

# HANNA & PLAUT LLP

ATTORNEYS AT LAW

## BAD FAITH LITIGATION IN TEXAS AND UPDATE OF RECENT EXTRA-CONTRACTUAL CASES

---

### Table of Contents

I.	ASSESSING THE REASONABLENESS OF AN INSURER’S DELAY OR DENIAL OF A CLAIM: AN ANALYTIC CONUNDRUM .....	H-18
II.	AN OVERVIEW OF <i>LYONS</i> v. <i>MILLERS CASUALTY</i> .....	H-19
	A. Facts and Procedure .....	H-19
	B. The <i>Lyons</i> Decision Rejects the <i>Simmons</i> Approach But Does Not Specifically Adopt the “ <i>Bona Fide</i> “ Dispute Test .....	H-20
III.	<i>DOMINGUEZ</i> FOLLOWS THE <i>LYONS</i> APPROACH.....	H-22
	A. Facts and Procedure of <i>Dominguez</i> .....	H-22
	B. <i>Dominguez</i> Follows <i>Lyons</i> and Requires the Insured To Prove a Negative Proposition, the Absence of a Reasonable Basis for Denying a Claim .....	H-22
IV.	<i>MORIEL</i> FOLLOWS <i>LYONS</i> BUT ARTICULATES A “BONA FIDE DISPUTE” STANDARD.....	H-23
	A. Facts and Procedure .....	H-23
	B. <i>Moriel</i> Addresses the Standard for Assessing Bad Faith and Approves a “Bona Fide Dispute” Standard.....	H-24
	C. Implications of <i>Lyons</i> , <i>Dominguez</i> , <i>Moriel</i> , and the Bona Fide Dispute Standard.....	H-25
V.	<i>RAKKAR</i> ANTICIPATED THE <i>LYONS</i> APPROACH AND PROVIDES COMMON LAW GLOSS FOR THE NEW STANDARDS .....	H-25
	A. The <i>Rakkar</i> Decision.....	H-25
	B. Categories of Evidence that Should Not Preclude Summary Judgment on the Issue of Bad Faith .....	H-26
VI.	SUBSEQUENT APPELLATE DECISIONS ON THE “BONA FIDE DISPUTE” STANDARD AND JUDGMENT AS A MATTER OF LAW .....	H-26
	A. <i>Columbia Universal Life Insurance Co. v. Miles</i> , 923 S.W.2d 803 .....	H-26
	B. <i>Aetna Casualty &amp; Surety Co. v. Garza</i> , 906 S.W.2d 543 .....	H-27
	C. <i>Cortez v. Liberty Mut. Fire Ins. Co.</i> , 885 S.W.2d 466 .....	H-28
	D. <i>Ramirez v. Transcontinental Insurance Co.</i> , 881 S.W.2d 818 .....	H-28
	E. <i>Rogers v. CIGNA Insurance Co. of Texas</i> , 881 S.W.2d 177 .....	H-29
	F. <i>Packer v. Travelers Indemn. Co. of Rhode Island</i> , 881 S.W.2d 172 .....	H-30
VII.	“NO HARM, NO FOUL”: <i>REPUBLIC INSURANCE V. STOKER</i> .....	H-31
	A. An Overview of <i>Republic Insurance v. Stoker</i> .....	H-32
	B. <i>Stoker</i> Holds No Coverage Then Generally No Bad Faith Claims.....	H-32
	C. Implications of <i>Stoker</i> .....	H-34

**BAD FAITH LITIGATION IN TEXAS AND UPDATE OF RECENT EXTRA-CONTRACTUAL CASES**

**By J. Hampton Skelton and David L. Plaut**

This paper addresses extra-contractual litigation in Texas and reviews the Texas Supreme Court's recently promulgated standards for assessing bad faith causes of action. In addition to reviewing *Lyons*, *Dominguez and Moriel*, the paper also provides an update of recent extra-contractual appellate decisions. We conclude with a discussion of the important Texas Supreme Court decision, *Republic Insurance Co. v. Stoker*, and the implications for that decision on extra-contractual litigation in Texas.

An important "bad faith" insurance case, *Lyons v. Millers Casualty Insurance Company of Texas*, 866 S.W.2d 597 (Tex. 1993), presented the Texas Supreme Court with "the opportunity to clarify the method by which Texas courts should conduct legal sufficiency review of fact findings of bad faith against an insurer." The supreme court's decision in *Lyons* addressed an issue that had divided Texas courts of appeals and created a difficult analytic conundrum. In *State Farm Lloyds v. Polasek*, 847 S.W.2d 279, 283 (Tex. App.—San Antonio 1992, writ denied), for example, the San Antonio Court of Appeals reversed on legal sufficiency grounds a jury finding of no reasonable basis for denial of a claim because there was allegedly undisputed evidence of a reasonable basis. In *State Farm Fire & Casualty Company v. Simmons*, 857 S.W.2d 126, 132-136 (Tex. App.—Beaumont 1993, writ denied), however, the Beaumont Court of Appeals rejected *Polasek* as controlling authority and emphasized that the question of bad faith should turn entirely on whether or not the insurer conducted an exhaustive investigation before denial of the claim. See generally Christopher W. Martin, *Polasek & Simmons: Texas Bad Faith at the Crossroads*, TEXAS BAD FAITH BULLETIN (Rutter Group, Jan. 1994) (hereafter "Martin, *Polasek & Simmons*"); Steven A. Schneider, *Polasek and*

*Simmons: The Continuing Debate Over the Insurer's Duty of Good Faith and Fair Dealing*, 12 THE ADVOCATE 225 (December 1993). In struggling to reconcile "the insurer's substantive rights under the *Aranda* test" with the "traditional statement of the no evidence standard of review," the *Lyons* court fashioned an approach for assessing the legal sufficiency of a bad faith finding that comes very close to articulating the "bona fide dispute" standard of *Polasek*.

Two subsequent decisions of the Texas Supreme Court -- *National Union Fire Insurance Company of Pittsburgh v. Dominguez*, 873 S.W.2d 373 (Tex. 1994) and *Transportation Insurance Company v. Moriel*, 37 Tex. Sup. Ct. J. 883 (Jun. 8, 1994) -- reiterate the *Lyons* standard for assessing an insurer's alleged bad faith in the delay or denial of a claim. Both decisions, like *Lyons*, charge insureds with proving a negative: the absence of a reasonable basis for denying or delaying a claim. Moreover, these decisions require particularized evidence of bad faith; "some evidence" of insurance coverage alone will not establish the absence of a reasonable basis for the denial or delay of a claim. In fact, the *Moriel* decision makes specific reference to *Lyons* as embracing a "bona fide dispute" standard. Before turning to a consideration of *Lyons*, *Dominguez*, and *Moriel*, however, this article addresses the analytic conundrum that developed as Texas courts of appeals wrestled with the meaning and analysis of the duty of good faith and fair dealing.

*Republic Insurance Co. v. Stoker* arguably limits the scope of bad faith liability in Texas. The decision appears to predicate recovery in bad faith cases, generally, on an initial showing of contractual liability.

### I. ASSESSING THE REASONABLENESS OF AN INSURER'S DELAY OR DENIAL OF A CLAIM: AN ANALYTIC CONUNDRUM

The Texas Supreme Court first recognized an insurer's tort duty of good faith and fair dealing to its insured in *Arnold v. National County Mutual Fire Insurance Company*, 725 S.W.2d 165 (Tex. 1987), stating "[a] cause of action for breach of the duty of good faith and fair dealing is stated when it is alleged that there is no reasonable basis for denial of a claim or delay in payment or a failure on the part of the insurer to determine whether there is any reasonable basis for the denial or delay." *Id.* at 167 (emphasis added). The *Arnold* court emphasized that the duty of good faith and fair dealing arises from the special relationship between the insurer and the insured resulting from the insurer's disproportionately favorable bargaining posture in the claims handling process.

A year later, in *Aranda v. Insurance Company of North America*, 748 S.W.2d 210 (Tex. 1988) the supreme court held that to establish an insurer's liability for the tort of bad faith the insured must 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 no reasonable basis for denying the claim or delaying payment of the claim. The *Aranda* court also distinguished the insurer's liability under the contract of insurance from the insurer's liability for the tort of bad faith. "[C]arriers," the supreme court emphasized, "will maintain the right to deny invalid or questionable claims and will not be subject to [bad faith] liability for an erroneous denial of a claim." *Id.* at 213. In other words, if the insurer has denied what is later determined to be a valid claim under the contract of insurance, the insurer must respond in actual damages up to the policy limits. But as long as the insurer has a reasonable basis to deny or delay payment of the claim, even if that basis is eventually determined by the

factfinder to be erroneous, the insurer is not liable for the tort of bad faith.

In the wake of *Aranda*, Texas courts of appeals have struggled with two competing approaches to assessment of the reasonableness of an insurer's denial of a claim. The first approach -- comprehensively reviewed in *State Farm Lloyds v. Polasek*, 847 S.W.2d 279 (Tex. App.—San Antonio 1992, writ denied) -- emphasizes that, as a matter of law, an insurer cannot be liable for bad faith in the denial of a claim as long as there is some evidence reasonably supporting the denial of the claim. The *Polasek* decision embraced a "*bona fide* controversy" standard that conceivably requires summary judgment for an insurer on bad faith claims whenever there is some evidence that the decision to deny coverage was reasonable. In *State Farm Fire & Casualty Company v. Simmons*, 857 S.W.2d 126 (Tex. App.—Beaumont 1993, writ denied) -- a decision creating an appellate split on this question -- the Beaumont Court of Appeals criticized the *bona fide* controversy standard for insulating insurers from bad faith liability and blasted the *Polasek* court for its allegedly frightening "abrogation of the common law."

Courts following the second approach to assessment of an insurer's reasonableness in denying a claim have left the question for the jury when there is "some evidence" of bad faith. *See, e.g., St. Paul Ins. Co. v. Rakkar*, 838 S.W.2d 622, 626 (Tex. App.—Dallas 1992, writ denied) (finding that submission of bad faith to the jury was proper because "the evidence raise[d] fact questions concerning both the reasonableness of [the insurer's] reliance on its investigators and whether [the insurer] actually relied on those investigations") (emphasis added). Although the Beaumont Court of Appeals in *Simmons* employed this latter approach in assessing the question of reasonableness, the court went far beyond any previous decision with its assertion that the appropriate inquiry in a bad faith case is whether "the insurer fulfill[ed] its duty to its insured by pursuing a thorough, systematic, objective, fair, and honest

investigation of the claim prior to denying such claim.” *Id.* at 136.

The Texas Supreme Court’s recent decision in *Lyons*, however, reaffirms *Aranda* and thus effectively overrules the plaintiff-oriented approach of the Beaumont Court of Appeals in *Simmons*. Implicitly rejecting the *Simmons* approach, the Texas Supreme Court in *Lyons* cited the *Polasek* decision, but did not explicitly adopt the *bona fide* controversy standard for reviewing the reasonableness of an insurer’s delay or denial of a claim.

## II. AN OVERVIEW OF *LYONS v. MILLERS CASUALTY*

### A. Facts and Procedure

The insurance claim in this case arose after a windstorm. The claimant, Ms. Golda Lyons, submitted a claim to Millers Casualty Company, her homeowner’s insurance carrier, for damage to the brick veneer and outside back staircase of her house. Following an investigation, Millers denied Lyons’ claim. Lyons sued for breach of contract and of the duty of good faith and fair dealing and asserted that the damage to her house was caused by the windstorm, a covered peril. Millers, however, claimed that the damage was caused by settling of the foundation, an excluded peril. *Lyons*, 866 S.W.2d at 598.

At trial Lyons testified that during a storm on April 29, 1984, she heard something banging on the outside of the house. She later discovered that bricks within the external veneer were cracked and loose and that the back staircase was standing “out of kilter.” According to Lyons and two of her neighbors, this damage did not exist before the storm. The storm also knocked over a hackberry tree in Lyons’ yard, which had fallen perpendicular to and away from the residence. Another hackberry tree, located inches from the damaged staircase, remained standing. *Id.* at 598-599.

After Lyons submitted her claim to Millers, an adjustor and a reconstruction expert for Millers inspected the house. The reconstruction expert concluded that the damage was not caused by the storm, but rather by settling and shifting of the foundation. He based this conclusion on several cracks he found in the foundation and the absence of any indication of impact between a tree and the house. The reconstruction expert also noted that the wood in the staircase was rotted. Millers denied the claim five days after receiving this expert’s written report, less than one month after the storm. *Id.* at 599.

When Lyons protested the denial of her claim, Millers dispatched a professional engineer to reinspect the property. This engineer’s conclusions were identical to the conclusion of the reconstruction expert. He likewise noted the existence of numerous cracks in the foundation, indicating settling and shifting, and the absence of any evidence of contact between a tree and the house. On October 5, 1984, based on its engineer’s report, Millers again denied Lyons’ claim. *Id.*

In August 1985, Ms. Lyons hired an engineer of her own to inspect the property. By the time of that inspection, the staircase had collapsed following a second storm. The plaintiff’s engineer concluded that the original damage to the staircase and the brick veneer had been caused by the first storm. He theorized that the surviving hackberry tree located near the staircase, rather than the one found laying on the ground, struck the house during the first storm, causing the damage. *Id.*

In February 1986 Lyons sued Millers for breach of contract, violation of the Texas Deceptive Trade Practices Act (DTPA) and the Texas Insurance Code, and breach of the duty of good faith and fair dealing. A jury found that one-quarter of the structural damage to the house was attributable to the windstorm, three-quarters was attributable to settlement of the structure, and that \$25,000 was the reasonable cost to repair the

residence. The jury further found that Millers violated the DTPA, and breached its duty of good faith and fair dealing in failing to pay Lyons' claim, awarding an additional \$75,000 in damages for those claims, plus exemplary damages of \$8,700. The trial court rendered judgment on the verdict for \$89,950, plus pre-judgment interest and attorneys' fees. *Id.*

In its review, the court of appeals determined that there was no evidence of a breach of the duty of good faith and fair dealing or a violation of the DTPA; it therefore rendered a take-nothing judgment on those claims. Lyons complained on appeal that the court of appeals' conclusion that no evidence supported the jury's finding of bad faith was erroneous. The Texas Supreme Court affirmed, however, finding that "there was no evidence to support the bad faith judgment for Lyons under the substantive test we adopted in *Aranda* . . . ." *Lyons*, 866 S.W.2d at 598.

### **B. The *Lyons* Decision Rejects the *Simmons* Approach But Does Not Specifically Adopt the "Bona Fide" Dispute Test<sup>1</sup>**

Noting the difficulty Texas courts of appeals have had in reconciling the insurer's "substantive rights under the *Aranda* test" with the traditional statement of the no evidence standard of review,"<sup>2</sup> the *Lyons* court held that:

when a court is reviewing the legal sufficiency of the evidence supporting a bad faith finding, its focus should be on the relationship of the evidence arguably supporting the bad faith finding to the elements of bad faith. The evidence presented, viewed in the light most favorable to the prevailing party, must be such as to permit the logical inference that the insurer had no reasonable basis to delay or deny payment of the claim, and that it knew or should have known it had

no reasonable basis for its actions. See *Pittman v. Baladez*, 312 S.W.2d 210, 216 (Tex.1958). The evidence must relate to the tort issue of no reasonable basis for denial or delay in payment of a claim, not just to the contract issue of coverage.

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

Emphasizing that this approach "is nothing more than a particularized application of our traditional no evidence review," the *Lyons* court asserted that "[t]his focus on the evidence and its relation to the elements of bad faith is necessary to maintain the distinction between a contract claim on the policy, and a claim of bad faith delay or denial of that claim, which arises from the tort duty . . . imposed on insurers in *Arnold* and *Aranda*." *Id.*

Despite its citation to *Polasek*, the supreme court in *Lyons* did not specifically adopt the *bona fide* dispute standard. *Lyons*' requirement that a plaintiff's bad faith evidence "relate to the tort issue of no reasonable basis" does not necessarily insulate insurers who have relied on expert reports in denying claims from bad faith exposure. Under *Lyons*, evidence that an expert's report was not objectively prepared, or that an insurer's reliance on such a report was unreasonable, or any other evidence from which a factfinder could infer that an insurer acted without a reasonable basis create fact questions for a jury to resolve. *Lyons*, 866 S.W.2d at 601. It is arguable, however, that the *Polasek* bona fide dispute standard was intended to operate in just such a fashion, and that *Lyons* merely elaborates the central dictates of *Polasek*.

The evidence offered by Ms. Lyons in support of the bad faith finding consisted of an expert's opinion that the windstorm caused the damage, and the testimony of Lyons and her neighbors that the brick veneer and staircase were visibly damaged after the storm. The supreme court found that this evidence

supported the jury's finding that Lyons' damage was caused in part by the wind, and therefore her claim was covered by the Millers policy. In other words, Millers was mistaken as to its contract liability. The supreme court determined that the jury was entitled to resolve the conflict between Lyons' evidence that the windstorm caused the damage and Millers' evidence that the settling of the foundation caused the damage. Because the jury concluded that the former was more credible, and some evidence supported that finding, the inquiry as to contractual liability was conclusive. *Id.* at 600-01.

The *Lyons* court emphasized, however, that "the issue of bad faith focuses not on whether the claim was valid, but on the reasonableness of the insurer's conduct in rejecting the claim." *Id.* at 601. Evidence of coverage might in some circumstances support a finding that an insurer lacked any reasonable basis for denying a claim, for example, when the insurer unreasonably disregards the evidence of coverage. Ms. Lyons, however, 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. Under the rule established in *Aranda*, Millers could deny Lyons' claim without exposing itself to a bad faith judgment if it reasonably relied on expert reports indicating her loss was not caused by a covered peril, even though its liability on the insurance policy was ultimately established. *Id.* Focusing on the specific elements that must be proved to support a finding of bad faith and the evidence offered to support that finding, the Texas Supreme Court agreed with the court of appeals that there was no evidence that Millers had no reasonable basis to deny payment of Lyons' claim.

In determining that there was "no evidence Millers had no reasonable basis," the *Lyons* court disregarded -- as no more than a scintilla

of bad faith -- evidence (1) that the claims adjuster refused to speak to the plaintiff after an investigator was sent out and the claim was denied, and (2) that the adjuster did not interview the plaintiff's neighbors. *Lyons*, 866 S.W.2d at 601 n.3 (citing *Kindred v. Con/Chem, Inc.*, 650 S.W.2d 61, 63 (Tex. 1983)). The supreme court emphasized that the testimony of the plaintiff's neighbors was merely cumulative of her own opinion that damage was visible after the storm, and the adjuster's refusal to speak to the plaintiff after the claim was denied the first time did not support an inference that Millers acted unreasonably. *Id.*<sup>3</sup> This understanding of the duty of good faith and fair dealing clearly rejects the view of the Beaumont Court of Appeals in *Simmons*, which would have dramatically increased bad faith exposure by assessing bad faith solely in terms of the exhaustiveness of an insurer's investigation of a claim. In this regard, *Lyons* follows *Polasek* and validates the observation of the San Antonio Court of Appeals that "[e]ven the most thorough investigation must stop somewhere." *Polasek*, 847 S.W.2d at 288.

### III. DOMINGUEZ FOLLOWS THE LYONS APPROACH<sup>4</sup>

A recent decision of the Texas Supreme Court -- *National Union Fire Insurance Company of Pittsburgh v. Dominguez*, 873 S.W.2d 373 (Tex. 1994) followed the *Lyons* standards for assessing the alleged bad faith of an insurer in denying or delaying a claim. The case arose in the workers' compensation context and involved allegations that the compensation carrier breached its duty of good faith and fair dealing. The worker alleged that his back injuries were "work related" but the workers' compensation insurer controverted the claim.

**A. Facts and Procedure of *Dominguez***

The claimant in this case -- Justo L. Dominguez, Jr. -- worked for a company performing geophysical work and operated a special type of industrial truck. The truck vibrated the ground as part of seismographic analysis. Dominguez' job called upon him to repair the truck on occasion and some of his duties involved bending, stooping, and maintaining certain fixed positions for periods of time. *Dominguez*, 873 S.W.2d at 374.

After complaining of a swollen toe and a sore back, Dominguez was instructed to see a doctor. He subsequently received chiropractic treatment and was afforded benefits under his company's disability policy, which covered non-work related conditions. Over the next several months, Dominguez signed a number of insurance forms which included a representation that the injury was not work related. *Id.*

The chiropractor soon referred Dominguez to a back specialist who began regular treatment. After five months of disability, Dominguez' employer encouraged him to see another doctor, who diagnosed the injury as a degenerative joint disease and recommended that Dominguez return to work as part of his therapy. The employer subsequently terminated the disability payments and put Dominguez on leave without pay. He was later terminated despite returning to work. Rather than seeking redress from his employer, Dominguez sent notice of an occupational disease to the Industrial Accident Board ("IAB"). *Id.*

The workers' compensation insurer received notice of Dominguez' claim and hired an adjusting and investigating service to begin its inquiry. The insurer subsequently filed a notice with the IAB that it was controverting the claim based on the failure to report the injury as an on-the-job injury, as well as a failure to report the injury within thirty days. The insurer's investigator continued to investigate the claim. The doctor

who had initially seen Dominguez diagnosed his back pain as stemming from a degenerative condition. Additionally, the insurer learned from his employer that Dominguez had never reported the injury as work related and had made express representations to the employer's group health carrier that his injury was not work related. A second physician, however, gave his opinion that Dominguez' condition was work related. *Id.* at 374-375.

After an IAB award of \$6,559.48, Dominguez appealed to district court. Before trial, Dominguez and the insurance carrier settled the suit for \$28,000, and the trial court entered an agreed judgment. Dominguez then filed a lawsuit alleging bad faith against the insurer. After a jury trial of the bad faith suit, the trial court entered judgment for \$322,988.36 in Dominguez' favor as compensatory and exemplary damages for breach of the duty of good faith and fair dealing. The court of appeals affirmed in part and reversed in part. Following its *Lyons* decision, the Texas Supreme Court in *Dominguez* reversed and rendered that the insured take nothing. Despite conflicting medical testimony about whether the insured's injury was "work related," the *Dominguez* court found no evidence that the insurer had breached its duty of good faith and fair dealing. *Id.* at 374.

**B. *Dominguez* Follows *Lyons* and Requires the Insured To Prove a Negative Proposition, the Absence of a Reasonable Basis for Denying a Claim**

In finding that the insurer had not breached its duty of good faith and fair dealing, the *Dominguez* court reiterated the dictates of *Lyons* and *Aranda*. *Dominguez*, 873 S.W.2d at 376 (holding that "[a] claimant who alleges a breach of the duty of good faith and fair dealing must establish (1) the absence of a reasonable basis for denying or delaying payment of the benefits of the policy, and (2) that the carrier knew or should have known that there was not a reasonable basis for

denying the claim or delaying payment of the claim). The *Dominguez* court also noted that “[t]he first element of the *Aranda* test, the absence of a reasonable basis for denying the claim, requires an objective determination of whether a reasonable insurer under similar circumstances would have delayed or denied the claimant’s benefits.” *Dominguez*, 873 S.W.2d at 376. The second element that the carrier knew or should have known that there was no reasonable basis for denial -- the *Dominguez* court characterized as “an attempt to balance the right of an insurer to reject an invalid claim and the duty of the carrier to investigate and pay compensable claims.” *Id.* (citing *Aranda*, 748 S.W.2d at 213).

*Dominguez* echoes the *Polasek* decision of the San Antonio Court of Appeals with its assertion that insurance claimants have “the burden of proving a negative proposition, the absence of a reasonable basis for denying a claim, of which the carrier knew or should have known.” *Dominguez*, 873 S.W.2d at 376. Moreover, *Dominguez* emphasized that under *Lyons*, “evidence of insurance coverage alone does not go to . . . absence of a reasonable basis for denial of the claim” and held that some evidence of coverage is not evidence of an absence of a reasonable basis for denying a claim. *Dominguez*, 873 S.W.2d at 376-77. The only evidence offered by *Dominguez* to establish bad faith was a letter sent by a doctor to *Dominguez*’ attorney, which stated the doctor’s opinion that the injury was work related. *Dominguez*, 873 S.W.2d at 376-77. This evidence did not relate, as *Lyons* requires, to the tort issue of no reasonable basis for denial of a claim, but only to the contract issue of coverage. While noting that the letter was “some evidence of coverage,” the Texas Supreme Court held that it was not “evidence of an absence of a reasonable basis for denying the claim.”<sup>5</sup>

The insured in *Dominguez* presented no evidence that “cast[ ] doubt on [the insurer’s] reliance on the medical professionals who diagnosed the condition as a degenerative disease.” *Id.* at 377. Nor did the insured

present any evidence contradicting his own statements that his condition was not work related. As a consequence, the Texas Supreme Court concluded that there was no evidence of a breach of the duty of good faith and fair dealing, reversed the judgment of the court of appeals, and rendered judgment that the insured take nothing. *Dominguez*, 873 S.W.2d at 377.

#### IV. MORIEL FOLLOWS LYONS BUT ARTICULATES A “BONA FIDE DISPUTE” STANDARD<sup>6</sup>

In another important recent decision -- *Transportation Insurance Company v. Moriel*, 879 S.W.2d 10 (1994) -- the Texas Supreme Court reiterated the *Lyons* standards for assessing bad faith, and made specific reference to the “bona fide controversy” test.<sup>7</sup> *Moriel* involved a workers’ compensation claim and subsequent allegations that the compensation carrier breached its duty of good faith and fair dealing. The worker, Juan Carlos Moriel, alleged that his impotency following an accident was a “work related” injury but the workers’ compensation insurer delayed payment for two years before finally paying the claim.

##### A. Facts and Procedure

The claim in this case arose when a stack of counter tops fell on Juan Moriel, an employee of a building materials company in El Paso. Moriel suffered three broken ribs, a broken wrist, and a fractured pelvis. As a result, he was hospitalized for twelve days. Moriel’s hospitalization costs were paid by his employer’s workers’ compensation carrier. *Moriel*, 879 S.W.2d at 13.

A few days after leaving the hospital, Moriel had some loss of movement in one leg. He subsequently returned to the hospital to undergo tests for possible nerve damage. Six weeks after the accident, Moriel attempted to resume sexual relations with his wife but discovered he was impotent. His orthopedist referred him to a urologist. The urologist

ordered tests from an El Paso lab, but these tests revealed no physical cause for Moriel's complaints. After the failure of hormone enhancement to remedy the impotency problem and further testing in El Paso, Moriel's doctor recommended that he undergo additional testing at a hospital in Houston. *Id.*

Moriel requested that his workers' compensation insurer authorize payments for the tests in Houston. After a number of letters back and forth and accompanying delay, the insurer agreed to pay for Moriel's testing but not his travel. *Id.* This authorization process caused a ten-day delay in testing. Subsequently, Moriel's insurer delayed for two years before paying the testing expenses and for over a year before paying the additional treatment expenses, and then only after the threat of collection efforts.

Moriel initially filed a workers' compensation claim against the insurer and was awarded \$30,033.77 from the IAB. The insurer appealed this award to district court. In the district court action, Moriel counterclaimed for additional compensation, unpaid medical bills, and bad faith claims practices. The parties ultimately settled the workers' compensation claim leaving Moriel's bad faith claim extant. *Id.* at 885.

At the trial of the bad faith claim, the jury found that the insurer delayed paying the medical bills without a reasonable basis, that it knew or should have known that it had no reasonable basis to delay payment, and that it acted "with heedless and reckless disregard" of Moriel's rights. The jury awarded Moriel \$1000.00 in actual damages, excluding mental anguish, \$100,000.00 in mental anguish damages, and \$1,000,000.00 in punitive damages. The trial court entered judgment on the verdict, and overruled the insurer's motions for judgment notwithstanding the verdict, new trial, remittitur, and to disregard the jury findings. The court of appeals affirmed with one justice dissenting. *Id.* at 13-14.

### **B. *Moriel* Addresses the Standard for Assessing Bad Faith and Approves a "Bona Fide Dispute" Standard**

Unlike *Lyons* and *Dominguez*, the Texas Supreme Court in *Moriel* was not confronted with a specific issue regarding the standard for assessing an insurer's bad faith. In fact, the insurer in *Moriel* conceded -- for purposes of the appeal -- that legally sufficient evidence supported the jury's conclusion that it had acted without any reasonable basis in delaying payment and was thus liable for bad faith. *Id.* at 25 & n.19. The only issues before the *Moriel* court were (1) how Texas courts should apply the definition of gross negligence from *Burk Royalty Co. v. Walls*, 616 S.W.2d 911 (Tex. 1981); (2) what constitutes legally sufficient evidence of gross negligence to support an award of punitive damages; and (3) what limits do the Due Process clause of the Fourteenth Amendment to the United States Constitution and the Due Course clause of the Texas Constitution place on punitive damages. *Moriel*, 879 S.W.2d at 13-14.

In the course of conducting an examination of the relationship of a claim for punitive damages to the underlying claims for breach of contract and bad faith, the *Moriel* court revisited the standards governing claims of bad faith. Noting that Texas law "recognizes a three-tier framework for measuring damages in an insurance coverage dispute," the *Moriel* court emphasized that "[a] bad faith case 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." *Id.* at 887. The court stressed the importance of preserving "distinct legal boundaries between the three bases of recovery to prevent arbitrariness and confusion at the critical thresholds." *Id.* (citing *Lyons v. Millers Casualty Ins. Co.*, 866 S.W.2d 597, 600 (Tex. 1993)). See also *Maryland Ins. Co. v. Head Indus. Coatings*

*and Services, Inc.*, 906 S.W.2d 218, 226 (Tex. App.—Texarkana 1995, no writ) (emphasizing that “[a] great distinction exists between an insurer’s contractual liability under the policy and a claim of bad faith regarding delay or denial of a claim under the policy”). In this regard, the court stated that “[a]n insurer’s nonpayment of a covered claim ordinarily is a breach of contract, and does not entitle a plaintiff to mental anguish.” *Id.*

Addressing the threshold for bad faith, the Texas Supreme Court stated that evidence which “merely shows a bona fide dispute about the insurer’s liability on the contract does not rise to the level of bad faith.” *Id.* (emphasis supplied). In his concurring opinion, Justice Doggett criticized this statement and the majority for “its first embrace of the so-called bona fide dispute rule.” *Moriel*, 879 S.W.2d at 39 (Doggett, J., concurring). According to Justice Doggett, “[b]y adopting the ambiguous bona fide dispute rule, the majority may be enabling insurers to defeat bad faith claims merely by bringing a challenge to coverage.” *Id.* Justice Cornyn’s majority opinion responds to Justice Doggett’s concurrence by noting that the bona fide dispute rule “is 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*, 879 S.W.2d at 18 n.8 (majority opinion). Under such circumstances, Justice Cornyn and the majority insist, “the parties may require a court to interpret policy language for them, or a jury to resolve factual disputes. Simply because the parties go to court does not raise an issue of the insurer’s bad faith.” *Id.*

The *Moriel* court’s assessment of this issue, dicta though it may be, tracks the bona fide controversy standard of the San Antonio Court of Appeals in *Polasek*. In keeping with this perspective, the Texas Supreme Court noted that “[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.* at 18. On the contrary, “an insured claiming bad faith must

prove that the insurer had no reasonable basis for denying or delaying payment of the claim, and that it knew or should have known that fact.” *Id.* (citing *Arnold* and *Aranda*). The *Moriel* court concluded its discussion of the standards for assessing bad faith claims with its observation that “[t]he bad faith of the insurer justifies an award of compensatory damages and nothing more. Only when accompanied by malicious, intentional, fraudulent, or grossly negligent conduct does bad faith justify punitive damages.” *Id.*

### **C. Implications of *Lyons*, *Dominguez*, *Moriel*, and the Bona Fide Dispute Standard**

The Texas Supreme Court’s decision in *Lyons* -- with its “particularized application” of the traditional no evidence review -- rejects the plaintiff-oriented approach of *Simmons* and, in substance, adopts the *Polasek* “bona fide dispute” standard. In so doing, the court has refused to compromise the important protections of *Aranda*. Moreover, the supreme court’s subsequent dicta in *Moriel* indicates a future willingness to allow summary disposition of bad faith claims whenever there is a bona fide dispute or controversy as to coverage and the plaintiff does not develop “some evidence” specifically related to an insurer’s alleged lack of a reasonable basis for denial or delay of a claim. In this regard, the *Lyons* and *Dominguez* decisions make it clear that evidence that an expert’s report was not objectively prepared, or that an insurer’s reliance on such an expert was unreasonable, or any other evidence from which a factfinder could infer that an insurer acted without a reasonable basis will create fact questions for a jury to resolve in the first instance. As a result, it is likely that insurers and bad faith plaintiffs will be put to the task of continuing to litigate -- for some time to come -- the reasonableness of an insurer’s reliance on experts that recommend the denial or delay of claims.

## V. RAKKAR ANTICIPATED THE LYONS APPROACH AND PROVIDES COMMON LAW GLOSS FOR THE NEW STANDARDS

### A. The *Rakkar* Decision

On December 8, 1993 -- the same day that it issued *Lyons* -- the Texas Supreme Court denied writ in *St. Paul Insurance Company v. Rakkar*, 838 S.W.2d 622 (Tex. App.—Dallas 1992, writ denied), undoubtedly because the decision anticipated the supreme court's own pronouncements on the standard for assessing an insurer's alleged bad faith. *Lyons* allows plaintiffs to create fact issues on the question of bad faith by challenging the reasonableness of an insurer's reliance on its experts. *Rakkar* is thus instructive as a case in which such a challenge was successful.

*Rakkar* involved the alleged arson of a small rental house owned by the insured, Sudeep S. Rakkar. The case was tried to a jury, which rendered a verdict in favor of the insured and assessed contractual and extra-contractual damages. On appeal, the insurer argued that because there was a *bona fide* controversy about whether there had been an arson, the denial of the insured's claim had been made in good faith as a matter of law. The Dallas Court of Appeals, however, affirmed the trial court's submission of bad faith to the jury noting that "the evidence raise[d] fact questions concerning both the reasonableness of St. Paul's reliance on its investigators and whether St. Paul actually relied on those investigations." *Id.* at 626.

The insured in *Rakkar* had reported to St. Paul that the fire occurred in the evening when he passed out while cooking on an hibachi grill inside the house in the month of August. Even though the house was still supplied with electric power, the insured claimed that he brought a charcoal grill into the kitchen to barbecue hot dogs. He had also disconnected water service to the house. The insured reported that while moving the grill he passed out from smoke inhalation, waking to find the

kitchen on fire. Subsequently, he drove to several neighbors' homes, then to a nearby marina, and spoke with several persons, all before calling the fire department. By the time the firefighters arrived at the property, little could be done to salvage the structure. The insurer's fire investigator concluded that the fire was intentionally set with flammable liquids. *Id.* at 626. The investigator based his conclusion on an examination of the spalling patterns in the concrete foundation, on the presence of hydrocarbon rings on the foundation, on the fire chief's narration of his interview with the insured, and on the findings of a chemist who examined the samples the investigator took from the house. *Id.*

In rejecting the insurer's assertion that it acted in good faith -- as a matter of law -- in denying the insured's claim, the Dallas Court of Appeals emphasized (1) that the insurer had failed to take into consideration the written statement the insured gave explaining how the fire started; and (2) that there were "inconsistencies" between the investigator's report and the chemist's failure to find any identifiable flammable materials in the samples taken from the house. *Id.* at 626-27. The *Rakkar* court noted that "[t]hese factors are some evidence that a reasonable insurance company would not have relied on the investigator's report." *Id.* at 627. Moreover, the court asserted that a fact question existed as to whether or not the insurer had actually relied on its investigator's report. *Id.* For these reasons, the Dallas Court of Appeals affirmed the trial court's submission of a bad faith question to the jury. *Id.*

In holding that questions concerning the fact or reasonableness of an insurer's reliance on its investigators may preclude summary judgment, the Dallas Court of Appeals anticipated the Texas Supreme Court's recent pronouncements in *Lyons*, which probably accounts for the denial of writ in *Rakkar*. The *Rakkar* decision was recently cited with approval by the Corpus Christi Court of Appeals in *Nicolau v. State Farm Lloyds*, 869 S.W.2d 543 (Tex. App.—Corpus Christi 1993)

(holding that “[i]n addition to the conflicting expert opinion, the party alleging bad faith must also bring direct or circumstantial evidence showing that the carrier’s expert’s opinion was questionable and that the carrier knew or should have known that the opinion was questionable”), *writ granted*, 37 Tex. S.Ct. J. 965 (1994), and together with *Lyons*, *Dominguez*, and *Moriel* helps establish the context in which the question of bad faith will be determined in the future.

### **B. Categories of Evidence that Should Not Preclude Summary Judgment on the Issue of Bad Faith**

In light of the foregoing, the following categories of evidence should not raise a fact question precluding summary judgment on the issue of bad faith:

- Evidence that merely shows a bona fide dispute about an insurer’s liability on the contract;
- Evidence of a simple disagreement between an insured’s expert and an insurer’s expert about whether the cause of the loss is one covered by the policy;
- Evidence that shows that the insurer reasonably relied on its expert’s report in denying coverage, even though the insurer’s liability may be ultimately established by a jury;
- Evidence that is merely cumulative of an insured’s own testimony that a given loss is covered; for example, when an investigator does not interview an insured’s neighbor after interviewing the insured;
- Evidence that the insurer failed to interview a witness to events related to coverage if the investigation is otherwise reasonable; and
- Evidence that the insurer’s investigation was not sufficiently exhaustive, so long as

the investigation was reasonable and not predisposed to a given outcome.

## **VI. SUBSEQUENT APPELLATE DECISIONS ON THE “BONA FIDE DISPUTE” STANDARD AND JUDGMENT AS A MATTER OF LAW**

### **A. Columbia Universal Life Insurance Co. v. Miles, 923 S.W.2d 803 (Tex. App.–El Paso 1996, writ filed)**

#### 1. Overview

The insured, Miles, purchased health insurance coverage for his family from Columbia. After receiving medical records in connection with a claim Miles submitted, Columbia discovered that Miles had an extensive medical history related to agammaglobulinemia, or IGA immune deficiency. Columbia’s underwriting manual specified that applicants with IGA immune deficiency were not insurable. Because Miles had not mentioned his condition on the application, in interviews, or in an amendment to the policy, Columbia concluded that Miles had intentionally concealed this preexisting condition to obtain coverage. Columbia decided to rescind the policy and refund all premiums paid. When Miles refused to accept this rescission, Columbia filed a declaratory judgment action; this action was consolidated with Miles’ action for bad faith cancellation. The El Paso Court of Appeals reversed a judgment on a jury verdict awarding bad faith damages.

#### 2. Miles Addresses the “Bona Fide Dispute” Standard in the Context of the Cancellation of an Insurance Policy

The *Miles* court surveys the development of the bad faith standard beginning with *Arnold* and examines the analytical conundrum created by *Polasek* and *Simmons*. Concluding that *Polasek* and the bona fide dispute standard best harmonize with the supreme court’s stance in *Lyons* and subsequent opinions, the *Miles* court restates

the standard in terms of the court's duties to: (1) ascertain the potential basis relied on by the insurer; and (2) conduct a qualitative evaluation of that basis to determine whether an insurer could reasonably rely on it. *Miles*, 923 S.W.2d at 810. Only if the insured can challenge the method by which the insurer's evidence was obtained or the conclusions to be drawn from the evidence actually collected does the insured stand a reasonable chance of supporting a bad faith claim. *See id.* As the court opines, the current standard by which conflicting coverage evidence is not legally sufficient to support a bad faith claim "preserves the insurer's right to choose whom it will believe." *Id.*

The *Miles* court also emphasized that the supreme court has used the *Aranda* test to "isolate an insurer's duty to investigate claims and make it dependent on the scope of facts necessary to establish a reasonable basis. Apparently, once a reasonable basis is made out, the insurer's duty to investigate a claim ceases." *Id.* at 807. The *Miles* court reasoned that "[i]n conducting this qualitative evaluation, the court must ask both how the insurer's evidence was obtained and what that evidence, if accepted as true, suggests about the validity of the claim." *Id.* at 810. The court thus concluded that "[i]f nothing is presented suggesting that the evidence upon which the insurer relied was obtained in an unobjective or unfair manner and if that evidence, viewed in isolation, reasonably suggests that the insured's claim is invalid or questionable, the insurer's basis is reasonable as a matter of law."

**B. *Aetna Casualty & Surety Co. v. Garza*, 906 S.W.2d 543 (Tex. App.—San Antonio 1995, writ dismissed)**

### 1. Overview

After her home was destroyed in an arson fire and her insurer, Aetna, refused for more than one year to provide her with a copy of her insurance policy, Plaintiff Carmela Garza sued Aetna for breach of contract, bad faith

with malice, and DTPA and Insurance Code violations. Garza made a claim under her policy one day after the fire, at which time Aetna began its investigation. Aetna had several of its own and independent investigators examine the site, take statements from Garza and her husband (from whom she was separated), and evaluate the loss. Although Aetna's investigation quickly concluded that the Garzas had neither opportunity nor motive to set the fire, Aetna persisted in focusing its investigation on them alone and disregarded all other leads. Moreover, Aetna created a catch-22 by refusing to pay Garza until she fulfilled her obligations under the policy and submitted to an examination under oath; however, Aetna ignored repeated requests by Garza and her attorneys for a copy of the policy destroyed in the fire and surrendered the copy only pursuant to court order after Garza had filed her suit.

### 2. Sufficient Evidence Supported the Jury's Finding of Bad Faith

The jury found in favor of Garza and awarded both compensatory and punitive damages for her bad faith claim and damages for DTPA violations. On appeal, the San Antonio Court of Appeals affirmed the DTPA and compensatory bad faith awards but reversed the punitive damages award, holding that the failure to investigate third-party arson suspects or provide a copy of the policy did not rise to *Moriel's* standard of ill-will or reckless disregard of an insured's rights sufficient to occasion an extraordinary harm such as "death, grievous physical injury, or financial ruin." *Id.* at 555.

**C. *Cortez v. Liberty Mut. Fire Ins. Co.*, 885 S.W.2d 466 (Tex. App.—El Paso 1994, writ denied)**

### 1. Overview

A machine operator developed a repetitious trauma injury that caused him to miss work. His employer had purchased insurance coverage for workers' compensation benefits. The compensation carrier began paying the machine operator weekly compensation benefits in September 1989. *Cortez*, 885

S.W.2d at 468. In May 1990, the machine operator underwent a carpal tunnel release with his treating physician. He went to another doctor in June 1991, for an independent examination. The independent medical examination (IME) doctor opined that the machine operator had “reached maximum medical improvement” and could return to work. *Id.* After the machine operator went in for an independent medical examination, the workers’ compensation carrier held a prehearing conference. After the prehearing conference, the carrier concluded that there was a reasonable basis to suspend the machine operator’s benefits. He stopped receiving weekly benefits in November 1991. The machine operator subsequently brought a workers’ compensation suit against the carrier. The IME doctor indicated that, although it was his opinion that the machine operator could return to work, he could not release him to work because that was the prerogative of the machine operator’s treating physician. *Id.*

Acknowledging that certain issues were indeterminable and without admitting liability, the parties settled the workers’ compensation suit and agreed to a judgment. The machine operator then sued the carrier for breach of the duty of good faith and fair dealing, alleging that the carrier did not have a reasonable basis for suspending his weekly compensation benefits. 2. Summary Judgment For Insurer: Uncontroverted Evidence of a Reasonable Basis

The workers’ compensation carrier filed a motion for summary judgment. In its motion, the carrier argued that: (1) reasonable basis for suspension of benefits was shown as a matter of law; (2) collateral estoppel barred the bad faith action; and (3) judicial admission barred the bad faith action. Without stating its grounds, the trial court granted summary judgment in favor of the workers’ compensation carrier. Affirming on appeal, the El Paso Court of Appeals cited *Polasek* and *Lyons* and reiterated that “[a] bad faith cause of action is not satisfied by proof that a carrier should have paid claimant’s benefits; it requires the worker to prove a negative, that no reasonable basis existed for denying,

delaying, or stopping payment.” *Cortez*, 885 S.W.2d at 468-69. Importantly, the plaintiff in this case did not controvert the IME doctor’s “unequivocal opinion” that he was able to return to work without restrictions. Because the carrier did not immediately cease making weekly payments, but continued them until a pre-hearing conference was held, the El Paso Court of Appeals found that summary judgment was appropriate. The importance of *Cortez* lies in the fact that it is yet another case interpreting *Lyons* as an extension of *Polasek* and permitting the disposition of bad faith claims in the summary judgment context.

**D. Ramirez v. Transcontinental Insurance Co., 881 S.W.2d 818 (Tex. App.—Houston [14th Dist.] 1994, writ denied)**

#### 1. Overview

In this summary judgment case, the plaintiff sued the worker’s compensation carrier for breach of the duty of good faith and fair dealing in the handling of his workers’ compensation claim. The plaintiff, a landscape laborer for a nursery, was unloading a truck when he allegedly fell and injured the right side of his face. Claiming the accident aggravated his TMJ syndrome, the plaintiff filed a claim for workers compensation benefits that the insurer declined to pay.

The Texas Workers Compensation Commission found that the plaintiff suffered an injury in the course and scope of his employment and awarded \$15,590.23. The award was appealed to the district court and the claim was later settled. Subsequently, the plaintiff filed suit for breach of the duty of good faith and fair dealing. The insurer filed a motion for summary judgment asserting that it had a reasonable basis for denying the plaintiff’s claim based on the information available to it at the time. *Id.* at 821. The trial court granted the insurer’s motion for summary judgment and the Houston Court of Appeals affirmed.

2. Ramirez Applies the “Bona Fide” Controversy Standard in the Summary Judgment Context

The Houston Court of Appeals in *Ramirez* reiterated the dictates of *Lyons*, *Dominguez*, and *Moriel* and held that the bona fide controversy standard for assessing an insurer’s bad faith was applicable in the summary judgment context. *Id.* at 824 and n. 3 (emphasizing *Polasek* and asserting that “the issue under a no-evidence review is not whether there is ‘some evidence’ that there was not a reasonable basis for denial, but whether there was no reasonable basis for denial”). The insurer’s summary judgment proof of a reasonable basis for denial of the claim included the following:

- (a) a disability certificate stating that the plaintiff was able to return to work without restriction;
- (b) several doctor’s reports and an MRI report reflecting that the plaintiff had a TMJ anomaly that was the result of “longstanding arthritic changes;”
- (c) statements by co-workers that they did not see the alleged accident and that the plaintiff was having problems with his jaw prior to the alleged accident; and
- (d) a doctor’s deposition testimony that he did not find evidence of recent trauma and emphasizing the findings in his earlier reports that the alleged accident did not cause the plaintiff’s injuries.

*Id.* at 824-25.

Attempting to establish a fact issue on the question of a reasonable basis for denial, the plaintiff argued that the summary judgment record reflected (1) conflicting expert opinion about the aggravation of the plaintiff’s TMJ syndrome by the alleged accident; and (2) an inadequate and “outcome oriented” investigation of the claim. In granting the

insurer’s motion for summary judgment, the *Ramirez* court emphasized that there was no evidence disputing or criticizing the medical opinion recommending denial of the claim nor any attack on the doctor’s credentials or impartiality. *Id.* at 826. As a result, the court found that the insurer conclusively established its reliance on a medical expert’s opinion as a reasonable basis for denying the claim.

Additionally, the *Ramirez* court asserted that there was nothing in the record to suggest that the insurer had ignored important evidence in its investigation. The summary judgment proof reflected that the insurer was aware of the conflict between two doctors’ opinions about whether the TMJ syndrome was aggravated by the alleged accident. To verify the accuracy of the history given by the plaintiff, the insurer had interviewed the plaintiff’s co-workers and these statements casted doubt on the validity of the plaintiff’s claims. Besides the co-workers statements and the conflicting conclusions reached by the medical experts, there was proof that the plaintiff did not seek medical treatment for nearly a month after the alleged accident. Moreover, there was medical evidence that any such accident did not change the longstanding, chronic nature of the plaintiff’s TMJ syndrome. *Id.* at 827-28. As a result, the *Ramirez* court held that “this conflicting evidence regarding coverage merely shows a bona fide dispute about [the insurer’s] liability on the insurance contract, not bad faith.” *Id.* at 828 (citing *Moriel* and *Lyons* and reiterating that the insurer “was entitled to give an erroneous answer to the question of coverage without subjecting itself to liability for bad faith”). (Emphasis added.)

**E. *Rogers v. CIGNA Insurance Co. of Texas*, 881 S.W.2d 177 (Tex. App.–Houston [1st Dist.] 1994, no writ)**

1. Overview

In this directed verdict case, the Houston Court of Appeals confirmed the continuing vitality of the *Polasek* decision in the bad faith

context. Plaintiff was injured when the car he was driving, which had been provided by his employer, was struck by a train. CIGNA, the workers' compensation carrier for plaintiff's employer, began paying indemnity and medical benefits for total incapacity after the accident. About three months after the accident, plaintiff returned to work. CIGNA stopped paying indemnity benefits six months after the accident.

Plaintiff filed a worker's compensation claim with the Industrial Accident Board (IAB), claiming that he was entitled to indemnity benefits for total and permanent incapacity. The IAB entered an award for partial incapacity and CIGNA filed suit to set aside the IAB's award. The jury entered a verdict of total and permanent incapacity. While the case was on appeal, the parties settled. Plaintiff then filed a bad faith action, alleging that CIGNA had no reasonable basis for denying his claim for indemnity benefits for total incapacity and was therefore in bad faith in the handling of the claim. The trial court granted a directed verdict for CIGNA and the Houston Court of Appeals affirmed.

***F. Packer v. Travelers Indemn. Co. of Rhode Island*, 881 S.W.2d 172 (Tex. App.–Houston [1st Dist.] 1994, no writ)**

## 2. Directed Verdict For Insurer Based on Undisputed Evidence of a Reasonable Basis for Denial of the Claim

Relying heavily on the analysis of the San Antonio Court of Appeals in *State Farm Lloyds, Inc. v. Polasek*, 847 S.W.2d 279 (Tex. App.–San Antonio 1992, writ denied), the *Rogers* court emphasized that there was undisputed evidence of a reasonable basis for disputing the claims for indemnity benefits. CIGNA had reports of four doctors indicating that plaintiff was not totally incapacitated. Additionally, plaintiff's treating physician released the plaintiff to return to work on full-time status three months after the accident. Plaintiff returned to the same job that he held before the accident, at the same amount of money. Shortly after he returned to work, his wages increased. Moreover, the plaintiff testified at trial that his earnings had increased every year since his accident. *Id.* at 184-85. These facts, which constituted some evidence that plaintiff did not lose earning capacity, gave CIGNA a reasonable basis to dispute plaintiff's claim for payments for partial incapacity. *Id.*

In determining that CIGNA had a reasonable basis for denial of the claim, the *Rogers* court emphasized that the trial court was required to "determine whether there was evidence before CIGNA that gave it a reasonable basis to deny Rogers' claim. . . . If there was such evidence, CIGNA was entitled to judgment as a matter of law. . . ." *Id.* at 183 (citing *Polasek* for the proposition that "[c]ourts and juries do not weigh the conflicting evidence that was before the insurer; they decide whether evidence existed to justify denial of the claim"). Holding for the insurer as a matter of law, the *Rogers* court reiterated that "if the insurer shows a reasonable basis for the denial or delay of the plaintiff's claim, the insurer cannot be liable for bad faith. *Id.* (citing *Lyons* and *Aranda*).

### 1. Overview

Plaintiff John Packer sustained a job-related back injury, the medical costs of which

were covered under a workman's compensation policy. Packer sued Travelers, claiming he was further damaged by a bad-faith delay in authorizing back surgery. In a treatment period covering one year, four physicians initially recommended conservative treatment and no surgery; one of the four -- the insured's personal physician -- later changed his initial diagnosis to recommend surgery. The insurer eventually approved surgery at the same time the compensation case was settled.

The trial court granted summary judgment for the insurer on the question of bad faith and the Houston Court of Appeals affirmed holding that "[a] bona fide controversy concerning an insurer's liability is sufficient reason for an insurer to fail to pay a claimant, and will not rise to the level of bad faith." *Packer*, 881 S.W.2d at 176 (citing *Moriel* and *Dominguez*). Asserting that "[t]his is particularly true if [the] controversy concerning liability is sparked by reliance on expert reports," the *Packer* court concluded that there were conflicting expert reports and that the insurer had not acted in bad faith by relying on these reports. *Id.*

## 2. Summary Judgment For Insurer: Bona Fide Controversy Between Medical Experts

Importantly, the plaintiff offered no substantive proof that the insurer's reliance on the expert medical reports was unreasonable nor any alleged shortcoming in the summary judgment evidence. *Id.* at 177. The insurer in *Packer* had offered the affidavit of its claims adjuster, as well as records from the various physicians who treated and/or examined the plaintiff. There was no evidence showing that the doctors' reports were not objective or that reliance on the reports was not reasonable. *Id.* (noting that "[r]equiring second opinions and relying on expert's reports will not support a bad faith claim under *Aranda*").

This holding is significant, especially in light of the plaintiff's assertion that the insurer's investigation was "outcome-

oriented" and had attempted to steer the plaintiff away from his choice of doctors. *Id.* (the claims log states "since clmt. not represented -- try to steer him to someone else" and "Called Dr. DeYoung--he showed! What happened? Disagreed w/surgery recommendation. (yea!)"). Finding a bona fide controversy as a matter of law despite apparent evidence of steering and an outcome-oriented investigation, the Houston Court of Appeals held that such evidence did not show that the insurer's reliance on the conflicting medical reports was an unreasonable basis for the denial of the claim. *Id.* (citing *Dominguez*, 873 S.W.2d at 376-77). The fact that the claims adjuster and the insurers' agents subjectively desired denial of the surgery claim was not evidence that the insurer acted inappropriately "based on the objective evidence presented to it in the form of the physicians' opinions." *Id.* As a result, the *Packer* court held that the plaintiff had failed to raise a fact issue. *Id.* at 175 n. 1 (noting that plaintiff presented no evidence challenging: (1) the medical opinions themselves; (2) the reasonableness of the insurance carrier in relying on the medical opinions; (3) the claims adjuster's qualifications; or (4) that a reasonable adjuster or insurer would not have similarly denied the claim).

*Packer* reiterates the bad faith standards of *Lyons*, *Dominguez*, and *Moriel* and clearly establishes that the *bona fide* controversy standard is properly applied in assessing the merits of an insurer's motion for summary judgment. *Id.* at 174 (stating that "[w]hile we recognize that *Lyons* was a "no evidence" case, its analysis is properly applied in a summary judgment case because the quantum of evidence necessary to raise a fact issue is the same in both contexts"). Moreover, *Packer* specifically holds that if an insurer can conclusively establish the existence of a bona fide controversy it will be entitled to summary judgment.

## VII. “NO HARM, NO FOUL”: *REPUBLIC INSURANCE V. STOKER*

*Republic Insurance Company v. Stoker*, 903 S.W.2d 338 (Tex. 1995), presented the Texas Supreme Court with the question of “whether an insurer breaches its duty of good faith and fair dealing to its insured if it denies a claim for an invalid reason when there was a valid reason for denial.” *Id.* Rendering judgment that the insureds take nothing, the court emphasized that “[a]s 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 (emphasis added). As long as an insurer determines in a timely manner that there is a reasonable basis for denying a claim, it can make “the right decision for the wrong reason.” *Id.* The Texas Supreme Court noted that all of the Stokers’ causes of action were based on their bad faith allegations and held that they were not entitled to recover against their insurer. *Stoker* thus predicates recovery in a bad faith case -- in the absence of some “extreme” act that causes injury independent of a policy claim<sup>8</sup> -- on an initial showing of contractual liability.

Justice Enoch authored the *Stoker* opinion and was joined by Chief Justice Phillips, Justices Gonzalez, Hightower, Hecht, Cornyn, and Owen. Delivering a concurring opinion joined by Justice Gammage, Justice Spector found no evidence that the insurer’s mishandling of the claim caused any damages to the insured. Because Republic caused no compensable mental anguish to the Stokers in its claims handling,<sup>9</sup> Justice Spector joined in the court’s take-nothing judgment. Her concurrence, however, strongly disagrees with “the language in the majority opinion suggesting that bad faith recovery may be dependent on the insurer’s contractual liability.” *Id.* at 342 (Spector, J., concurring). Justice Spector characterizes *Stoker* as allowing “an insurer to deny a claim for any reason that comes to mind -- without any investigation at all -- as long as the insurer eventually finds some

valid basis for denial.” *Id.* at 345 (Spector, J. concurring). Although this doomsday assessment of *Stoker* overstates the breadth of the majority opinion, the decision does insulate insurers from bad faith exposure when there is no coverage in a given case and there has been adequate claims handling and investigation.

### A. An Overview of *Republic Insurance v. Stoker*

#### 1. Facts

*Stoker* arose out of a three-car accident in which the claimants’ automobile struck the rear end of another vehicle. An unidentified pickup truck had dropped a load of furniture on the highway, causing a chain reaction collision. This truck was not struck by any of the vehicles involved in the collision. The Stokers’ car was damaged in the accident, but since they had no collision insurance they submitted a claim to recover under their uninsured/underinsured vehicle coverage with Republic Insurance. *Id.* at 339.

Republic hired Southwest to investigate the Stokers’ claim. Southwest recommended that the uninsured motorist claim be denied because it concluded that Mrs. Stoker, who was the driver, was more than fifty percent at fault in causing the accident. A Republic claims examiner confirmed Southwest’s decision. Additionally, Mrs. Stoker acknowledged at the trial of her bad faith claim that fault is an issue in recovering under the uninsured motorist coverage. *Id.*

Supplementing the majority’s factual recitation, the concurring opinion emphasizes that “[t]he Department of Public Safety officer who investigated the accident concluded in his report that the accident was caused by the unknown driver’s failure to secure the load of furniture.” *Id.* at 342 (Spector, J., concurring). Moreover, at the time Southwest recommended denial of the Stokers’ claim, its adjuster had not received or reviewed the DPS accident report, spoken to the DPS officer, or visited the scene. He had not interviewed

either of the other two drivers involved in the accident nor had he interviewed Mrs. Stoker's daughter, who was riding in the car at the time of the accident, or her husband, who was driving immediately behind her when the accident occurred. *Id.* at 339.

The Stokers policy provided uninsured motorist coverage for damages caused by an unidentified hit and run vehicle only if the vehicle hit the insureds' car. The language of the policy was in accord with the requirements of Insurance Code art. 5.06-1(2)(d) (in order to recover under uninsured motorist coverage "actual physical contact must have occurred."). Republic did not rely on the lack of physical contact with the pickup in its pre-suit denial of the Stokers' claim. *Id.*

## 2. Procedure

Following Republic's denial of the uninsured motorist claim, the Stokers sued for breach of contract, breach of the duty of good faith and fair dealing, as well as violations of the DTPA and the Insurance Code. The Stokers predicated all of their allegations against Republic and Southwest on the fact that the companies had given an invalid reason for denial of the Stokers' claim -- Mrs. Stoker's alleged fault. *Id.* at 339. After the lawsuit was filed and in support of its motion for summary judgment, Republic offered a completely different justification for its denial of the claim: namely that there was no direct contact between Mrs. Stoker's car and the truck that dumped the furniture. *Id.* at 342 (Spector, J., concurring).

The trial court granted summary judgment on the contract issue. It then submitted the balance of the case to a jury which found that Republic and Southwest had breached their duty of good faith and fair dealing and violated the DTPA and article 21.21 of the Insurance Code. The statutory violations were premised solely on the Stokers' bad faith claims. The trial court rendered judgment for the Stokers on the verdict. The court of appeals affirmed both the summary judgment

on the policy claim and the judgment for extra-contractual damages. *Id.* at 341.

## **B. *Stoker* Holds No Coverage Then Generally No Bad Faith Claims**

### 1. The Majority's Holding

The only issue the Texas Supreme Court addressed on appeal was "whether the defendants are liable to the Stokers for denying their claim for an incorrect reason -- the accident was mostly Mrs. Stoker's fault -- when there was a correct reason for denial which the defendants did not give the Stokers -- the incident was not covered by the policy." 903 S.W.2d at 340. Holding that "[a]s a general rule there can be no claim for bad faith when an insurer promptly denied a claim that is in fact not covered," the court rendered judgment that the Stokers take nothing on all of their claims, including bad faith, and violations of the DTPA and Insurance Code. *Id.* at 341. While accepting the premise "that a policy claim is independent of a bad faith claim," *id.* at 340-41, *Stoker* permits recovery for the bad faith denial of a claim -- in the absence of coverage -- only under the most limited of circumstances. *Id.* at 341 (in denying a claim, an "insurer may commit some act, so extreme, that would cause injury independent of the policy claim").

### 2. *Stoker* Limits the Scope of *Viles*

In addition to holding that, generally, there can be no bad faith in the absence of coverage, the *Stoker* majority specifically distinguished and limited its 1990 decision, *Viles v. Security National Insurance Company*, 788 S.W.2d 566, 567 (Tex. 1990). *Viles* had allowed recovery not only for a failure to pay, but also for a failure to investigate. *Id.* (citing *Arnold v. National County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987)). Emphasizing that the duty recognized in *Arnold* emanates "not from the terms of the contract, but from an obligation imposed in law," *Viles* expressly recognized a duty to investigate. *Id.* at 568 ("The 'special relationship' between the insured and insurer

imposes on the insurer a duty to investigate claims thoroughly and in good faith, and to deny those claims only after an investigation reveals there is a reasonable basis to do so.”). *Stoker*, however, should preclude bad faith exposure for an alleged failure to investigate when (1) the insurer promptly denies a claim; (2) there is no coverage; and (3) the insurer does not commit any “extreme” act that causes injury to the insured independent of the policy claim. *Id.* at 341 (citing *Aranda*, 748 S.W.2d at 214).

In *Viles*, the insurer investigated and denied the claim because the insured’s property damage allegedly predated coverage. *Stoker*, 903 S.W.2d at 340. The insurer denied the claim before the *Viles* submitted a proof of loss and before their time for doing so had expired. After the claim was denied, the *Viles* did not submit a proof of loss because they believed it would have been futile to do so. At trial, the evidence established, contrary to the insurer’s position, that the damage existing before coverage had already been repaired. *Id.* Thus, the claim was improperly denied. Nevertheless, the insurer attempted to justify denial of the claim based on the *Viles* failure to file a timely proof of loss.

The majority found the *Stokers*’ claim a far-cry from the *Viles*’ claim. “Unlike the situation in *Viles*, the *Stokers*’ accident was never covered by their policy because there was no collision with the pickup truck.” *Id.* (emphasis added). Reasoning that “[t]he facts compelling denial of the *Stokers*’ claim were in existence at the time of the denial,” the *Stoker* majority simply ignored the language in *Viles* that “a reasonable basis for denial [of a claim] must be judged by the facts before the insurer at the time the claim was denied.” (Emphasis added.) Under *Stoker*, an insurer’s reliance on a “different, perhaps erroneous, reason for denying coverage is not dispositive.” *Id.* at 340.

*Stoker* focuses specifically on whether a reasonable insurer would deny a claim “based on the facts existing at the time of denial . . . .” *Id.* This language modifies *Viles* by

permitting the insurer to raise the fact of non-coverage at any time before trial, whether or not the fact of non-coverage was actually before the insurer at the time of denial of the claim. The Texas Supreme Court in *Stoker* was unwilling to preclude Republic “from relying on a reason for denying [the insureds’] claim that existed at the time, even if it was not the reason Republic gave.” *Id.* at 341. This rule limits *Viles* and expands the scope of what insurers may rely upon to prove the reasonability of a decision to deny coverage. *Stoker* simply does away with the requirement that reasonableness be judged by the facts before the insurer at the time a claim is denied.

### 3. Justice Spector’s Concurring Opinion

Justice Spector’s concurrence in *Stoker* criticizes the majority for departing from *Viles*, which “makes plain that an insurer may be held liable for failure to conduct an adequate investigation -- even if the claim ultimately proved to be invalid.” The concurrence notes that under the majority’s view “even if there had been evidence of damages, the *Stokers* could not recover for bad faith because a reasonable insurer under similar circumstances would have denied the *Stokers*’ claim.” *Id.* at 343. Spector also criticizes the majority for enabling insurers to escape bad faith liability despite slip-shod investigations and erroneous coverage decisions. *Id.* (noting that “even if an insurer completely fails to investigate a claim, or provides misleading information to deter the insured, it may still escape liability for bad faith by finding some reasonable basis for denying the claim sometime before trial.”)

Justice Spector also takes the majority to task for ignoring the court’s assertion in *Transportation Insurance Company v. Moriel*, 879 S.W.2d 10, 17 (Tex. 1994) that a bad faith action “is separate from any cause of action for breach of the underlying insurance contract.” Spector notes that *Moriel* specifically held a lack of coverage would not preclude recovery for bad faith. *Id.* at 344 (citing *Moriel*, 879 S.W.2d at 18, n.8

(agreeing that “claims for insurance contract coverage are distinct from those in tort for bad faith; resolution of one does not determine the other.”)). Because the record did not contain any evidence of damages to the Stokers as a result of Republic’s conduct, Justice Spector concurred in the judgment but refused to join “in the majority’s unnecessary and unfortunate writing constricting the future recovery of bad faith damages.” *Id.* at 345.

#### 4. The Recent Akin Decision

A recent mandamus decision of the Texas Supreme Court -- *Liberty National Fire Insurance Company v. Akin*, 927 S.W.2d 627 (Tex. 1996) -- addressed the issue of whether a trial court had to sever and abate the plaintiff’s bad faith claims from the contract claim in a foundation case. A majority of the court refused to adopt “an inflexible rule that would deny the trial court all discretion and which would require severance in every case, regardless of the likelihood of prejudice.” *Id.* at 630. The *Akin* court saw an inflexible rule requiring such severance as a “usurpation of the trial court’s discretion” as well as “unnecessary, unwise, and inefficient.” *Id.*

In dicta, the *Akin* majority briefly touched on the meaning of the court’s *Stoker* decision. The *Akin* majority reiterated that although insurance coverage claims and bad faith claims are by their nature independent, “in most circumstances, an insured may not prevail on a bad faith claim without first showing that the insurer breached the contract.” *Id.* at 629 (citing *Stoker* and *Moriel*). The court also noted that “[w]hile *Stoker* held that a judgment for the insurer on the coverage claim prohibits recovery premised only on a bad faith denial of a claim, it does not necessarily bar all claims for bad faith.” *Id.* This observation is in line with *Stoker*’s assertion that in denying a claim, an “insurer may commit some act, so extreme, that would cause injury independent of the policy claim”. In the ordinary claims denial situation, however, an adequate investigation and non-coverage should foreclose any bad faith liability.

### C. Implications of *Stoker*

Although some will read *Stoker* as merely a continuation of the trend of insurer-friendly decisions, the importance of *Stoker* and other recent insurance decisions really lies in the Texas Supreme Court’s willingness (1) to grapple with complex insurance policy provisions to reach a definitive understanding of the meaning of those provisions;<sup>10</sup> and (2) to provide specific parameters for the previously amorphous “bad faith” cause of action.<sup>11</sup> Notwithstanding the creative pleading of claimants and insureds attempting to invoke insurance coverage, the Texas Supreme Court is now delineating the meaning of insurance policy provisions -- and the duties raised thereby -- with greater precision and clarity than at any time since *Arnold* was first articulated. In this regard, *Stoker* clearly limits the scope of potential bad faith liability and effects the following changes in the law:

1. As a general rule, there can be no bad faith liability when there is a reasonable investigation and no insurance coverage;<sup>12</sup>
2. In a case involving non-coverage, the facts regarding non-coverage do not have to be before the insurer at the time of the denial of a claim and may be raised subsequently during litigation;
3. In a case involving non-coverage, an insurer’s denial of a claim for an improper reason will not preclude the insurer from relying on a later-discovered proper reason for denying a claim; and
4. Even in cases of non-coverage, claimants and insureds may still argue that the insurer caused compensable damages by failing to deny a claim promptly and/or by committing some “extreme” act which caused injury independent of the policy claim, thus warranting the imposition of bad faith liability.

## END NOTES

---

1. The traditional statement of the standard of review for legal sufficiency requires a court to consider only the evidence favoring the judgment for the insured and to disregard all evidence to the contrary. *See, e.g., Havner v. E-Z Mart Stores, Inc.*, 825 S.W.2d 456, 458 (Tex. 1992); W. Wendell Hall, *Revisiting Standards of Review in Civil Appeals*, 24 ST. MARY'S L.J. 1045, 1133 (1993); William Powers, Jr. & Jack Ratliff, *Another Look at "No Evidence" and "Insufficient Evidence,"* 69 TEXAS L. REV. 515, 522 (1991); Robert W. Calvert, *"No Evidence" and "Insufficient Evidence" Points of Error*, 38 TEXAS L. REV. 361, 362-63 (1960).

2. Justice Doggett's dissent in *Lyons*, however, castigates the majority for "announcing a new rule, previously unknown in a no evidence review . . . ." Justice Doggett asserts that the *Lyons* majority improperly attempts to circumvent the Texas Constitution to consider the credibility and weight of evidence in conducting a factual sufficiency review. The dissent ignores, however, the fact that the plaintiff in *Lyons* failed to adduce any evidence that the reports of the insurer's experts were not objectively prepared or that reliance on those reports was unreasonable.

3. In his dissent, Justice Doggett rejects the majority's characterization of the bad faith evidence. According to Justice Doggett, the letter sent by a doctor to Dominguez' attorney was only a part of the evidence presented to the jury on the issue of bad faith. The denial of the claim, the dissent asserts, was based on the recommendation of an investigator who never interviewed Dominguez' managing supervisor. *Dominguez*, 873 S.W.2d at 378 (Doggett, J. dissenting). The dissent insists that this alleged failure to interview a witness to events related to coverage was evidence of bad faith. *Id.* Justice Doggett also criticizes the majority for ignoring an allegedly slipshod investigation by an insurer's investigator who "completely misrepresented the claimant's post-injury health care." *Id.* According to the dissent, the alleged inaccuracies in the investigator's report in addition to the investigator's failure to consult the insured's supervisor constituted evidence of bad faith. *Id.*

4. *Moriel* specifically addresses the standards for the imposition of punitive damages in bad faith insurance cases. Importantly, the Texas Supreme Court has now required that any case with a punitive damages claim be bifurcated for trial. In addition, the case holds that an insurer is liable for punitive damages only if the bad faith tort was accompanied by gross negligence at a

---

minimum. *See Moriel*, 879 S.W.2d at 24 (asserting that “an insurance carrier’s refusal to pay a claim cannot justify [punitive damages] unless the insurer was actually aware that its action would probably result in extraordinary harm not ordinarily associated with breach of contract or bad faith denial of a claim -- such as death, grievous physical injury, or financial ruin”).

5. *Id.*, 903 S.W.2d at 341 (Enoch, J.).

6. *Id.*, 903 S.W.2d at 342 (Spector, J., concurring).

7. *See, e.g., State Farm Life Insurance Company v. Beaston*, 907 S.W.2d 430 (Tex. 1995). In *Beaston*, the Texas Supreme Court was called upon to interpret the terms of a life insurance policy and to decide whether a plaintiff can recover mental anguish damages from an insurance company for a violation of Article 21.21 of the Texas Insurance Code absent a finding that the defendant acted knowingly.

8. *See, e.g., Lyons v. Millers Casualty Insurance Company of Texas*, 866 S.W.2d 597 (Tex. 1993) (emphasizing that “[t]he evidence [of bad faith] must relate to the tort issue of no reasonable basis for denial or delay in payment of a claim, not just to the contract issue of coverage”); *National Union Fire Insurance Company of Pittsburgh v. Dominguez*, 873 S.W.2d 373, 376-77 (Tex. 1994) (following *Lyons* and emphasizing that “evidence of insurance coverage alone does not go to . . . absence of a reasonable basis for denial of the claim”); *Transportation Insurance Company v. Moriel*, 879 S.W.2d 10 (Tex. 1994) (embracing a “bona fide dispute” test for assessing the question of bad faith).

9. Claimants and insureds, however, may argue that *Stoker* precludes DTPA and Insurance Code “bad faith” liability only when those alleged violations arise out of the same nucleus of operative fact as the allegations of common law bad faith.