURANCE

Contrary expert opinion testimony and evidence of insurer knowledge of its engineering expert's predisposition to find damages excludable under homeowner's policy, was sufficient to support jury finding that insurer's denial of claim did not rest on reasonable basis.

Nicolau v. State Farm Lloyds, No. 13-92-467-CV, Op. Serv.—Civil T2-93-51-521 (Tex. App.—Corpus Christi, Dec. 16, 1993).

FACTS: Mr. and Mrs. Nicolau, Romanian refugees, submitted a claim under their homeowner's policy with State Farm Lloyds for an underground plumbing leak. The Nicolaus, who had lived in their home since 1979, had it insured for $113,000. The policy excluded losses caused by inherent vice (for example a construction or foundation defect) or by settling (foundation movement), but extended coverage for losses caused by accidental discharge or leakage from a plumbing system. The policy also provided for additional living expenses, a coverage designed to reimburse the insureds for costs caused by the home becoming partially or wholly unlivable.

In 1984, a foundation repair contractor first examined the Nicolaus' home. That contractor determined that the home was either settling or heaving and recommended that the Nicolaus hire a structural engineer. Elevation readings taken on the home showed that the living room wing of the house was over four inches below the center of the house while the front bedroom wing was two inches below the rear of the house. As a result of the differential movement, the house had suffered minor cracking in the sheetrock and brick veneer.

Following the structural engineering analyses, the Nicolaus hired Maverick Engineering to investigate the cause of the movement. Maverick concluded that the foundation on the two front wings had settled due to shrinkage of the underlying clay. Testimony by the Nicolaus' expert witnesses established that the settling was caused by

Or, hemolytic sclerocytosis?

A When Dr. Canales told me.

Q Now, before your parents asked you to see Dr. Canales, were you having any problems?

A No.

Q Were you in pain?

A No.

Q Did you ever receive a letter denying your claim?

A No.

Q Do you know if your father ever received a letter denying the claim?

A Yes.

Q Okay. That was that October 30th letter that we were talking about?

A Yes.

Q Did he ever receive a letter denying your claim after that?

A No.

Q Has the insurance company paid any of your bills?

A No.

Q Would you tell the jury what problems were caused by this insurance company not paying your bills?

A Well, sometimes I can't sleep at night

because I am very worried that, the fact that I owe more than $14,000 and I have to pay. Also that I am afraid to answer the phone because maybe there's a collector who wants to collect the money and then to open the mail box, so, just to receive some mail and it makes me very afraid of that because, also, my credit is ruined and I can't get any credit or I can't buy any car or something, and I am almost already graduated from college and I don't know what to do.

Q Now, the jury will be asked --

MR. COLDWELL: Your Honor, I will ask to strike the answer about her credit is ruined. That is a hearsay statement of what somebody looking at her credit or the Credit Bureau may view her as opposed to her parents only, and that is a hearsay statement, and it is therefore not responsive to the question of how it makes her feel. It instills hearsay and it should be stricken from the record.

THE COURT: I will overrule the objection.

MR. LANGFORD: Thank you.

Q (BY MR. LANGFORD) Now, the jury will be asked about what mental anguish you have suffered and how that has taken place. Have you ever suffered any mental anguish as a result of their failing to pay your

DENISE CASTANEDA

was recalled as a rebuttal witness by the plaintiff and after having been first duly sworn was examined and testified as follows:

DIRECT EXAMINATION

BY MR. LANGFORD:

Q Denise, I need to ask you some questions about damage to your credit reputation.

MR. COLDWELL: Counsel is leading his witness.

THE COURT: Well, I will sustain the objection.

Q (BY MR. LANGFORD) Tell the jury if you have had any damage to your credit reputation.

A Yes. That being that have -- I haven't paid my medical bills. That is my credit is ruined on that.

MR. COLDWELL: Your Honor, Your Honor, the term "my credit" implies what other people are doing with regard to her. That is a term that must, necessarily, involve hearsay of people outside the courtroom that I could never cross examine. I ask that the response be stricken. In other words, I object to the response as being non-responsive and including, in it, hearsay.

THE COURT: Overrule the objection.

Q (BY MR. LANGFORD) Denise, have you applied for any credit cards since December of 1991?

A Yes.

Q Have you been able to obtain any credit cards?

A No.

MR. COLDWELL: Your Honor, whether she has obtained them from anybody, or not, is hearsay. That decision is one that somebody makes with regard to giving her credit, or not, is based upon a lot of factors, some of which being employment, age, residence, citizenship. And therefore, I submit that for her to put before this jury a damage to her credit, entails hearsay and other matters, and goes into rank speculation. And it is improper.

THE COURT: Overrule the objection.

Q (BY MR. LANGFORD) What was your answer?

A No.

Q You have applied for credit cards?

A Yes,

Q Okay. Have you been able to get those? Have you been able to obtain any credit cards?

A No.

Q Do you know why?

A Because of my credit.

MR. COLDWELL: That again is hearsay. And what other people analyze, or apply for the reasons for denying credit, she can not possibly testify to it. And I certainly can't cross examine the reasoning of those people, because they are not only going to be offered -- they are not going to be offered as evidence in Court.

THE COURT: Overrule the objection.

Q (BY MR. LANGFORD) Do you know why you have not been able to get a credit card?

A Because of my credit. And I think that I have to pay my medical bills, the amount of the medical bills.

Q Okay. Other than the medical bills, do you have any other bills that would reflect badly upon your credit?

A No.

Q I will show you what is marked as exhibit number 44, Plaintiff's exhibit number 44 and ask if you have received that letter, if you have received that letter?

A Yes.

MR. COLDWELL: Your Honor, this letter is hearsay. But it is a document which can not be

APPENDIX 12

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96-0249

NO. 96-0249

ORIGINAL

* * *

IN THE SUPREME COURT OF TEXAS

AUSTIN, TEXAS

* * *

PROVIDENT AMERICAN INSURANCE COMPANY,

Petitioner

V.

DENISE CASTAÑEDA,

Respondent

* * *

RESPONSE TO APPLICATION FOR WRIT OF ERROR

* * *

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ATTORNEYS FOR RESPONDENT

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* * *

IN THE SUPREME COURT OF TEXAS

AUSTIN, TEXAS

* * *

PROVIDENT AMERICAN INSURANCE COMPANY,

Petitioner

V.

DENISE CASTAÑEDA,

Respondent

* * *

RESPONSE TO APPLICATION FOR WRIT OF ERROR

* * *

TO THE HONORABLE SUPREME COURT OF TEXAS:

Denise Castañeda presents this Response to Application for Writ of Error filed by Provident American Insurance Company. The parties will generally be referred to as "Denise" and "Provident American."

STATEMENT OF THE CASE

The unanimous opinion of the court of appeals correctly states the nature and result of this suit. *See Provident Am. Ins. Co. v. Castañeda*, 914 S.W.2d 273 (Tex. App. - El Paso 1996, writ requested).

REPLY TO PETITIONER'S STATEMENTS OF ISSUES AND JURISDICTION

A. Provident American's "Factual" Discussions Ignore the Standard of Review

Many factual statements in Provident American's Application are incomplete or represent a one-sided, adversarial perspective of the record. In particular, the "Statement of Facts" portion of the Application often consists of (1) "no evidence" arguments based upon Provident American's unilateral characterization of the record; or (2) "facts" supporting the insurer's argument that Denise's health condition was not covered by its policy, even though the jury found against Provident American on its non-coverage defensive issues and those findings have not been challenged on appeal.

The insurer's Application largely bypasses "no evidence" standards requiring the appellate court to consider only the evidence and inferences tending to support the jury's liability findings which, when viewed in their most favorable light, support the verdict in Denise's favor. Under this standard, all evidence and inferences contrary to the verdict must be disregarded and if more than a scintilla of evidence supports the liability findings, then Provident American's no evidence point must fail. *See Havner*

v. E-Z Mart Stores, Inc., 825 S.W.2d 456, 458 (Tex. 1992); *see also Carr v. Jaffe Aircraft Corp.*, 884 S.W.2d 797, 799 (Tex. App. - San Antonio 1994, no writ)(appellate court "not jury number two").

B. Provident American's Defensive Theories Were Either Rejected by the Jury or Not Submitted

Provident American accuses the Castañedas of misrepresenting Denise's condition and other matters when applying for health insurance. Provident American, however, didn't deny Denise's claim on the basis of misrepresentation and didn't submit that theory to the jury.

Provident American's Application also dwells on its version of facts relating to Denise's pre-existing condition, Denise's hemolytic spherocytosis (HS) as manifesting within a 30-day waiting period, and Denise's condition as a disease of her gallbladder. Provident American did not request a submission on pre-existing condition and the jury found against the carrier on all other defensive issues. (Tr. 94-95). On appeal, Provident American has not challenged the jury's refusal to find that Denise's HS manifested before July 17, 1991 or that her sickness or disorder involved her gallbladder.

C. The Twenty Liability Findings Against Provident American

The jury answered "yes" to Question No. 1 which submitted fifteen distinct theories of liability in disjunctive form. (Tr. 88-89). The jury answered "yes" to Question No. 3 which submitted unconscionability broadly in a two-part disjunctive format. (Tr.

90). The jury also answered "yes" to Question No. 4 which disjunctively submitted three distinct theories of laundry list liability, DTPA §§ 17.46(b)(5), (7) & (12), actionable under the Code and DTPA. (Tr. 91).

So long as sufficient evidence supports a finding on merely one of those twenty violations, the verdict on liability and causation against Provident American must be upheld. *See Jeep Eagle Sales Corp. v. Mack Massey Motors, Inc.*, 814 S.W.2d 167, 175 (Tex. App. - El Paso 1991, writ denied); *see also Redman Homes, Inc. v. Ivy*, 39 Tex. Sup. Ct. J. 481, 483 (April 12, 1996). The court of appeals upheld the judgment by holding that legally and factually sufficient proof supported two of the liability/causation findings against Provident American. 914 S.W.2d 279-80; *see also Redman Homes, supra*. Provident American conceded that it must overturn every one of those twenty liability findings to prevail on appeal. (App. 12, 29).

Provident American's liability arguments are based almost entirely on common law good faith and fair dealing concepts such as the "reasonable basis defense" and a carrier's obligation to settle once its liability becomes "reasonably clear." Included among the many liability findings against Provident American, however, are findings that the insurer made misrepresentations in violation of both the DTPA's laundry list and Article 21.21 §4, and engaged in unconscionable conduct in violation of §17.50(a)(3) of the DTPA. The judgment may be supported based on those

findings alone. Provident American's arguments concerning common law issues are irrelevant to its statutory liability for committing knowing misrepresentations and engaging in an unconscionable course of action.

The court of appeals' opinion does not interfere with an insurer's right to contest a claim nor does it otherwise compel settlement. Rather, the opinion enforces the straightforward language of the DTPA and Code by affirming a judgment against an insurer who continued to deny coverage after becoming aware its denial was wrongful and otherwise engaged in a purposeful effort to protect its interests at the expense of its insured's.

D. Watson Doesn't "Trump" *Vail*

The simple answer to Provident American's "trumping" argument is that *Watson* expressly reaffirmed *Vail* in first-party cases. Provident American is aware that *Watson* doesn't "trump" *Vail* because the insurer asks this Court to overrule *Vail*. *See* Reply Point Three (A) & (B), *infra*. In the face of *Watson*'s explicit reaffirmance of *Vail* in the first-party context, no court, including this Court, has construed *Watson* as re-writing the DTPA and Code so as to limit consumers to interest penalties and the common law. To the extent *Vail* and *Watson* are inconsistent, any inconsistency does not extend to the viability of claims against an insurer based on findings of unconscionable conduct, laundry list violations or misrepresentations violating Article 21.21 §4 -- all of which support the judgment here.

REPLY POINTS

REPLY POINT ONE

The court of appeals correctly affirmed the trial court's judgment because the jury's findings on liability and causation are supported by legally sufficient evidence.

REPLY POINT TWO

The court of appeals correctly affirmed the trial court's judgment because the jury's findings that Provident American acted knowingly are supported by legally sufficient evidence.

REPLY POINT THREE

The court of appeals correctly affirmed the trial court's judgment because that judgment is based upon viable theories of liability which are supported by legally sufficient evidence.

REPLY POINT FOUR

The court of appeals correctly affirmed the trial court's judgment, which is based upon broad-form liability submissions, because: (1) broad-form submission is required whenever feasible, absent extraordinary circumstances which are not present here; (2) the trial court did not abuse its discretion by using broad-form submission; (3) any alleged problems with a liability sub-part not being supported in law or in fact amount to harmless error; and, (4) any error in the broad-form liability submission was waived.

REPLY POINT FIVE

The court of appeals correctly affirmed the trial court's judgment because: (1) legally sufficient evidence supports the jury's finding on actual damages; (2) the damage question was properly submitted in broad form; and, (3) any error in the broad-form damage submission was waived.

REPLY POINT SIX

The court of appeals correctly affirmed the trial court's judgment awarding attorney's fees against Provident American because: (1) the fees submission was correct; (2) any error in the fees submission was waived; and, (3) Provident American does not claim that any alleged deficiencies in the fees submission constituted harmful error.

STATEMENT OF FACTS

A. The Erroneous Denial Based on a Six-Month Waiting Period

Denise underwent surgery on August 6, 1991. (Px-3). Thereafter, her father submitted a claim for the medical bills and expenses arising out of the surgery. Provident American never paid any of the expenses arising from Denise's surgery. (Rx-2 17; Rx-1 39).

On October 28, 1991, Dr. Roberto Canales wrote Provident American a letter. In that letter, he informed the insurer that on July 20, 1991, he examined Denise for the first time, diagnosing her as suffering from HS, "which had never been diagnosed until now." (Px-4). Dr. Canales' letter concluded with

a request for cooperation from Provident American in processing claims for services provided to Denise Castañeda. (Px-4).

On October 30, 1991, the Policy Benefits Department forwarded a form letter to Guillermo Castañeda acknowledging his request for benefits for his daughter's treatment. Mr. Castañeda was informed that "no benefits will be payable at this time ... [because] coverage is not provided for sickness or disorder involving the gallbladder during the first six months from the effective date of the policy." (S.F. 195-96, 472; Px-9). After denying Denise's claim on October 30, 1991 based on the six-month gallbladder provision, Provident American closed Denise's file. (S.F. 199).

At trial, witnesses from Provident American's Claims Department readily acknowledged that denying Denise's claims based upon the six-month "gallbladder" provision was incorrect. Ann Russell, the director of all operations for the insurer other than the financial department, described the October 30 letter as an "incorrect denial." (Rx-2 41-42). Laurie Haggard, the claims manager for Provident American, described this claims denial as "made in error," "improper," and "incorrect." (Rx-1 27, 42-43, 44). The insurer's President nevertheless insisted at trial that Denise's condition involved the gallbladder, as opposed to an accidental or secondary illness. (S.F. 197).

On November 12, 1991, Guillermo Castañeda forwarded a letter to Provident American enclosing Dr. Canales' letter of that same date. This letter reiterated that Denise's HS had never been

diagnosed until July 20 and stated that any gallbladder problems were secondary to HS. (S.F. 196-97; Px-5, Px-6, Px-10). On his letter to Provident American, Guillermo included the handwritten notation: "This is the second letter, please reply as soon as possible. Thank you." (Px-15). It is undisputed that Provident American did not respond to Guillermo or Dr. Canales.

On November 22, 1991, someone in the Claims Department of Provident American spoke with someone at Sierra Medical Center, the hospital where the surgery on Denise was performed. (Px-11). According to the insurer's internal records, the hospital was informed that "there is no coverage" because the surgery fell within the six month waiting period. (S.F. 407-08; Px-11).

The internal records of Provident American also reflect that on December 4 and December 6 of 1991, the Claims Department spoke with doctors inquiring about coverage for Denise's expenses. On each occasion, the doctors were told "gallbladder w/in first 6 mos." (S.F. 408-09; Px-12, Px-13).

B. The Denial/Non-Denial Based on the 30-Day Manifestation Provision

By letter dated December 12, 1991, Cherylen Tidwell of the Claims Department, referred Guillermo to the policy provision precluding coverage for an illness or disease manifesting itself less than thirty days after the policy date and to Dr. Canales' records as indicating a history of jaundice and hepatitis. (Px-16). After asking for records, the letter concludes: "Upon

receipt of the necessary information, we will gladly reopen this claim for possible disbursement of benefits." (Px-16).

At trial, Provident American's witnesses refused to agree that the December 12 letter constituted a denial of Denise's claim. Some witnesses refused to concede that Denise's claim was ever denied, even though it was undisputed that it was never paid.

The claims manager, Laurie Haggard, testified that she didn't feel Denise's claim was denied in the December 12 letter and didn't know when, if ever, it was denied. (Rx-1 38-39). Provident American's insurance expert testified that the December 12 letter was not a denial. (S.F. 788-89). The insurer's President, Robert Clines, refused to characterize the December 12 letter as a denial -- albeit he did so in a largely incomprehensible fashion. (S.F. 200-01, 204). Clines characterized the December 12 correspondence as a "special letter ... [which] took the position that it was not payable on that day." (S.F. 203, 245-46). When discussing the carrier's computer records which reflected a denial based upon the 30-day waiting period, Clines stated: "There was a denial on that basis. But there was not a denial." (S.F. 202).

Ann Russell, the director of operations, testified that the denial of coverage was "very clear-cut" because of the proximity of the issuance of the policy to the claim. (Rx-2 11). According to Russell, Provident American denied Denise's claim based upon the pre-existing condition exclusion in the policy. (Rx-2 14-15,

19). Russell conceded, however, that the Castañedas were never sent a letter denying coverage based upon a pre-existing condition, but were instead sent a "form letter" denying the claim based on the involvement of the gallbladder. (Rx-2 20). Contradicting some of her other testimony, Russell testified that the December 12 letter represented a denial of coverage based upon the 30-day waiting period. (Rx-2 21, 23). However, before Russell testified, Provident American's President had already told the jury that Denise's claim had not been denied based on a pre-existing condition and the December 12 letter was not a denial of her claims. (S.F. 200-01, 204, 245-46).

So, summarizing Provident American's claim handling in the more than four months after Denise's surgery and up until December 12, 1991:

-- The insurer had wrongfully denied Denise's claims based upon an inapplicable six-month waiting period for diseases involving the gallbladder.

-- The insurer was still informing doctors and hospitals that coverage was unavailable due to the six-month period despite the inapplicability of the exclusion.

-- The insurer, without ever informing the insured, had evidently denied Denise's claim based upon a pre-existing condition exclusion, an exclusion which the insurer now concedes is inapplicable.

-- The insurer had closed Denise's claims file even though at trial it would insist that it had not yet denied her claim.

C. Provident American Confirms, Re-Considers and Denies Coverage -- All at the Same Time

Dr. Canales received a copy of the December 12 denial/non-denial letter from Provident American. As introduced at trial, Dr. Canales' copy of that letter contained the following handwritten notation:

> 12/17/91
>
> Chris from Provident called and sd received letter (2nd) examiner will review letter along w/records. *Sd she doesn't doubt benefits will be paid.* Sd Mr. Castañeda will be notified regarding outcome within ten days or so [sic]. (emphasis added).

(S.F. 417-18; Px-27).

On January 13, 1992, Dr. Canales again wrote Provident American informing the insurer that Denise's HS had never been diagnosed prior to July 20 and asking for cooperation in processing the Castañeda's benefit claims. (Px-7). On January 23, 1992, Mr. Castañeda provided a chronology to Cherylen Tidwell of the Claims Department, emphasizing that he and his wife were unaware until the third week of July, 1991 that someone in his wife's family had HS. (Px-19). Mr. Castañeda's letter enclosed additional correspondence from physicians. (Px-19). It is undisputed that Provident American did not reply to either Dr. Canales' or Mr. Castañeda's letters.

As previously discussed, the insurer's witnesses insisted at trial that Provident American did not deny coverage on December 12 and never actually formally denied coverage. A February 2, 1992 internal phone record report for the insurer, however, recites that a physician inquiring about coverage was told: "At this time it is not being re-considered." (Px-20).

On February 19, 1992, someone in the Claims Department spoke with Guillermo Castañeda by telephone. (Px-22). By this time, the carrier had closed Denise's file and told health care providers that coverage was being denied and was not being reconsidered. Yet in this telephone conversation, Guillermo Castañeda was told that "he should have something in about two weeks." (S.F. 405-06; Px-22). It is undisputed that no one at Provident American contacted Mr. Castañeda in two weeks. Actually, no one at the insurer ever contacted Mr. Castañeda after December 12, 1991. (S.F. 548)

On March 17, 1992, Dr. Castillo, the surgeon who operated on Denise, wrote Provident American asking the insurer to reconsider its denial of benefits. (Px-8). The surgeon's letter reiterated that Denise had not been diagnosed with HS until Dr. Canales made that diagnosis and that she had no gallbladder symptomology. (Px-8). In addition, Dr. Castillo's letter stated that Provident American had represented that coverage would be provided for Denise: "In telephone conversation with my office assistant, the surgery was approved and hospitalization was approved, before they

were admitted." (Px-8). It is undisputed that Provident American never replied to Dr. Castillo's letter. Provident American never responded to any of the letters written by Drs. Canales, Castillo, Varela, or Juarez. (Px-24).

D. Mr. Castañeda Complains to the State Department of Insurance

On March 18, 1992, Mr. Castañeda sent a certified letter to Provident American reiterating that his claims remained unpaid and that he had been forwarding letters from physicians for eight and one-half months stating that Denise's claims did not arise out of a pre-existing disease and the gallbladder surgery was incidental to HS. (Px-4). A copy of this letter was sent to the Commissioner of Insurance. It is undisputed that Provident American did not reply to Mr. Castañeda.

On April 1, 1992, a complaints examiner for the Texas Department of Insurance, Consumer Services, directed Provident American to respond to Mr. Castañeda's complaints. (Px-25). Robert Clines responded on behalf of Provident American with a letter that primarily focused on Denise's brother's symptoms. (Px-25). Although Clines' letter claimed that Denise had a medical history similar to her brother's, Denise, her mother and her father all testified to the contrary at trial. (S.F. 549, 575, 579-80, 602-06, 608-09, 619-21, 629-30, 652; Px-25).

Clines' letter to the State Department of Insurance concluded: "The policy contract specifies that the origin of symptoms is evidence of the existence of an illness under both the

pre-existing condition and thirty-day sickness limitations." (Px-25). As Denise's insurance expert testified at trial, the policy contains no such specification about the "origin of symptoms" as being evidence of the existence of an illness under the policy limitations. (S.F. 320-22). Even Provident American's expert admitted that the insurer could not deny the claim based upon symptoms alone, but would have to determine that any symptoms were related to an excluded condition. (S.F. 802-03). Although Clines told the Department of Insurance that Denise's claim had been denied, in part, on a pre-existing condition, he told the jury that it had not been denied on that basis. (S.F. 246).

On July 6, 1992, someone from Provident American spoke with Dr. Canales. At that time, Dr. Canales was once again told that Denise's claim was being denied based on the six-month waiting period for a disease involving the gallbladder. (Px-26). This six-month waiting period was not the reason Provident American gave to the Department of Insurance on April 15, 1992 or Mr. Castañeda on December 12, 1991. (Px-16; Px-25). It was also not a proper basis for denying Denise's claim, as every witness in the insurer's claim department testified at trial. (Rx-2 41-42; Rx-1 27, 42-43, 44).

REPLY POINT ONE
(Restated)

The court of appeals correctly affirmed the trial court's judgment because the jury's findings on liability and causation are supported by legally sufficient evidence.

STATEMENT, ARGUMENT & AUTHORITIES
(Under Reply Point One)

A. Twenty Different Liability/Causation Findings Support the Judgment

As discussed, Provident American acknowledges that to prevail on appeal, it must set aside all twenty liability/causation findings against the insurer. (App. 12, 29). Provident American's Application, however, focuses almost entirely on its arguments about the "reasonable basis defense" and whether its liability for coverage ever became reasonably clear. These common law concepts are simply irrelevant to the vast majority of the findings such as those based on unconscionability and misrepresentations in violation of §17.46(b) of the DTPA and Article 21.21 §4 of the Code. (Tr. 88-89, 90, 91).

B. Unconscionable Conduct and Purposeful Misrepresentations

1. Provident American's Outcome-Oriented Approach to Coverage

The jury could have easily concluded that from the moment the insurer received notice of Denise's claims, the carrier engaged in a search for some reason to deny coverage, making an internal/secret decision to deny coverage for a variety of different reasons, but never telling the Castañedas. Even though the carrier never told Mr. Castañeda that coverage was being denied, the carrier had already decided to deny coverage and was telling some health care providers that no benefits would be available. Internally, however, Provident American couldn't even agree on the theory on which to deny coverage, whether it was pre-

existing condition, 30-day manifestation period, or the six-month waiting period.

Texas courts have repeatedly recognized that evidence showing that the insurer was "outcome-oriented," was predisposed to denying coverage or attempted to lull its insured into an action while searching for exclusions to escape liability will support the jury's findings on unconscionable conduct, misrepresentations and other statutory violations under the DTPA and Insurance Code. *See State Farm Fire & Cas. Co. v. Simmons*, 857 S.W.2d 126, 132-33 (Tex. App. - Beaumont 1993, writ denied); *How Ins. Co. v. Patriot Fin. Serv.*, 786 S.W.2d 533, 541 (Tex. App. - Austin 1990, writ denied); *see also First Tex. Sav. Ass'n v. Reliance Ins. Co.*, 950 F.2d 1171, 1178 (5th Cir. 1992). ("Under Texas law, an insurance company that improperly denies, delays, or handles a claim may be liable to the insured ... for certain violations under Tex. Ins. Code Art. 21.21, §16.").

2. Provident American's Approach to Coverage: Blame the Insured

Provident American's approach to the "manifestation" issue also illustrates why the jury could have easily believed that the carrier was invoking the 30-day clause as an excuse to deny coverage. According to Provident American's President, Clines, it was "obvious" that Denise had HS before July 17, 1991. (S.F. 250-51). It was undisputed, however, that Denise was never diagnosed with HS prior to July 20, 1991. (H 46-47). Then, contradicting his earlier testimony, Clines admitted that the

Castañeda family "never knew she had hemolytic spherocytosis until July 20th of 1991." (S.F. 546).

The testimony by Provident American's claims manager, Laurie Haggard, provided an even more persuasive illustration of why the jury was entitled to find that the carrier had denied Denise's claims without a reasonable basis, in bad faith, and unconscionably. (Tr. 88-89). After first testifying that HS definitely manifested within thirty days of the policy's effective date because Denise's mother and father "knew something was wrong," she then conceded she had no idea at all when it had manifested.

> Q. But on Denise, what I'm asking you is: How did this sickness manifest itself?
>
> A. I don't know. I've said this already. I don't know.

(Rx-1 52).

Similarly, the jury was entitled to conclude that the personal attack on the Castañeda family for having allegedly lied and concealed information when applying for the family group policy was part of the carrier's strategy to do anything to justify a denial of coverage. Provident American's President testified that the alleged misrepresentations were not even the basis for denying coverage and the insurer had never attempted to rescind the policy. (S.F. 205-06, 246, 249-50). Notably, Provident American did not request a jury submission on misrepresentation.

Although the Castañeda family was accused of "conspiring" to set up Provident American and obtain coverage for the HS-related conditions of Denise and her brother, the insurer's expert testified that only a highly qualified hematologist, such as herself, was capable of recognizing the disease.

> Q. Does the fact that no doctor has come forth to say, "I diagnosed this before July 17, 1991," does that affect your opinion that this condition manifested itself before that date?
>
> A. No. No.
>
> Q. Why not?
>
> A. Well, because not everybody is trained to recognize it.
>
> Q. It is a field which you could recognize because of your training and specialty in that area?
>
> A. Yes.

(Rx-27). According to Provident American's expert, what usually prompts persons with HS to seek medical attention so as to become aware of their condition is an attack of gallstones (which did not happen here) or when another family member has been diagnosed and the rest get checked (which, it is undisputed, is precisely what happened here in mid-July, 1991). The testimony by Denise's mother and father rebuts Provident American's accusations of misrepresentation and non-disclosure. (S.F. 352-53, 549-52, 558-67, 573-81, 625-31, 639-41, 654-55)

The jury was also entitled to believe that, even at trial, Provident American was making up reasons, years after its denial/non-denial, to justify never having paid Denise's claims.

Throughout Clines' testimony, he refers to medical records which he claims disappeared or were never provided. (S.F. 269-70 391, 414, 478-79, 520-21, 526). Clines could not identify these missing records, stating only that he "personally" believed that the insurer had not received all records pertinent to Denise's condition. (S.F. 526). Not only was there nothing in the record to substantiate Clines' "personal" views, the claims manager for Provident American testified that once the insurer requested additional records from Mr. Castañeda, the carrier had the responsibility to follow up on that request. (Rx-1 39).

On another occasion, Clines discussed Dr. Canales' testimony that medical records indicating Denise had sore sites, which the insurer viewed as evidence of manifestation, had been incorrectly transcribed. (S.F. 511-12). At that point, Clines essentially accused Dr. Canales of having altered his records to obtain insurance coverage for his patient. (S.F. 513).

The after-the-fact effort to justify wrongfully denying coverage was additionally demonstrated by a summary of the contents of Provident American's claims file prepared by the carrier. Many of the letters on the list were described in terms highly favorable to Provident American's denial of coverage. (Dx-3). On cross examination, it became immediately apparent that these self-serving statements appeared nowhere in the described letters or elsewhere in the claims file. (S.F. 529-31, 533-34; Dx-3).

All of this evidence establishes that the jury's affirmative finding on unconscionable conduct by Provident American should be upheld. (Tr. 90). When an insured, such as Guillermo Castañeda, pays the premium and the insurer refuses to provide coverage, the jury can reasonably conclude that the insured received a valueless policy. *See Allied Gen. Agency, Inc. v. Moody*, 788 S.W.2d 601, 606 (Tex. App. - Dallas 1990, writ denied). Texas courts have also recognized that a jury finding on unconscionability will be upheld when the insurer uses its superior knowledge and bargaining position to lull the insured into inaction while searching for reasons to avoid coverage. *See How Ins. Co. v. Patriot Fin. Serv.*, 786 S.W.2d 533, 541 (Tex. App. - Austin 1990, writ denied).

3. A Classic Case of Actionable Misrepresentations Under §17.46(b) and Art. 21.21 §4

"Misrepresentations as to coverage and benefits are precisely the sort of conduct which gives rise to a section 17.46[b] cause of action." *Marshall v. Aetna Cas. & Sur. Co.*, 724 S.W.2d 770, 772 (Tex. 1987). Question No. 4 was a pure laundry list misrepresentation submission consisting of sub-sections (5), (7) and (12) of Section 17.46(b). (Tr. 91). The jury answered "yes" to Question No. 4. (Tr. 91). The jury also answered "yes" to Question No. 1 which included a misrepresentation submission under Art. 21.21 §4 of the Code. (Tr. 88-89). The judgment may be upheld based on Provident American's liability under the laundry list findings or under the Art. 21.21 §4 findings or under both.

It is undisputed that Denise's surgeon contacted Provident American and inquired about her insurance before performing surgery. (S.F. 467-68). It is likewise undisputed that Provident American pre-approved Denise's surgery. After pre-approving the surgery, however, Provident American denied coverage and refused to pay the surgeon's bill. The jury was entitled to view Provident American's about-face on coverage as a misrepresentation. *See Webb v. International Trucking Co.*, 909 S.W.2d 220, 228, 231 (Tex. App. - San Antonio 1995, no writ)(carrier's confirmation of coverage followed by denial of coverage supported treble damage judgment under §17.46(b)(12)).

Provident American claims that its pre-approval of surgery is not a representation of coverage but merely a statement that a patient is an insured under a policy. The jury was not required to accept Provident American's version of how the carrier usually handles pre-approvals or allegedly handled Denise's situation but could instead rely on the other evidence, such as its own President's testimony. (Px-8). The President agreed that Denise's surgeon had a financial interest in verifying coverage and that his company provides information on the "general terms" of the policy when pre-approving treatment. (S.F. 467-68).

Another doctor, in addition to the surgeon, was told that Provident American would provide coverage for medical bills and expenses arising out of Denise's operation and treatment. (Px-27; Px-8). Representing to a health care provider that insurance

coverage would be provided and thereafter denying coverage constitutes a classic example of an actionable misrepresentation under the DTPA and the Insurance Code. *See Hermann Hosp. v. National Std. Ins. Co.*, 776 S.W.2d 249, 250-51 (Tex. App. - Houston [1st Dist.] 1989, writ denied); *see also Marshall, supra* at 772.

Provident American's misrepresentations regarding the six-month gallbladder provision provide an even stronger basis for affirming the judgment. Witnesses from Provident American's Claims Department uniformly agreed that denying Denise's claims based upon the six-month gallbladder provision was incorrect. (Rx-1 27, 42-43-44; Rx-2 41-42). Even after its Claims Department recognized that the six-month gallbladder provision was inapplicable, Provident American still told health care providers that their bills would not be paid and Denise did not have coverage because of the gallbladder provision. As early as December 12, 1991, when Provident American notified Denise's father by letter that the 30-day manifestation provision precluded coverage, the insurer knew its denial based on the gallbladder provision was wrong. (Px-16; Rx-1 25-26). Yet, Provident American told health care providers on March 23 and July 6 of 1992 that no coverage would be provided based upon the six-month gallbladder provision. (S.F. 409-10; Px-23, Px-26).

In sum, Provident American represented to health care providers that Denise's claim was not covered and would not be

paid based upon the six-month gallbladder provision when the insurer had already decided that the gallbladder provision was inapplicable and that its initial denial on that basis was erroneous. The jury was entitled to find that these representations were knowing misrepresentations concerning Provident American's insurance services and the rights conferred by the Provident American insurance policy, i.e., violations of §17.46(b)(5),(7) & (12) of the DTPA and Article 21.21 §4 of the Code. *See Marshall, supra* at 772; *Hopkins v. Highlands Ins. Co.*, 838 S.W.2d 819, 823 (Tex. App. - El Paso 1992, no writ)("false or misleading representations of the policy contract" violate Art. 21.21 §4 and are actionable under Art. 21.21 §16).

C. Provident American's Repeated Failure to Acknowledge Communications

Provident American's argument, that no evidence supports the finding that the carrier failed to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, is spurious. (App. 28; Tr. 89). Provident American's own witnesses essentially conceded liability on this issue. 914 S.W.2d at 280.

It is undisputed that Mr. Castañeda never received any response from Provident American directed to him after the December 12 denial/non-denial letter. (S.F. 548). The carrier's President, Clines, conceded that Provident American told Mr. Castañeda that it would get back to him within two weeks, but they never did. (S.F. 405-07, 548; Rx-1 37). Clines agreed that the

failure to properly communicate with an insured violates the Insurance Code, conceding that the insurer responded to Mr. Castañeda only after he complained to the Texas Department of Insurance. (S.F. 404). Provident American's expert similarly testified that carriers are required to respond to communications from their policyholders and that Provident American should have, but did not, respond as required by law. (S.F. 793-95). Both the director of operations and the claims manager for Provident American testified that the insurer's failure to respond and follow up on Denise's claim was unusual and not proper. (Rx-1 39; Rx-2 28).

D. Jury Was Entitled to Find Provident American Lacked a Reasonable Basis to Deny Coverage

Even if Provident American is right about the standard of liability, i.e., the reasonable basis defense has somehow been incorporated into all DTPA and Code liability provisions, the judgment should still be affirmed.

First, Provident American had no reasonable basis, as a matter of law, to continue denying Denise's claim and refuse to pay her medical bills based upon the six-month gallbladder provision after the carrier had decided that provision was inapplicable. *See Aetna Cas. & Sur. Co. v. Garza*, 906 S.W.2d 543, 546 (Tex. App. - San Antonio 1995, writ dism'd by agr.). Second, Provident American had no reasonable basis for denying Denise's claim by deciding to apply a 30-day manifestation exclusion to a complex, rare medical condition without first consulting a

physician. Provident American's own hematologist testified only an expert, such as herself, could determine when Denise's condition manifested. (Rx-27). Yet, both Provident American's Claims Manager and Director of Operations conceded that Denise's claim was denied, based on the 30-day manifestation provision, without anyone in claims having talked to the carrier's in-house medical staff. (Rx-2 25; Rx-1 31-32). The Claims Manager even admitted that she actually had "no idea" when Denise's HS had manifested -- yet she still authorized the denial. (Rx-1 52). Eventually, the Claims Manager conceded that this denial, as made on December 12, 1991, was improper. (Rx-1 44).

Third, the jury could have reasonably concluded that all of the evidence on Provident American's flip-flopping on coverage, hopping from exclusion to exclusion to justify denying coverage and refusing to even concede that coverage was ever denied established that the insurer knew that it had no reasonable basis to deny Denise's claims.

As part of its "reasonable basis" argument, Provident American has cited the testimony of a Dr. Mary Milam. Dr. Milam, however, was deposed two days before trial and was not even contacted by Provident American until roughly a month before trial. (S.F. 258; Rx-7). The jury was entitled to reject Provident American's last-minute reliance on a physician to justify having denied Denise's claim more than two years earlier. *See E.I. DuPont de Nemours & Co. v. Robinson*, 38 Tex. Sup. Ct. J.

852, 855, 860 (June 15, 1995)(discussing questionable reliability of expert opinion formed solely for litigation).

E. Expert Testimony Supports All Twenty Liability Findings

The jury heard testimony from an insurance expert that Provident American had committed unfair, false, misleading and deceptive acts or practices as submitted in Questions Nos. 1 and 4. (S.F. 281, 296-97, 319-22, 324-26, 369-70, 371-72). This expert testimony is, by itself, sufficient to support liability findings against Provident American. *See Nationwide Mut. Ins. Co. v. Crowe*, 857 S.W.2d 644, 651-52 (Tex. App. - Houston [14th Dist.]), *judgmt set aside by agr.*, 863 S.W.2d 462 (Tex. 1993). On appeal, Provident American does not mention this expert proof much less complain about its probative force, competency or reliability. *See DuPont, supra*.

F. Provident American's Misconduct Amounts to Much More than Mere Breach of Contract or Simple Denial of Coverage

This misconduct by Provident American involves affirmative misrepresentations, denials of coverage based on an exclusion the carrier had already specifically decided did not apply to Denise's claim, and months of searching for any reason, no matter how tenuous or even illogical, to justify denying coverage. It is far different and worse than a "mere" denial of coverage or a "mere" breach of contract. *See International Trucking, supra* at 230.

The court of appeals' opinion does not interfere with an insurer's right to contest a claim nor does it otherwise compel settlement. Rather, the opinion enforces the straightforward

language of the DTPA and Code by affirming a judgment against an insurer who continued to deny benefits even after becoming aware its denial was wrongful and otherwise engaged in a purposeful effort to protect its interests at the expense of its insured's.

G. There is Clearly Sufficient Evidence of Producing Cause

Provident American pre-approved Denise's surgery and then denied coverage for the surgery. Provident American represented to health care providers that their bills would be paid and didn't pay those bills. The jury was entitled to believe that if the surgery had not been approved, the surgery would not have occurred since there was not an emergency situation; consequently, Denise would not have incurred the medical bills. Similarly, if Provident American had paid the health care providers, rather than misrepresenting that Denise's condition was not covered under the six-month gallbladder provision, then Denise would not have had liability for outstanding medical bills. If Denise did not have those outstanding medical bills, her credit reputation would not have been damaged.

Provident American's emphasis on the fact that the insurer did not make representations directly to Denise misses the point. In essence, the carrier is attempting to inject a reliance requirement into a DTPA/Code cause of action -- a requirement this Court has rejected. *See Celtic Life Ins. Co. v. Coats*, 885 S.W.2d 96, 99 (Tex. 1994). "The proof need only establish that the damages were factually caused by the defendant's

misrepresentation." *See Hart v. Berko, Inc.*, 881 S.W.2d 502, 507 (Tex. App. - El Paso 1994, writ denied)(citing cases). So long as there is evidence that misconduct or misrepresentations by Provident American were a producing cause of Denise's damages then the trial court's judgment should be affirmed. *See D/FW Commercial Roofing Co. v. Mehra*, 854 S.W.2d 182, 185 (Tex. App. - Dallas 1993, no writ)(DTPA has no "privity" requirement and plaintiff's standing is determined by relationship to transaction at issue not relationship to defendant).

The fact that the misrepresentations were made after the initial sale of a policy is immaterial. First, some liability submissions were phrased in terms of future performance by Provident American. (Tr. 91). Second, the ultimate issue is not the timing of the misrepresentations but cause in fact. *See Hart, supra*. If Provident American is right about misrepresentations having to be made at the time an insurance policy is sold, an insurer could never incur statutory liability for claims handling which necessarily occurs after the policy is in effect. The Legislature did not intend to exempt claims handling from the DTPA and Code.

As part of its causation arguments, Provident American relies on *Parkway Co. v. Woodruff*, 901 S.W.2d 434 (Tex. 1995). That case is legally and factually distinguishable. *Parkway* involved the DTPA's prohibition against unconscionable conduct as applied to the sale of a house. In contrast to that one-time transaction

involving the sale of a good, Provident American's insurance policy involves ongoing insurance services with periodic premium payments. Furthermore, an insurance policy necessarily contemplates that there will be future services as the very purpose of insurance is to provide the insured with protection against future events. *See Allied Gen. Agency, Inc. v. Moody*, 788 S.W.2d 601, 608 (Tex. App. - Dallas 1990, writ denied). More importantly, the jury submission on the laundry list, Question No. 4, was framed in terms of future performance. (Tr. 91).

Provident American's complaint about the court of appeals having allegedly failed to address causation is meritless. After discussing the record in detail, the court of appeals specifically overruled the insurer's Point of Error Two which attacked the sufficiency of the evidence to support the jury's liability and causation findings in response to Question Nos. 1, 3 and 4. *See* 914 S.W.2d at 280. Moreover, the causal connection between Provident American's denial of coverage and Denise's lost benefits was undisputed. As a matter of common sense, Denise's loss of benefits never occurs if Provident American accepts coverage instead of denying benefits based on an exclusion the carrier knows is inapplicable. With respect to lost credit, the court of appeals specifically discussed Denise's testimony on how those unpaid bills caused her credit reputation to be damaged. 914 S.W.2d 281-82.

REPLY POINT TWO
(Restated)

The court of appeals correctly affirmed the trial court's judgment because the jury's findings that Provident American acted knowingly are supported by legally sufficient evidence.

STATEMENT, ARGUMENT & AUTHORITIES
(Under Reply Point Two)

The jury found that Provident American committed the conduct, inquired about in the fifteen sub-parts of Question No. 1, "knowingly." (Tr. 90). The jury also found that Provident American "knowingly" made the misrepresentations asked about in the three-part laundry list submission, Question 4. (Tr. 91-92). The evidence here, as discussed under Reply Point One, is of the type routinely relied upon by Texas appellate courts to uphold jury verdicts and treble damage judgments, including:

(1) Provident American was not protecting the interests of its insured, but was outcome-oriented and predisposed to denying coverage. *State Farm Fire & Cas. Co. v. Simmons*, 857 S.W.2d 126, 132-33 (Tex. App. - Beaumont 1993, writ denied).

(2) Provident American relied solely on matters it perceived as favoring its position on coverage and benefits, and summarily ignored anything inconsistent with its position, i.e., letters from numerous physicians. *See id.* at 132, 139.

(3) Provident American misled the Castañedas into believing that their interests were being protected and the insurer was amenable to re-considering its position, when in reality the

insurer had already decided to deny coverage, was telling health care providers it was denying coverage, and was continuing to search for ways to deny coverage. *See id.* at 139-43; *Commonwealth Lloyds Ins. Co. v. Thomas,* 825 S.W.2d 135, 144-45 (Tex. App. - Dallas 1992), *judgmt set aside by agr.,* 843 S.W.2d 486 (Tex. 1983).

(4) Provident American went through a succession of unjustifiable or erroneous reasons to deny coverage, adopting a new excuse each time the previous excuse proved meritless. *See How Ins. Co., supra* at 541.

(5) Even after its Claims Department recognized that the six-month gallbladder provision was inapplicable, Provident American still told health care providers that their bills would not be paid and Denise did not have coverage because of the gallbladder provision. When Provident American notified Denise's father by letter, dated December 12, 1991, that the 30-day manifestation provision precluded coverage, the insurer had already decided its denial based on the gallbladder provision was wrong. (Px-16; Rx-1 25-26). Yet, Provident American told health care providers on March 23 and July 6 of 1992 that no coverage would be provided based upon the inapplicable six-month gallbladder provision. (S.F. 409-10; Px-23, Px-26).

(6) Provident American created a self-serving document (Dx-3) and engaged in other after-the-fact attempts to justify its wrongful denial of coverage so as to entitle the jury to conclude

the insurer had engaged in a "cover up." *State Farm Fire & Cas. Co. v. Gros*, 818 S.W.2d 908, 915 (Tex. App. - Austin 1991, no writ).

(7) State Board of Insurance statistics demonstrated that Provident American consistently ranked, over a three-year period, as one of the worst health insurance companies for consumer complaints. (S.F. 718-20; Px-41, Px-42, Px-43). *See Paramount Nat'l Life Ins. Co. v. Williams*, 772 S.W.2d 255, 259 (Tex. App. - Houston [14th Dist.] 1989, writ denied).

REPLY POINT THREE
(Restated)

The court of appeals correctly affirmed the trial court's judgment because that judgment is based upon viable theories of liability which are supported by legally sufficient evidence.

STATEMENT, ARGUMENT & AUTHORITIES
(Under Reply Point Three)

A. Rather than "Trumping" *Vail* -- *Watson* Reaffirms *Vail* in First-Party Cases

If Provident American is right, then the *Watson* court would have had to overrule *Vail*. Instead, *Watson* expressly reaffirmed the validity of *Vail* in first-party cases such as this case. *See Allstate Ins. Co. v. Watson*, 876 S.W.2d 145 (Tex. 1994). For that reason, some courts have concluded that *Vail* remains the law in first-party actions "until the Texas Supreme Court tells us that it is not to be followed in a case involving an insured." *Crum & Forster, Inc. v. Monsanto Co.*, 887 S.W.2d 103, 118 (Tex. App. -

Texarkana 1994, no writ); *accord Maryland Ins. Co. v. Head Industrial Coatings & Servs., Inc.*, 906 S.W.2d 218, 225 (Tex. App. - Texarkana 1995, writ requested).

Even if *Watson* modified *Vail*, that opinion does not purport to entirely eliminate all avenues of recovery under Article 21.21 §16 and the DTPA. Even those courts concluding that a Section 17.46(a) claim is no longer valid after *Vail* have recognized that other Code/DTPA remedies remain viable. *See Hart v. Berko, Inc.*, 881 S.W.2d 502, 508-09 (Tex. App. - El Paso 1994, writ denied). In *Hart*, the court affirmed the judgment for the insured based upon an affirmative answer to a broad-form liability question which included sub-parts on Article 21.21 §4(1) and §4(2) and DTPA laundry list provision, §17.46(b)(12) -- liability theories submitted and answered affirmatively in this case. *See id.* at 508, 510-11. (Tr. 88-89, 91).

Nothing in *Watson* can be construed as eliminating an insured's right to rely on laundry list provisions, §17.46(b) of the DTPA, as a basis for an insurer's liability under the DTPA and Code. In *Watson*, this Court reaffirmed that a plaintiff has a private cause of action under Article 21.21 §16 for practices "*defined [as] unlawful deceptive trade practices in* Section 17.46 of the DTPA." *Watson, supra* at 147 (emphasis by supreme court). Later in its opinion, the *Watson* court confirmed that Article 21.21 "expressly makes actionable" violations of 17.46 of the DTPA. *See id.* at 149. *Watson* merely held, in a summary judgment

appeal, that a third-party claimant's general allegations about unfair claims settlement practices could not be found in the board orders or the laundry list. Here, there are findings, supported by legally and factually sufficient evidence, on violations of Article 21.21 §4, board orders, unconscionable conduct, and the laundry list. (Tr. 88-91).

Post-*Watson* opinions from this Court illustrate that all or most of *Vail* remains alive in the insured-insurer context. After *Watson*, the Texas Supreme Court remanded for retrial an insured's suit against a carrier based on an allegedly wrongful claim denial. *See Spencer v. Eagle Star Ins. Co.*, 876 S.W.2d 154 (Tex. 1994). In *Spencer*, the insureds alleged they had viable liability theories under three causes of action recognized in *Vail*: Unfair settlement practices under Article 21.21-2; breach of the duty of good faith and fair dealing as an unlisted, unfair practice under a board order; and, failure to settle as an unlisted deceptive trade practice. *See id.* at 156. As one court observed:

> If these theories are not available to an insured, why did the supreme court remand the *Spencer* case for new trial? If none of these theories are actionable, there would be nothing left to try.

Crum & Forster, supra at 118.

In 1995, this Court resolved a third-party claimant's suit against a liability carrier, which alleged a violation of the Code through §17.46(b)(23) of the laundry list, based solely upon "no evidence" grounds and not upon the claimant's lack of standing or

the non-existence of a cause of action. *See Transport Ins. Co. v. Faircloth*, 898 S.W.2d 269, 271-72 (Tex. 1995). If Section 17.46(b) no longer provides a basis for recovering treble damages against an insurer under Article 21.21, there would have been no reason for this Court to engage in a "no evidence" review. *See Crum & Forster, supra* at 118; *see also Webb v. International Trucking Co.*, 909 S.W.2d 220, 224, 228 (Tex. App. - San Antonio 1995, no writ)(*Watson* and *Faircloth* do not foreclose all third-party claims under Art. 21.21 §16).

In truth, Provident American knows *Watson* doesn't "trump" *Vail*. That is the reason why Provident American has asked this Court to overrule *Vail*. (App. 17). Unless this Court decides to re-write the DTPA and the Code by eliminating Article 21.21 §4 and the DTPA's laundry list and unconscionability provisions as viable theories of liability, the judgment here is based on sound legal theories and legally sufficient evidence.

B. Restricting Consumers to Interest Penalties and Common Law Relief Would Violate Legislative Intent

By enacting the enhanced damage provisions and other remedies created by the DTPA and Code, the Texas Legislature recognized that then-available remedies, such as common law causes of action and interest on unpaid benefits, were insufficient to deter and punish insurance companies and other commercial entities from unfairly treating the public. *See Smith v. Baldwin*, 611 S.W.2d 611, 616 (Tex. 1981). These enhanced damage provisions serve

three important functions: encouraging private consumer litigation, reducing the need for public enforcement, and deterring statutory violations. *See Pennington v. Singleton*, 606 S.W.2d 682, 688-90 (Tex. 1980); *State Farm Fire & Cas. Co. v. Price*, 845 S.W.2d 427, 440 (Tex. App. - Amarillo 1992, writ dism'd).

Provident American's position would deny protection to the very people who are most likely to need it. The DTPA, as well as the Code, was designed to protect the public, "that vast multitude which includes the ignorant, the unthinking, and the credulous, who, in making purchases, do not stop to analyze, but are governed by appearances and general impressions." *See Spradling v. Williams*, 566 S.W.2d 561, 563 (Tex. 1978). For the vast majority of these people, their only experience with a controversy over insurance will involve a denial of coverage as opposed to the less frequently invoked prohibitions concerning false advertising, bait-and-switch scams, etc.

Limiting an insured, such as Denise, to a recovery solely based on an interest penalty and common law remedies would not just violate legislative objectives, but would be contrary to the liberal construction mandates found in both the DTPA and Code. *See* Tex. Bus. & Com. Code §17.44; Tex. Ins. Code Art. 21.21 §1(b). Such a restriction would likewise violate the statutory provisions stating that the remedies under the Code and DTPA are cumulative, not exclusive of any other procedures or remedies provided for in

any other law. *See Mayo v. John Hancock Mut. Life Ins. Co.*, 711 S.W.2d 5, 6-7 (Tex. 1986)(insured may recover both 12% penalty under Art. 3.62 and treble damages under Code).

REPLY POINT FOUR
(Restated)

The court of appeals correctly affirmed the trial court's judgment, which is based upon broad-form liability submissions, because: (1) broad-form submission is required whenever feasible, absent extraordinary circumstances which are not present here; (2) the trial court did not abuse its discretion by using broad-form submission; (3) any alleged problems with a liability sub-part not being supported in law or in fact amount to harmless error; and, (4) any error in the broad-form liability submission was waived.

STATEMENT, ARGUMENT & AUTHORITIES
(Under Reply Point Four)

A. Provident American's Attack on Broad-Form Submission is Contrary to Supreme Court Authorities and Rule 277

This case was submitted broadly without objection from Provident American. On appeal, the insurer claims the trial court's judgment should be reversed because it is not possible to pinpoint the specific basis for the jury's liability findings.

This case is no different than any other case which is submitted broadly as required by Rule 277. If Provident American is correct, then broad-form submission would be per se reversible. This would inevitably result in a return to submitting "each issue distinctly and separately." *See Texas Dep't of Human Servs. v. E.B.*, 802 S.W.2d 647, 648 (Tex. 1990). As this Court has

stressed, "Rule 277 was designed to abolish the distinctly and separately requirement." *Id.* at 649; *accord Island Rec. Devel. Corp. v. Republic of Tex. Sav. Ass'n*, 710 S.W.2d 551, 555 (Tex. 1986); *Brown v. American Tr. & Stor. Co.*, 601 S.W.2d 931, 937 (Tex.), *cert. denied*, 449 U.S. 1015 (1980).

In a termination of parental rights case, this Court rejected the argument that the parties and courts are entitled to know the precise basis for each finding made by the jury, stating:

> The controlling question in this case was whether the parent-child relationship between the mother and each of her two children should be terminated, not what specific ground or grounds under Section 15.02 the jury relied on to answer affirmatively the questions posed. All ten jurors agreed that the mother had endangered the child by doing one or the other of the things listed in Section 15.02.

See E.B., supra at 649. In so holding, the Texas Supreme Court stressed that the trial court did not abuse its discretion by tracking the pertinent statutory language in a jury instruction and then submitting a broad-form question. *See id.* at 649.

If the trial court does not abuse its discretion by relying on a broad-form submission in a case requiring proof by clear and convincing evidence and involving the termination of a mother's relationship with her two daughters, the trial judge did not abuse his discretion here by using a broad-form liability submission tracking statutory and regulatory language. *See id.; see also Island Rec., supra* at 555 ("This Court has clearly mandated that Rule 277 means precisely what it says and that trial courts are

permitted, and even urged, to submit the controlling issues of a case in broad terms so as to simplify the jury's chore.").

At worst, the inability of an appellate court to pinpoint the precise liability findings made by a jury in response to a broad-form liability submission is harmless error. Provident American concedes that it cannot satisfy the harmful error test but only show a "possibility" of an alleged error. (App. 44, 47). So long as one of the legal theories propounded in a broad-form liability submission is a legally recognized cause of action and is factually supported by the evidence, then the judgment must be upheld regardless of whether other submitted theories are legally and factually supported. *See Redman Homes, Inc. v. Ivy*, 39 Tex. Sup. Ct. J. 481, 483 (April 12, 1996); *Hart v. Berko, Inc.*, 881 S.W.2d 502, 511 (Tex. App. - El Paso 1994, writ denied); Tex. R. App. P. 81(b)(1). The briefing under the preceding reply points demonstrates that the liability submission here was based on viable legal theories and there is legally and factually sufficient evidence to support the jury's affirmative answer on one or more liability theories.

B. Provident American's Attack on Broad-Form Submission was Waived

Provident American didn't object to the charge on the grounds that the submission would make it impossible to draft an accurate judgment or result in a judgment based on speculation. More importantly, Provident American didn't object to the charge on the grounds that broad-form submission would prevent the insurer from

making a proper appellate presentation -- its principal complaint on appeal about the charge.

Provident American claims that its complaint about the broad-form submission was preserved through post-verdict motions. By failing to object to the charge, however, Provident American waived its complaint about broad-form submission. A complaint about uncertainty or ambiguity in the verdict, allegedly making it impossible to determine the basis for the jury's findings, must be raised by objection to the court's charge prior to submission. *See Speed v. Eluma Int'l, Inc.*, 757 S.W.2d 794, 800-01 (Tex. App. - Dallas 1988, writ denied). The alleged deficiency in the liability questions could have been easily cured had Provident American objected before submission. "A party cannot wait until the trial is finished, then seek to reverse an unfavorable verdict by complaining of an error which the trial court could have corrected had it been timely informed of the error." *Hallett v. Houston Nw. Med. Ctr.*, 689 S.W.2d 888, 890 (Tex. 1985).

REPLY POINT FIVE
(Restated)

The court of appeals correctly affirmed the trial court's judgment for actual damages because: (1) legally sufficient evidence supports the jury's finding on actual damages; (2) the damage question was properly submitted in broad form; and, (3) any error in the broad-form damage submission was waived.

STATEMENT, ARGUMENT & AUTHORITIES
(Under Reply Point Five)

A. Introduction

The actual damages recoverable under the Code are identical to the damages recoverable under the DTPA. *Stewart Title Guar. Co. v. Sterling*, 772 S.W.2d 242, 247 (Tex. App. - Houston [14th Dist.] 1989), *rev'd on other grounds*, 822 S.W.2d 1 (Tex. 1992). This Court has repeatedly confirmed that the concept of "actual damages" should be broadly construed, stating:

> The object of awarding a plaintiff recovery is to compensate for the actual loss sustained as a result of the defendant's conduct. The DTPA embraces this concept by permitting the injured consumer to recover the greatest amount of actual damages alleged and factually established to have been caused by the deceptive trade practice, ... The amount of actual damages recoverable under the DTPA is determined by the total loss sustained as a result of the deceptive trade practice.

Kish v. Van Note, 692 S.W.2d 463, 466 (Tex. 1985); *accord Henry S. Miller Co. v. Bynum*, 836 S.W.2d 160, 162 (Tex. 1992). Because of the statute's liberal approach to compensatory damages, the injured party is not restricted to a contractual measure of damages or technical criteria such as "benefit-of-the-bargain" or "out-of-pocket;" rather, the plaintiff may recover all of her losses. *See Bynum* at 162; 914 S.W.2d 273.

B. Loss of Policy Benefits

This is a DTPA/Code case. It is not a contract case or a common law tort action. Loss of the policy benefits wrongfully withheld is a correct measure of damages as a matter of law.

"An insurer's unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the

policy benefits wrongfully withheld." *Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 136 (Tex. 1988). In 1995, this Court reiterated that policy benefits wrongfully withheld are actual damages under the DTPA and the Insurance Code because those statutes are cumulative of other remedies, whether in contract or tort. *See Twin City Fire Ins. Co. v. Davis*, 904 S.W.2d 663, 666 (Tex. 1995)(reaffirming *Vail* holding on wrongfully withheld policy benefits as actual damages in statutory action). Distinguishing *Vail* as involving a statutory claim, the *Davis* court held that wrongfully withheld policy benefits are not tort damages which will support a recovery of exemplary damages. *Id.* That holding is not in point here since this case is a statutory action as opposed to a common law tort case.

The jury's findings established that Provident American wrongfully denied policy benefits. *See Davis, supra; Vail, supra.* Provident American assumed the burden of proof to show non-coverage. (Tr. 94-95). The jury decided against Provident American on the only theories of non-coverage submitted. (*Id.*). Those findings have not been challenged on appeal, the insurer's denial of coverage was therefore wrongful and Denise is entitled to recover the benefits wrongfully withheld.

Denise's recovery for the full $14,348.90 in lost policy benefits is supported by both the law and record. It is undisputed that she submitted claims in this amount and those benefits were never paid by Provident American. (S.F. 941-42; 914

S.W.2d at 281). To the extent those benefits should have been reduced by deductibles or allegedly excluded expenses, or limited to usual and customary charges, Provident American had the burden to request a limiting instruction in connection with the damage submission. *See Cameron v. Terrell & Garrett, Inc.*, 618 S.W.2d 535, 538 n.4 (Tex. 1981); *see also Jim Howe Homes, Inc. v. Rogers*, 818 S.W.2d 901, 903 (Tex. App. - Austin 1991, no writ). By failing to do so, Provident American waived any right to complain about the measure of damages submitted or the jury's failure to make deductions from the total claims submitted by Denise. *See id.*

C. Denise's Damaged Credit Reputation

Denise's testimony on her damaged credit reputation was not contradicted. The following uncontroverted evidence is legally sufficient support for the actual damages finding:

-- Denise was sent bills by health care providers.

-- She could not pay those bills.

-- Denise, although insured through her parents' policy, is an adult legally responsible for her own debts.

-- Denise had applied for several credit cards since December, 1991 and was turned down because of a negative credit rating.

-- The only factor that caused her to have a bad credit rating would have been her unpaid medical bills.

-- In Denise's opinion, her credit has been ruined.

(S.F. 814-16). This testimony is legally sufficient to support the jury's implicit finding on damage to her credit reputation of

$35,651.10 ($50,000 less unpaid medical bills of $14,348.90) or the entire $50,000 finding. *See Bynum, supra* at 162 (allowing recovery of loss of credit under DTPA ensures plaintiff is made whole).

Loss of credit reputation is an intangible damage. *See Lochabay v. Southwestern Bell Media, Inc.*, 828 S.W.2d 167, 171 (Tex. App. - Austin 1992, no writ)(describing lending services as intangible item for purposes of DTPA). As observed by one court:

> The amount of damages for loss of credit must only be established with the degree of certainty to which it is susceptible. Damages must be established with reasonable certainty. If it is impossible to establish the exact amount of damages, failure to do so is not a basis for denying recovery.

Commonwealth Lloyds Ins. Co. v. Thomas, 825 S.W.2d 135, 146 (Tex. App. - Dallas 1992), *judgmt set aside by agr.*, 843 S.W.2d 486 (Tex. 1993); *see also Bradbury v. Scott*, 788 S.W.2d 31, 39 (Tex. App. - Houston [1st Dist.] 1989, writ denied)(where amount of actual damages is not capable of definite ascertainment, and prima facie liability is established, determination of amount is necessarily lodged in discretion of jury). Thus, once the fact of Denise's damage was proven, the jury had broad discretion to determine the amount. *See id.*

D. Broad-Form Damage Submission was Feasible and Provident American's Appellate Complaints about Broad-Form Submission were Waived

The trial court did not abuse its discretion by submitting damages broadly. *See E.B., supra* at 649. Moreover, Texas courts

have recognized that a defendant waives any complaint about the sufficiency of the evidence to support a multi-element damage award when it has failed to request findings on each element of damages. *See Haryanto v. Saeed*, 860 S.W.2d 913, 922 (Tex. App. - Houston [14th Dist.] 1993, writ denied). It is undisputed that Provident American made no such request in this case.

Provident American claims that its appellate complaint about the failure of the jury charge to provide separate answer blanks for each element of damage is preserved for appeal under *Wingate v. Hajdik*, 795 S.W.2d 717 (Tex. 1990). In *Wingate*, however, this Court held that a special exception and a motion for new trial preserved a complaint about an unsegregated damage award because it was a non-jury case and the defendant could not have anticipated that the trial court would award damages erroneously. *See id.* at 720 n.2. In so holding, the majority distinguished the cases cited by the dissent, requiring objections to overly broad or inclusive jury questions to preserve error, as involving jury trials as opposed to bench trials. *Id.*

The judgment in this case arises from a jury trial and, therefore, is governed by the supreme court authorities cited in the dissenting opinion in *Wingate*. Since this was a jury trial, Provident American could have easily anticipated that the damages awarded would be unsegregated and the liability findings would not be separate and distinct. The carrier was thus required to object to any allegedly overly broad questions to preserve error for

appellate review. *See Wingate, supra* at 722 (Spears, J., dissenting); *see also Exxon Corp. v. Allsup*, 808 S.W.2d 648, 659 (Tex. App. - Corpus Christi 1991, writ denied)(failure to specifically object that question did not allocate damages between multiple causes of action waived any error).

Even if Provident American's complaint has not been waived, "the only way that a defendant can successfully attack a multi-element damages award on appeal is to address each and every element and show that not a single element is supported by sufficient evidence." *Haryanto, supra* at 922; *accord Greater Houston Trans. Co. v. Zrubeck*, 850 S.W.2d 579, 589 (Tex. App. - Corpus Christi 1993, writ denied). So long as the aggregate evidence (the evidentiary support for one or more of the damage elements submitted to the jury) supports the finding, the damages awarded will be upheld even if there is insufficient evidence on some elements. *See id.* In this case, the combined evidence on loss of benefits and damage to credit reputation, or the evidence on damaged credit reputation alone, supports the $50,000 award. *See id.*

REPLY POINT SIX
(Restated)

The court of appeals correctly affirmed the trial court's judgment awarding attorney's fees against Provident American because: (1) the fees submission was correct; (2) any error in the fees submission was waived; and, (3) Provident American does

not claim that any alleged deficiencies in the fees submission constituted harmful error.

STATEMENT, ARGUMENT & AUTHORITIES
(Under Reply Point Six)

As Provident American correctly observes, the submission on attorney's fees tracked PJC 110.16. This PJC submission for attorney's fees has been routinely followed by Texas courts in an Insurance Code action. *See Benefit Trust Life Ins. Co. v. Littles,* 869 S.W.2d 453, 472 (Tex. App. - San Antonio 1993), *judgmt set aside by agr.,* 873 S.W.2d 704 (Tex. 1994); 914 S.W.2d at 283. The unsettled aspect of submitting fees in the "recovery" format does not involve the propriety of the submission but the calculation of fees after the jury has made its percentage finding. *See Great Am. Ins. Co. v. North Austin Mun. Util. Dist.,* 908 S.W.2d 415, 528 (Tex. 1995). Fees were calculated here in accordance with *Great American* and Provident American does not complain of that calculation. *See id.*

Provident American cites *Roberts v. Grande,* 868 S.W.2d 956, 961 (Tex. App. - Houston [14th Dist.] 1993, no writ) as disapproving the PJC submission. Actually, the *Roberts* court recognized that an award of attorney's fees under the Code is properly based upon the plaintiff's "recovery." *See id.* at 961.

Provident American analogizes the fees submission here to a damage finding based upon speculation. If this analogy is correct, Provident American waived any error by failing to request

an instruction on the correct measure of damages, i.e., a definition or instruction on "recovery." *See Cameron v. Terrell & Garrett, Inc.*, 618 S.W.2d 535, 538 n.4 (Tex. 1981)(any error in omission of explanatory instruction on measure of damages was waived by defendant's failure to request such instruction).

The court of appeals correctly recognized that at no point in its appellate attack on the fees submission did Provident American claim it was in any way harmed by the manner in which the case was submitted. 914 S.W.2d at 283. In the court of appeals, Provident American didn't have a point of error or argument claiming that the attorney's fees awarded in the judgment were excessive or not supported by factually sufficient evidence, nor did the carrier request a remittitur. In this Court, Provident American does not claim that the award of fees exceeded the amount contemplated by the jury or was otherwise inflated. *See Great Am., supra* at 428. In the absence of a claim by Provident American that any deficiencies in the fees submission were reasonably calculated to and probably did cause an improper judgment, this Court is not required to review the merits of Point of Error No. 15. *See* Tex. R. App. P. 81(b)(1).

PRAYER

Respondent, Denise Castañeda, respectfully requests the Court to refuse or deny the Application for Writ of Error; or, in the alternative, if writ is granted, to affirm the judgment of the

court of appeals in its entirety; and award her such other and further relief to which she is justly entitled.

Respectfully submitted,

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ATTORNEYS FOR RESPONDENT

CERTIFICATE OF SERVICE

I hereby certify that on the 16th day of May, 1996, a true and correct copy of Response to Application for Writ of Error has been sent by U.S. Mail, postage prepaid, to Mr. Scott Patrick Stolley, Thompson & Knight, 1700 Pacific Avenue, Suite 3300, Dallas, Texas 75201-4693.

_____
TIMOTHY PATTON