

IN THE SUPREME COURT OF TEXAS

=====
No. 96-0249
=====

PROVIDENT AMERICAN INSURANCE COMPANY, PETITIONER

v.

DENISE CASTAÑEDA, RESPONDENT

=====
ON APPLICATION FOR WRIT OF ERROR TO THE
COURT OF APPEALS FOR THE EIGHTH DISTRICT OF TEXAS
=====

Argued on January 8, 1998

JUSTICE OWEN delivered the opinion of the Court, in which CHIEF JUSTICE PHILLIPS, JUSTICE HECHT, JUSTICE BAKER, and JUSTICE ABBOTT joined, and in which JUSTICE ENOCH joined in all but part V.

JUSTICE ENOCH filed a concurring opinion.

JUSTICE GONZALEZ filed a dissenting opinion, in which JUSTICE SPECTOR joined.

JUSTICE HANKINSON did not participate in the decision.

Denise Castañeda seeks damages from Provident American Insurance Company for alleged violations of the Insurance Code and the Deceptive Trade Practices Act arising out of the denial of her claim for benefits under a health insurance policy and the manner in which her claim was handled. Because the evidence is legally insufficient to support the jury's verdict, we reverse and render judgment that Castañeda take nothing.

I

Denise Castañeda's father, Guillermo Castañeda, Sr., applied for medical insurance with Provident American Insurance Company in May 1991. He sought a policy that would cover the

entire family including his daughter Denise, who was twenty-one years old at the time, her sister, and their brother Guillermo, Jr. During the application process, Guillermo Castañeda, Sr. failed to disclose that just two days before he applied for the policy, Guillermo, Jr. had received medical attention from a physician for jaundice, anemia, and suspected hepatitis. Denise had received medical treatment for jaundice and hepatitis several years prior to the date her father applied for health insurance.

Provident American issued a policy to the family effective June 17, 1991. The policy contained two limitations that are relevant here: (1) it did not cover expenses resulting from a sickness that “manifests” within thirty days of the policy’s effective date; and (2) it excluded diseases or disorders of certain internal organs, including the gallbladder, unless the loss occurred more than six months after the policy’s effective date.

Less than thirty days after the issuance of the policy, the family learned that Denise’s uncle had been diagnosed with hemolytic spherocytosis (HS), a hereditary condition that causes misshapen blood cells. The spleen destroys these cells, which causes the sufferer to exhibit anemia, jaundice, and, in 90% of the cases, gallstones. The treatment for this condition is to remove the spleen and, if gallstones are present, the gallbladder. Because the disease is hereditary, it was suggested that the Castañedas be tested for HS. Denise and Guillermo, Jr. had exhibited yellow skin all of their lives, and on July 20, 1991, the third day after the thirty-day period expired, they were taken to a physician who diagnosed them that same day with HS and referred them to a blood specialist. They saw the hematologist two days later, and he concurred in the HS diagnosis. Two weeks later, Denise and Guillermo, Jr. each had their spleen and gallbladder surgically removed.

The Castañedas submitted claims to Provident American, which were denied. Provident American first asserted the six-month policy exclusion for disorders of the gallbladder but later

denied the claims on the basis that HS had manifested within thirty days of the policy's effective date.

Denise Castañeda sued Provident American, alleging violations of the DTPA and of article 21.21 of the Texas Insurance Code, and Guillermo Castañeda, Sr. sued on behalf of Guillermo, Jr. The two suits were consolidated, but Guillermo Castañeda, Sr. later nonsuited his claims. Denise Castañeda proceeded to trial, and the district court submitted three liability questions based on article 21.21 of the Insurance Code and on the DTPA.¹ The jury answered "yes" to each and found that Provident American had engaged in knowing conduct. The jury awarded \$50,000 for Denise Castañeda's loss of credit reputation and loss of benefits, collectively, but found no mental anguish damages. The jury also awarded reasonable attorney's fees of 33% of Castañeda's recovery. The trial court rendered judgment on the verdict, trebling the damages and adding a twelve percent penalty on the lost benefits.

The court of appeals affirmed, except as to the twelve percent penalty.² Regarding other points of error, the court of appeals concluded that the trial court had erroneously submitted at least one subpart of the first liability question (subpart A)³ but held that this error was harmless because two other subparts (J and H) were properly submitted and supported by legally and factually sufficient evidence.⁴ The court of appeals also held that the evidence was sufficient to support the award of \$50,000 for loss of credit reputation and loss of benefits.⁵ Provident American filed an

¹ The liability issues submitted to the jury are included in Appendix A.

² 914 S.W.2d 273, 284.

³ *Id.* at 277.

⁴ *Id.* at 280.

⁵ *Id.* at 281-82.

application for writ of error with this Court, which we granted. Because there is no evidence to support a finding of liability based on any of the theories submitted to the jury, we do not reach the question of whether a trial court’s judgment may be affirmed if a liability question includes a theory that is not legally cognizable but other viable theories are included within the same question. Likewise, we do not reach Provident American’s complaint that attorney’s fees were improperly based on a percentage of the recovery, an issue that we addressed in *Arthur Andersen & Co. v. Perry Equipment Corp.*⁶ after the court of appeals’ decision became final in this case.

II

We begin our review with the first question submitted to the jury.⁷ The numerous subparts of Question 1 can be distilled into three categories: (1) whether Provident American denied the claim without a reasonable basis or after its liability had become reasonably clear, (2) whether there was a misrepresentation about the policy, and (3) whether Provident American engaged in unfair claims settlement practices. We first consider whether there was any evidence to support a finding that Provident American denied Castañeda’s claim without a reasonable basis or after its liability had become reasonably clear.

III

The trial court submitted two instructions to the jury regarding Provident American’s denial of the claim. Subpart J of Question 1 was based on article 21.21-2, section 2(b)(4)⁸ and defined an unfair or deceptive act or practice as including: “[n]ot attempting in good faith to effectuate a

⁶ 945 S.W.2d 812, 818-19 (Tex. 1997) (holding that a plaintiff must ask the jury to award attorney’s fees in a specific dollar amount in a DTPA case).

⁷ See Appendix A, Question 1.

⁸T EX. INS. CODE art. 21.21-2, § 2(b)(4).

prompt, fair, and equitable settlement of a claim when liability has become reasonably clear.”⁹ Subpart G of Question 1 was a hybrid theory that defined an unfair or deceptive act or practice as including: “[d]enying 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.”¹⁰ This instruction embodied the pre-*Giles*¹¹ common-law definition of bad faith, but the jury issue included producing cause,¹² which is the causation element for an article 21.21 claim.¹³ However, the parties agree that only statutory claims were tried and that no common-law bad faith claim was submitted. Provident American did not urge the trial court to exclude subpart G from the definitions of an “[u]nfair or deceptive act or practice”¹⁴ and contends only that there is no evidence to support a jury finding based on this definition. Our no-evidence review of subpart G is governed by our pre-*Giles* decisions because this instruction was couched in the same terms as the pre-*Giles* definition of common-law bad faith. Thus, our decisions in *Lyons v. Millers Casualty Insurance Co.*¹⁵ and *National Union Fire Insurance Co. v. Dominguez*¹⁶ guide us in reviewing the record to see if there is any evidence that would support a jury finding based on subpart G.

To determine whether there is any evidence to support a jury finding under Subpart G or J,

⁹ See Appendix A, Question 1, subpart J.

¹⁰ See Appendix A, Question 1, subpart G.

¹¹ *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48 (Tex. 1997).

¹² See Appendix A, Question 1.

¹³ A breach of the common-law duty of good faith and fair dealing inherent in the dealings between an insurer and its insured must be the proximate, rather than producing, cause of damage. See *Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210, 215 (Tex. 1988); see also *Union Pump Co. v. Allbritton*, 898 S.W.2d 773, 775 (Tex. 1995) (discussing the difference between proximate and producing cause).

¹⁴ See Appendix A, Question 1.

¹⁵ 866 S.W.2d 597 (Tex. 1993).

¹⁶ 873 S.W.2d 373 (Tex. 1994).

we must first identify the potential bases Provident American had for denying Castañeda's claim.¹⁷ Then we must determine whether there is any evidence that no reasonable insurer could have denied payment of her claim and whether there is any evidence that liability had become reasonably clear.¹⁸

A

At varying times, Provident American gave varying reasons for denying Denise Castañeda's claim, but all were grounded in a common nucleus of facts. Provident American cited a policy provision that excluded coverage for a sickness or disorder involving the gallbladder unless the loss occurred more than six months after the date the policy went into effect.¹⁹ Provident American also relied on policy provisions that limited coverage to an illness or disease that first manifested more than thirty days after the policy went into effect.²⁰ At least one Provident American employee thought that the claim also could have been denied based on the pre-existing condition provision of the policy, although that clause was never invoked. We conclude that, considering all the facts in existence at the time of the denial, there is no evidence that there was no reasonable basis for Provident American's denial of Castañeda's claim (subpart G) or that liability had become reasonably clear (subpart J).

We first consider denial based on manifestation of HS prior to the end of the thirty-day

¹⁷ *Id.* at 376.

¹⁸ *Id.*; *see also* TEX. INS. CODE art. 21.21-2, § 2(b)(4).

¹⁹ The policy provided: "Coverage is not provided for sickness or disorder involving the following unless loss incurred six months after the Policy Date: hernia, varicose veins, hemorrhoids, reproductive organs, appendix, tonsils, adenoids or gallbladder."

²⁰ The insuring clause, which is the first paragraph of the policy, stated that it provided benefits only for accidental bodily injury and "sickness, which first manifests itself more than thirty (30) days after the effective date of this Policy, hereinafter referred to as such sickness." In the definitions section, the policy defined "[s]ickness" as an "illness or disease of a member of the Family Group which first manifests itself more than 30 days after the Policy date and while the policy is in force." Other provisions stated that coverage extended to services and supplies "necessary for the treatment of the injury or sickness."

period. The parties dispute when Castañeda's illness manifested. Castañeda argues that there is some evidence that her hereditary illness first manifested after the thirty-day period, and Provident American contends that it manifested before the end of the thirty-day period. However, even if Castañeda were correct, evidence of coverage, standing alone, would not constitute evidence of bad faith denial. In *State Farm Lloyds v. Nicolau*,²¹ we reconfirmed what we held in *Transportation Insurance Co. v. Moriel*,²² *National Union Fire Insurance Co. v. Dominguez*,²³ and other cases, which is that evidence showing only a bona fide coverage dispute does not demonstrate that there was no reasonable basis for denying a claim. By the same token, evidence of a coverage dispute is not evidence that liability under the policy had become reasonably clear.

We held in *Dominguez* that one physician's opinion that the plaintiff's condition was work-related did not raise a fact issue of whether there was no reasonable basis for denial of a claim because the insurer was entitled to rely on the opinion of other medical professionals who had diagnosed the condition as a degenerative disease.²⁴ Likewise, in *Lyons*, we held that the jury was entitled to resolve a conflict in the evidence about whether a windstorm had damaged a home but that evidence related to contractual coverage was not evidence of bad faith unless there was also evidence that the information on which the insurance company relied in denying the claim was unreliable or not objectively prepared.²⁵ Thus, when medical evidence is conflicting, liability is not reasonably clear, and it cannot be said that the insurer had no reasonable basis for denying the claim

²¹ 951 S.W.2d 444, 448 (Tex. 1997).

²² 879 S.W.2d 10, 17 (Tex. 1994).

²³ 873 S.W.2d at 376-77.

²⁴ *Id.* at 377.

²⁵ See *Lyons v. Millers Cas. Ins. Co.*, 866 S.W.2d 597, 600-01 (Tex. 1993).

unless the medical evidence on which the insurer based its denial is unreliable and the insurer knew or should have known that to be the case.²⁶

In *Nicolau*, this Court concluded that there was evidence of no reasonable basis to deny the claim because the carrier had either relied on an expert's report that the carrier knew "was not objectively prepared" or because "the insurer's reliance on the report was unreasonable."²⁷ By contrast, there is no evidence in this case that any of the information on which Provident American ultimately relied in denying coverage was "not objectively prepared" or that reliance on the information was unreasonable. The medical records revealed that just three days after the thirty-day waiting period expired, Denise Castañeda saw a physician and was diagnosed with a hereditary blood disorder. Two weeks later, she underwent surgery to remove her spleen as treatment for this condition. During surgery it was confirmed that her disorder had caused gallstones, and her gallbladder was also removed.

The undisputed evidence showed that Denise Castañeda and her brother had exhibited symptoms even before their father applied for the policy. Castañeda's father wrote to Provident American, providing facts that supported a conclusion that the disease had manifested before the end of the thirty-day period and that there was no coverage. Guillermo Castañeda, Sr. advised the following:

- Days before he applied with Provident American for a policy, his son's school nurse noted that his son was "drastically jaundice [sic] and lethargic;" she recommended

²⁶ See also *Connolly v. Service Lloyds Ins. Co.*, 910 S.W.2d 557, 563 (Tex. App.—Beaumont 1995, no writ) (holding that the carrier established its good faith as a matter of law when summary judgment evidence demonstrated a bona fide controversy regarding the need for back surgery and the carrier relied on a report that surgery was not necessary)(citing *Packer v. Travelers Indem. Co.*, 881 S.W.2d 172, 176 (Tex. App.—Houston [1st Dist.] 1994, no writ)); *Ramirez v. Transcontinental Ins. Co.*, 881 S.W.2d 818, 826 (Tex. App.—Houston [14th Dist.] 1994, writ denied) (holding that an insurer had conclusively established a reasonable basis for denying a claim when it relied on an expert's opinion, even though another expert had expressed a conflicting opinion).

²⁷ *State Farm Lloyds v. Nicolau*, 951 S.W.2d 444, 448 (Tex. 1997).

that Guillermo Castañeda take his son to a physician, and he did.

- During the thirty-day waiting period, the Castañedas received a call from Denise's uncle who informed them he had been diagnosed with "Congenital Spherocytosis and a Splenectomy was performed."
- "The physicians warned that every member of my wife's family with jaundice symptoms must be examined."
- "So as Denise and [her brother] had their skin a little yellow throughout their whole lives [sic], both were checked and diagnosed . . . July 20, 1991 [three days after the end of the thirty-day waiting period]."

There is no evidence calling into question Provident American's reliance on this information or its reliance on medical records and on communications with Denise Castañeda's physicians.

The dissent argues that Provident American's failure to consult a physician before it denied the claim is some evidence to support the jury's verdict. In the same vein, the dissent points to the testimony of an expert witness for Provident American who said that HS is a rare condition requiring special expertise for diagnosis. But the issue is not whether a layperson could diagnose HS. It is undisputed that Denise Castañeda had HS and that HS was the reason for her surgery. The issue is whether there was no reasonable basis for an insurer to conclude that HS had first manifested before the end of the thirty-day period in light of the medical records and other information reasonably available to the carrier at the time it denied the claim. There is no evidence that a reasonable insurer could not have relied on information which indicated that HS had manifested before the end of the thirty-day period.

The dissent implies that a factfinder could reasonably infer from the testimony of Provident American's expert regarding claims-handling practices of insurance companies that Provident American did not have enough information to deny the claim when it did. The record does not comport with the dissent's characterization of the evidence. While the expert did say that a company

should not deny a claim if it does not have enough information, he did not testify that Provident American lacked adequate information to deny the claim. The expert testified directly to the contrary.

The dissent also asserts that a Provident American employee, Laurie Haggard, testified that she did not have enough information to deny the claim when she sent a December 1991 letter, which quoted the thirty-day policy provision and said that Provident American would re-open the claim upon receipt of new information.²⁸ The dissent takes this testimony entirely out of context. It is clear from Haggard's testimony that when she prepared and sent the December 1991 letter, she had concluded that Denise Castañeda's claim was not payable but that reconsideration would be forthcoming if information was provided by the insured that HS had first manifested after the thirty-day period. Haggard's testimony and unchallenged documentary evidence also confirm that additional information was provided after December 1991 and that this additional information did not support the conclusion that HS first manifested within the three-day window. By no stretch of the imagination can one infer from Haggard's testimony that Provident American did not have adequate information to deny the claim.

In order for subpart G to support a verdict, Castañeda was required to come forward with some evidence that no reasonable insurer could have believed that HS had manifested before the end of the thirty-day period (an objective prong of the "no reasonable basis" definition of bad faith)²⁹ and that Provident American knew or should have known that it had no reasonable basis for denying the claim based on the thirty-day waiting period (the second prong).³⁰ In order for subpart J to support

²⁸ ___ S.W.2d at ___.

²⁹ See *Dominguez*, 873 S.W.2d at 376.

³⁰ *Id.*

a verdict, Castañeda was required to come forward with some evidence that liability was reasonably clear. She did not meet her burden.

The jury's failure to find that HS first manifested prior to July 17, 1991 is not dispositive of the issue of liability under the DTPA or the Insurance Code, which are extra-contractual claims. Provident American requested a defensive issue in an effort to establish that there was no coverage under the contract of insurance.³¹ But even if the jury's negative answer to this issue amounted to a finding of contractual coverage, coverage is not the equivalent of and cannot be the only evidence of bad faith. In *Lyons*, the jury found that the insured's loss was covered by the policy, but we explained that "bad faith focuses not on whether the claim was valid, but on the reasonableness of the insurer's conduct in rejecting the claim."³² There is no evidence that Provident American had no reasonable basis for concluding that HS had first manifested in Denise Castañeda prior to the end of the thirty-day period.

Provident American was not required to appeal the jury's failure to find that HS had manifested before the end of the thirty-day period because Castañeda never sought and did not receive any contractual relief. The only theories of liability at issue in the trial court were extra-contractual ones.

³¹ The jury was asked:

Do you find from a preponderance of the evidence the HEMOLYTIC SPHEROCYTOSIS of Plaintiff, DENISE CASTAÑEDA, 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

³² See *Lyons v. Millers Cas. Ins. Co.*, 866 S.W.2d 597, 601 (Tex. 1993).

We express no opinion regarding the dissent's extended discussion of whether there was contractual coverage and the meaning of "manifest" as used in Castañeda's policy. We note only that there is considerable authority that "manifest" does not necessarily mean manifest to the insured.³³

B

Castañeda contends that Provident American is liable on an independent ground because one of the reasons it gave for denying coverage was the policy's exclusion of gallbladder disorders during the first six months that the policy was in effect. After Provident American initially had denied coverage on that basis, one of Castañeda's physicians advised that the gallbladder surgery was secondary to HS. At least some individuals within Provident American's organization thereafter concluded that the gallbladder exclusion did not apply. The claim was then denied based on the thirty-day provision discussed above, and the thirty-day provision was cited as the reason for denial when Provident American subsequently responded to an inquiry from the Department of Insurance. However, many months after the claim had been denied because of the thirty-day provision, one of Denise Castañeda's physicians called Provident American to inquire once again why the claim had not been paid and was told that it was because of the six-month exclusion regarding the gallbladder.

³³ See, e.g., *Dirgo v. Associated Hosps. Serv., Inc.*, 210 N.W.2d 647, 650 (Iowa 1973) (holding that condition is manifest when it would be manifest to a person learned in medicine from symptoms or other physical conditions that the illness or disease exists); *Bishop v. Capitol Life Ins. Co.*, 545 P.2d 1125, 1129 (Kan. 1976) (holding that symptoms of heart disease were active or manifest because they were manifest to one learned in medicine prior to the effective date of the policy); *Southards v. Central Plains Ins. Co.*, 441 P.2d 808, 811, 813-14 (Kan. 1968) (equating origination of disease with manifestation and holding that insured's Bright's disease was active and manifest because it was manifest to those learned in medicine before the policy became effective, although insured had no knowledge that he had the disease); *Dowdall v. Commercial Travelers Mut. Accident Assoc.*, 181 N.E.2d 594, 596 (Mass. 1962) (holding that symptoms of disease were manifest long before issuance of the policy when symptoms first appeared years earlier and physician had reasonable cause to believe the plaintiff had multiple sclerosis even though definitive diagnosis was not made until later); *Rosenberg v. North Dakota Hosp. Serv. Assoc.*, 136 N.W.2d 128, 132 (N.D. 1965) (holding that "originates" includes "manifest" and indicating that disease would have been manifest if physicians could have diagnosed it); *Richards v. American Sec. Life Ins. Co.*, 303 P.2d 1110, 1112 (Okla. 1956) (equating "originates" with manifests and holding that a cataract may manifest by a distinct symptom or condition from which one learned in medicine could with reasonable accuracy diagnose the specific ailment that thereafter caused the hospital confinement); see generally RHODES, COUCH ON INSURANCE, § 41A:41 (2d rev. ed. 1982).

The president of Provident American also maintained at trial that the claim was not payable because of the gallbladder exclusion and the thirty-day provision.

We assume, but need not decide for purposes of our analysis, that the removal of Castañeda's gallbladder did not fall within policy exclusions. We thus assume that the gallbladder exclusion was not a valid basis for denying coverage. But not every erroneous denial of a claim subjects an insurer to liability, as we confirmed once again in *Republic Insurance Co. v. Stoker*.³⁴ There is no evidence in this record that no reasonable insurance company would have denied coverage in light of other facts.

One of Provident American's employees did testify that it was "improper" to deny the claim based on the gallbladder exclusion, and all but the president of the company agreed that reliance on the gallbladder exclusion was misplaced. This testimony is evidence that Provident American denied the claim for the wrong reason, but it does not amount to evidence that no insurer could reasonably have denied the claim. We addressed an analogous situation in *Lyons*³⁵ when we distinguished *Aranda v. Insurance Co. of North America*.³⁶ We pointed out in *Lyons* that the insured in *Aranda* alleged not only that there was evidence of coverage but also that the carrier's adjusters determined that Aranda's claim was compensable and advised the carriers to pay the claim.³⁷ There is no evidence that anyone at Provident American thought that Castañeda's claim was covered and should be paid. Every Provident American employee, including the employee who concluded that

³⁴ 903 S.W.2d 338, 340 (Tex. 1995) (stating that as long as the insurer has a reasonable basis to deny or delay payment of the claim, even if that basis is erroneous, the insurer is not liable for bad faith) (citing *Lyons*, 866 S.W.2d at 600); see also *Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex. 1988) (stating that carriers "will not be subject to liability for an erroneous denial of a claim" unless there was no reasonable basis for denial).

³⁵ 866 S.W.2d at 601.

³⁶ 748 S.W.2d at 213.

³⁷ See *Lyons*, 866 S.W.2d at 601; see also *Aranda*, 748 S.W.2d at 213-14.

reliance on the gallbladder exclusion was improper, testified that the claim nevertheless was not payable because of the thirty-day provision in the policy. The dissent’s statement that Provident American’s own witnesses testified that the claim was denied without a reasonable basis has no support in the record.

As just discussed above, there was no evidence that no reasonable carrier could have concluded that HS first manifested prior to the end of the thirty-day waiting period. We explained in *Stoker* that in determining if an insurer had no reasonable basis to deny coverage, the facts existing at the time of denial are dispositive.³⁸ We said, “[t]he Stokers cannot preclude Republic from relying on a reason for denying their claim that existed at the time, even if it was not the reason Republic gave.”³⁹ From the time Provident American first denied the claim based on the gallbladder exclusion through the trial of this case, there were facts that gave rise to another coverage question—the thirty-day waiting period. There is no evidence that, in view of the thirty-day provision, Provident American’s liability under the policy was reasonably clear when it denied coverage or that it had no reasonable basis for denying coverage.

Castañeda and the dissent contend that because Provident American gave different reasons for denying the claim at different times, there is some evidence that the denial was pretextual, citing *Nicolau*⁴⁰ and *Simmons*.⁴¹ In *Nicolau*, the Court concluded that there was some evidence that the carrier knew that the expert report on which it relied was of questionable validity.⁴² In *Simmons*, the

³⁸ See *Stoker*, 903 S.W.2d at 340.

³⁹ *Id.* at 341.

⁴⁰ *State Farm Lloyds v. Nicolau*, 951 S.W.2d 444 (Tex. 1997).

⁴¹ *State Farm Fire & Cas. Co. v. Simmons*, 963 S.W.2d 42 (Tex. 1998).

⁴² See *Nicolau*, 951 S.W.2d at 448-50.

Court concluded that there was evidence that the investigation was biased and outcome-oriented because there was evidence that the carrier knowingly and repeatedly ignored evidence that the insureds did not burn down their home and that they had no motive for arson.⁴³ Our use of the term “pretextual” in *Nicolau* and *Simmons* did not mean that an insured is relieved from its burden of offering evidence that liability had become reasonably clear or that there was no reasonable basis for denying the claim. We did not redefine the common-law tort of bad faith or the legal sufficiency standard of review for article 21.21 cases to include a mechanism by which a factfinder could conclude that the denial was pretextual even though there was a reasonable basis for denying the claim. The use of the concept “pretextual” was another way of saying that there must be some evidence that there was no reasonable basis for denying the claim or that liability was reasonably clear. Here, there is no evidence that Provident American ignored information that would lead a reasonable person to conclude that liability under the policy was reasonably clear or that there was no reasonable basis to deny the claim.

IV

Other instructions submitted to the jury within Question 1 (subparts H, I, and K) concern Provident American’s settlement practices.⁴⁴ Subpart K is based on subsection 2(b)(5) of article 21.21-2⁴⁵ and asked whether Provident American had compelled Castañeda to institute suit to recover amounts due under the policy by offering substantially less than was ultimately recovered. Subsection 2(b)(5) provides a remedy when an insurer neither unreasonably denies nor delays making a settlement offer but nonetheless makes an offer that is so clearly deficient that it is

⁴³ See *Simmons*, 963 S.W.2d at 45-47.

⁴⁴ See Appendix A, Question 1.

⁴⁵ EX. INS. CODE art. 21.21-2, § 2(b)(5).

functionally a denial of the claim. There is no evidence that Provident American offered any settlement, and thus any jury finding based on this subpart would have had no support in the record.

Castañeda contends that she is entitled to recover damages equivalent to policy benefits if Provident American failed to acknowledge communications about the claim (subpart H) or if it failed to adopt reasonable standards for investigating claims (subpart I). Neither the statutes nor any of our decisions supports such a proposition.

We indicated in *Stoker*⁴⁶ that failure to properly investigate a claim is not a basis for obtaining policy benefits. We did recognize, though, that there might be liability for mishandling a claim if the mishandling resulted in damage to the insured other than policy benefits or damages flowing from the denial of the claim. We said: “We do not exclude, however, the possibility that in denying the claim, the insurer may commit some act, so extreme, that would cause injury independent of the policy claim.”⁴⁷ 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.⁴⁸ Castañeda and the dissent fault Provident American’s investigation of the claim and claims-handling procedures on a number of counts, but 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, as we discuss in Part IV.B below.

A

Provident American failed to respond to certain letters and phone calls during 1992, which was many months after Denise Castañeda’s surgery. Guillermo Castañeda, Sr. continued to contact

⁴⁶ See *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995).

⁴⁷ *Id.*

⁴⁸ *Id.* at 342, 345 (Spector, J., concurring).

Provident American long after the claim had been denied a second time and after there already had been extensive correspondence among Provident American, Castañeda's father, and her physicians. Provident American had sent a letter on December 12, 1991 to Guillermo Castañeda, Sr. explaining the thirty-day waiting period and stating that "[u]pon receipt of the necessary information, we will gladly reopen this claim for possible disbursement of benefits." Provident American subsequently received additional information, including the letter from Guillermo Castañeda, Sr. described in detail in Part III.A above, and more correspondence from Denise Castañeda's physicians. As we have seen, none of this information indicated that HS first manifested within the three-day window between the expiration of the thirty-day period and the day Castañeda was diagnosed with HS. In fact, all information indicated the opposite.

The result of the activity that occurred after Provident American's December 1991 letter was that the claim still was not paid, and the physicians were told by Provident American that it would not be paid. While Provident American may not have communicated directly with the Castañedas, and its conduct is less than exemplary, this does not amount to "failing to adopt and implement reasonable standards for prompt investigation of claims" or "failing to acknowledge with reasonable promptness pertinent communications with respect to claims."⁴⁹

Under Castañeda's theory, a carrier would be liable if it did not respond to each and every request for payment or inquiry by an insured or the insured's physician sent *after* the claim had been denied and the reasons for the denial had been explained. Nothing in the DTPA nor the Insurance Code imposes liability on such a basis.

B

Provident American contends and we agree that its conduct in handling the claim did not

⁴⁹ See Appendix A, Question 1, subparts H and I.

cause any injury independent of the denial of policy benefits. The only damages awarded by the jury that were not policy benefits were for loss of credit reputation. But any loss of credit reputation stemmed from the denial of benefits, not from any failure of Provident American to communicate with Castañeda or to properly investigate her claim. Generally, loss of credit reputation would not flow from “some act, so extreme” by the carrier in denying the claim that it caused “injury independent of the policy,” as contemplated in *Stoker*.⁵⁰

Moreover, there is no evidence of lost credit reputation in this case. Denise Castañeda testified that she had applied for credit cards and was turned down. This evidence is legally insufficient. As we recently held in *St. Paul Surplus Lines Insurance Co. v. Dal-Worth Tank Co.*, “[t]o prove that credit rating is harmed is to prove nominal damages; not until a loan is actually denied or a higher interest rate charged is there proof of actual damages which may be compensated.”⁵¹ We explained that there must be a showing that the inability to obtain a loan “resulted in injury and proof of the amount of that injury.”⁵² There is no evidence of this character before us.

V

Denise Castañeda contends that by pre-approving her surgery, Provident American represented that her condition was covered, and that when Provident American thereafter failed to pay her claim, this amounted to a violation of the Insurance Code and the DTPA. The pre-approval in this case was not a representation that is actionable under the Insurance Code or the DTPA. Nor is there any evidence that Castañeda relied on the pre-approval to her detriment.

⁵⁰ See *Stoker*, 903 S.W.2d at 341.

⁵¹ 974 S.W.2d 51, 53 (Tex. 1998) (quoting 5 CUNNINGHAM, CORBIN ON CONTRACTS § 1007 (Supp. 1998)).

⁵² *Id.*

At the time Provident American authorized surgery, it had not been given material facts that were in the possession of the Castañedas and the physicians who treated Denise Castañeda. Provident American did not know that Denise Castañeda had exhibited symptoms and had been treated for jaundice and hepatitis long before her father applied for the policy. Nor did it know that the hereditary disease HS had been diagnosed in another family member within the thirty-day waiting period or that Denise Castañeda's brother, Guillermo, Jr., also an insured, had been treated for jaundice, suspected hepatitis, and anemia just two days before their father met with Provident American to apply for this policy. Under these circumstances, Provident American's pre-authorization at most amounted to an uninformed conclusion on its part, based on what it knew from the insured and the insured's physicians, that Castañeda's blood disorder was a covered sickness, namely, that HS had not manifested prior to the end of the thirty-day waiting period or was not otherwise excluded. The pre-approval does not constitute a false, misleading, or deceptive act; a misrepresentation of the terms of an insurance policy; or an assertion with respect to insurance that was untrue.

Castañeda's position, if accepted, would impose strict liability on carriers that are not given pertinent facts before a procedure is pre-approved and who later learn that they have a good faith, reasonable basis for denying coverage. We do not hold today that pre-approval of medical procedures can never constitute an actionable representation under article 21.21 or the DTPA. And we are not called upon to consider any other theory of liability. We hold only that the pre-approval given in this case does not subject Provident American to liability under the DTPA or article 21.21 because neither the insureds nor their physicians imparted key facts before the pre-approval was given.

Provident American also contends and we agree that there is no evidence that Castañeda

relied on the pre-approval to her detriment. There is no evidence that but for the pre-approval, Castañeda would not have had the surgery. The evidence at trial was that removal of the spleen is the only known cure for HS. Castañeda never offered any evidence that she would have foregone the surgery if her insurer had not pre-approved it. This case is similar to the situation presented in *Royal Globe Insurance Co. v. Bar Consultants, Inc.*,⁵³ in which a bar was damaged by vandals. The insured called the insurer the next morning and was told that the loss was covered and to go ahead and have the damage repaired. The policy in fact expressly excluded loss caused by vandalism.⁵⁴ We held that no detriment was shown from reliance on the insurer's post-loss representation of coverage because the bar's owner conceded that he would have made the repairs even if there were no coverage.⁵⁵ The representation of coverage by Provident American, like the representation in *Royal Globe*, will not support the judgment in this case because there is no evidence of reliance by the Castañedas.

VI

Two other liability issues were submitted. Question 3 inquired if Provident American had engaged in unconscionable conduct as defined in former DTPA section 17.45(5).⁵⁶ Castañeda argues that the same evidence that she contends supports findings of liability under Question 1 is also evidence of unconscionability. But none of the evidence regarding the manner in which Provident American handled the claim nor the reasons for its denial of the claim amount to evidence that

⁵³ 577 S.W.2d 688 (Tex.1979).

⁵⁴ *Id.* at 690-91.

⁵⁵ *Id.* at 694-95 (distinguishing pre-loss representations, which were actionable, from post-loss representations, which were not actionable).

⁵⁶ See Act of May 10, 1977, 65th Leg., R.S., ch. 216, § 1, 1977 Tex. Gen. Laws 600, 600, amended by Act of May 19, 1995, 74th Leg., R.S., ch. 414, § 2, 1995 Tex. Gen. Laws 2988, 2989.

Provident American took “advantage of the lack of knowledge, ability, experience, or capacity” of Castañeda to a grossly unfair degree or that its conduct resulted in a “gross disparity between value received and consideration paid,” which were the definitions of unconscionability in Question 3. The only additional argument Castañeda makes regarding unconscionability is that her father paid the specified premium for this policy but that the policy was valueless because her claim was denied. Of course, if the policy did cover her claim, she was entitled to recover policy benefits, and the policy was not “valueless.” If the policy did not cover this claim, it was still not valueless because it covered a myriad of other illnesses Castañeda could have contracted while the policy was in effect. Likewise, there is no evidence to support the findings under Question 4, which inquired if Provident American had made representations that goods or services had characteristics they did not have or were of a particular quality, or that an agreement conferred rights that it did not contain.

In sum, there is no support in the evidence for any of the extra-contractual claims on which Denise Castañeda obtained findings. Castañeda did not plead and did not obtain a determination from the trial court that Provident American was liable for breach of the insurance contract. Accordingly, there is no basis on which Castañeda may recover based on this record.

* * * * *

Because the judgment against Provident American is not supported by legally sufficient evidence, the judgment of the court of appeals is reversed, and judgment is rendered that Castañeda take nothing.

Priscilla R. Owen
Justice

OPINION DELIVERED: December 31, 1998

Appendix A

Question 1 read:

Did PROVIDENT AMERICAN INSURANCE COMPANY engage in any unfair or deceptive act or practice that was a producing cause of damages to DENISE CASTAÑEDA?

“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

B. Making or causing to be made any statement misrepresenting the terms, benefits, or advantages of an insurance policy; or

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

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

E. Making any misrepresentation relating to insurance.

“Misrepresentation” means any of the following:

1. any untrue statement of a material fact; or

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

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

4. any material misstatement of law; or

5. the failure to disclose any matter required by law to be disclosed.

F. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue; or

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

- H. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies; or
- I. Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies; or
- J. Not attempting in good faith to effectuate a prompt, fair, and equitable settlement of a claim when liability has become reasonably clear; or
- 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.

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 3 read:

Did PROVIDENT AMERICAN INSURANCE COMPANY engage in any unconscionable action or course of action that was a producing cause of damages to DENISE CASTAÑEDA?

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 4 read:

Did PROVIDENT AMERICAN INSURANCE COMPANY engage in any false, misleading, or deceptive act or practice that was a producing cause of damages to DENISE CASTAÑEDA?

“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
- b. Representing that goods or services are or will be of a particular quality if they were of another; or
- c. Representing that an agreement confers or involves rights that it did not have or involve.

Answer “Yes” or No.”

Answer: yes