

# IN THE SUPREME COURT OF TEXAS

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No. 96-0249

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PROVIDENT AMERICAN INSURANCE COMPANY, PETITIONER

v.

DENISE CASTAÑEDA, RESPONDENT

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

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**Argued on January 8, 1998**

JUSTICE GONZALEZ, joined by JUSTICE SPECTOR, dissenting.

I dissent from the Court's opinion and judgment because it turns the no-evidence standard on its head. The Court ignores important evidence that supports the judgment, emphasizing evidence and indulging inferences contrary to the verdict, and resolves all conflicts in the evidence against the verdict. I would affirm the judgment of the court of appeals.

I

In order to put my disagreement with the Court's opinion in context, the following recitation includes facts favorable to the jury verdict which the Court chooses to ignore. In May 1991, Guillermo Castañeda applied for a health insurance policy for his family, including his wife, Amparo Castañeda, and their children, Guillermo Jr., Thania, and Denise Castañeda. Provident American Insurance Co. (Provident) issued the policy with an effective date of June 17, 1991. On July 14, 1991, the Castañedas learned that Amparo's brother had been diagnosed with a condition called hemolytic spherocytosis (HS), a genetic condition causing misshapen blood cells. The spleen

destroys the blood cells, often causing anemia and jaundice. The Castañedas were advised that any of their children with yellowish skin tone should be tested. Guillermo Jr. had a yellow skin tone and recently had been diagnosed with anemia, which seemed to cure itself with rest. Denise seemed healthy and had not seen a doctor in years. She was active in sports, marching band, and aerobics. Her skin coloring was yellowish like her father, thus they decided to have Guillermo Jr. and Denise Castañeda tested. On July 18 1991, a Dr. Gutierrez saw Guillermo Castañeda, Jr., but was unable to diagnose the condition and referred the Castañedas to a specialist, Dr. Canales. On July 20, 1991, Dr. Canales diagnosed HS in both children.

Ms. Castañeda's doctors decided to treat the condition by removing her spleen. Her surgeon's assistant called Provident and obtained pre-approval for the surgery. Ms. Castañeda underwent surgery on August 6, 1991. A preoperative evaluation revealed she had gallstones. While removing her spleen, the surgeon decided to remove her gallbladder also.

Two weeks later, her father submitted a claim for the medical bills and expenses from the surgery. Provident responded in October 1991 that no benefits would be paid "at this time," because gallbladder conditions treated during the first six months from the effective date of the policy were excluded from coverage. In October and November 1991, Dr. Canales wrote Provident letters explaining that he only diagnosed Ms. Castañeda when he examined her for the first time on July 20, 1991, and that the gallbladder problems were secondary to HS.

On December 12, 1991, the claims department again wrote a letter to Mr. Castañeda stating that the company would not pay the claim. In the letter, Provident no longer relied on the six-month exclusion. Instead it referred to the policy provision precluding coverage for an illness or disease manifesting itself less than thirty days after the policy date and noted that Dr. Canales' records

indicated a history of jaundice and hepatitis. The letter continues:

We will need complete office records from Dr. Canales to evaluate Denise's claim. We also need to know of any other physicians who may have treated Denise, to establish a definite date of onset for this illness.

Upon receipt of the necessary information, we will gladly reopen this claim for possible disbursement of benefits.

In January 1992, Dr. Canales again wrote Provident, reiterating the date he diagnosed HS. Mr. Castañeda also wrote explaining the events leading up to the diagnosis of his daughter's illness and subsequent treatment, supported with correspondence from the doctors. Despite its representation in December that it would reopen the file upon receipt of such information, Provident neither acknowledged the letters nor reopened the file.

In February 1992, Mr. Castañeda called Provident to check the status of his claim. An employee in the claims department told Mr. Castañeda that he should have a response in about two weeks. In March 1992, the operating surgeon wrote Provident asking it to reconsider denial of benefits because Ms. Castañeda had no gallbladder symptomology, and the HS was not diagnosed until Dr. Canales examined her. Provident never responded to either Mr. Castañeda's or the surgeon's communications.

Finally, Mr. Castañeda complained to the Texas Department of Insurance. It directed Provident to respond to Mr. Castañeda's complaints. The president of the company, Robert Clines, replied to the Department of Insurance in a letter dated April 15, 1992. In it he claimed that Ms. Castañeda had a medical history similar to her brother, who had symptoms of HS. The letter concluded, "The policy contract specifies that the origin of symptoms is evidence of the existence of an illness under both the pre-existing condition and thirty-day sickness limitations." Despite these

representations to the Department of Insurance, however, in July 1992, Provident was still telling Dr. Canales that the reason for denying Ms. Castañeda's claim was the six-month waiting period for a disease involving the gallbladder.

The testimony about how Provident handled the claim internally is confusing at best. Its witnesses could not agree whether it denied the claim because of a preexisting condition, the thirty-day manifestation period, or the six-month exclusion for gallbladder conditions. With the exception of its president, all of Provident's witnesses testified that the October 1991 rejection of the claim as a condition involving the gallbladder was improper.

Provident treated Mr. Castañeda's and Dr. Canales' subsequent communications as an appeal of the initial denial, which went to Laurie Haggard, the assistant claims department manager. She testified that the October 1991 letter denying the claim because of involvement of the gallbladder was "incorrect." Although she had never heard of HS before she reviewed the denial, she did not consult Provident's in-house medical staff before sending the December 1991 letter raising the thirty-day manifestation issue. She said that probably no one else at the company sought medical advice either, or else it would have been noted in the file. Haggard decided to deny Guillermo Jr.'s claim, but "felt like we needed some additional information" for Denise Castañeda. Haggard said she did not know when Ms. Castañeda's condition manifested. She did not know how it manifested. She thought that there might be records from Dr. Juarez which would show that the claim was not covered. However, Provident never asked specifically for those records. Haggard agreed that "you have to have proof" to deny a claim and that it was improper for Provident to fail to follow up on its request for more information, but "that's just the way it happened on this particular claim."

The director of operations, Ann Russell, thought the denial of the claim was "clear-cut"

because it occurred so close in time to the effective date. She first testified that the company properly denied coverage for non-disclosure of a preexisting condition. After reviewing the claims file on the witness stand, however, she admitted that the claim was never denied for that reason. She then asserted that the claim was properly denied because of the thirty-day manifestation exclusion stated in the December 1991 letter. Ms. Russell testified that she “would have probably been the final arbiter to deny this claim,” but had never heard of HS before the Castañedas’ cases, and did not consult the company’s medical director.

The insurance expert witness for Provident asserted that the December 1991 letter was not a denial but merely a request for more information. He testified that if a company did not have enough information on hand to deny a claim, it could not do so merely on its surmise that there might be other evidence out there that would support denial. Provident’s medical expert, an hematologist, testified that HS is a rare condition requiring special expertise to diagnose.

The president of the company testified that the December 12, 1991 letter was not a denial,, but a “special letter” seeking more information. Later in his testimony, however, he asserted that the letter *was* a denial. He testified that he “ultimately” consulted the company’s staff doctor, although the consultation was not reflected in any of the company’s files as was customary company practice. The doctor died prior to this litigation. The president also said he consulted a medical treatise on the subject. However, he never said when he first reviewed the claim. It must have been after the denial in December 1991, since the operations manager said she had the final say. The more reasonable inference is that the president of the company did not review the claim until the Department of Insurance demanded a response.

After hearing this evidence, the jury returned a verdict generally favorable to Ms. Castañeda.

The jury failed to find that Ms. Castañeda's illness manifested itself within the excluded time frame.

The charge reads:

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

The jury found bad faith and various DTPA and Insurance Code violations including: engaging in false, misleading, or deceptive acts or practices; making representation with respect to insurance that was untrue, deceptive, or misleading; knowingly misrepresenting pertinent facts or policy provisions relating to coverages at issue; failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies; and failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies.

Based on the favorable jury findings, the trial court rendered judgment in favor of Ms. Castañeda. The court of appeals affirmed the judgment except for a twelve percent penalty for failure to pay the claim within 30 days. 914 S.W.2d 273. It held that Ms. Castañeda had private causes of action under the DTPA for failing to settle the claim in good faith and failing to acknowledge the insured's communication promptly and held that the evidence was legally and factually sufficient to support the judgment.

The Court sustains Provident’s no evidence points by relying on evidence contrary to the jury’s verdict, calling it “undisputed”. However, even if some testimony is not directly contradicted, it may still conflict with other evidence in the record, and there may still be a fact question on the ultimate issues. The Court fails to carefully articulate rules governing when and for what purpose it may consider evidence contrary to a verdict and thus creates more confusion about the “no evidence” standard.

Our recent writings on legal insufficiency have caused concern that perhaps we have fundamentally altered no-evidence review. *See generally*, Powers, *Judge and Jury in the Texas Supreme Court*, 75 Tex. L. Rev. 1699 (1997); Gallagher & Vaught, *Factual and Legal Sufficiency in the Texas Supreme Court: A Debate*, in STATE BAR OF TEXAS PROF. DEV. PROGRAM, ADVANCED CIVIL APPELLATE PRACTICE COURSE, X (1996). An analysis of the legal sufficiency of evidence, properly conducted, is a perfectly legitimate means for addressing pure legal questions. However, when we review legal sufficiency, we must make it abundantly clear that we are not merely reweighing the evidence contrary to the constitutional limits on our authority. *See* TEX. CONST. art. V, § 6. When we rely on evidence contrary to the verdict to overturn it, we must carefully explain how our analysis fits within the framework of legal sufficiency standards of review.

We have repeatedly held that an appellate court reviewing no evidence complaints may consider only the evidence and inferences that tend to support the finding and must disregard all contrary evidence and inferences. *See, e.g.*, *Continental Coffee Products v. Cazarez*, 937 S.W.2d 444, 450 (Tex. 1996); *Brown v. Edwards Transfer Co., Inc.*, 764 S.W.2d 220, 223 (Tex. 1988); *Holley v. Adams*, 544 S.W.2d 367, 370 (Tex. 1976); *see generally* Calvert, “No Evidence” and “Insufficient Evidence” *Points of Error*, 38 Tex. L. Rev. 361, 364 (1960). In other cases, however,

we have stated broadly that all evidence may be considered in a no evidence review. *Formosa Plastics Corp. v. Presidio Eng'rs & Contractors, Inc.*, 960 S.W.2d 41, 48 (Tex. 1998); *Merrell Dow Pharms., Inc. v. Havner*, 953 S.W.2d 706, 711 (Tex. 1997), cert. denied, 118 S.Ct. 1799 (1998). The apparent conflict has led one commentator to conclude that our court has expanded the scope of review and considers all evidence in a no-evidence challenge. See Hall, *Standards of Review in Texas*, 29 ST. MARY'S L. J. 351, 478-79 (1998).

We have never overruled *Garza v. Alviar*, 395 S.W.2d 821, 823 (Tex. 1965), or *In re King's Estate*, 244 S.W.2d 660, 661 (Tex. 1951), or the legion of opinions that rely on them. However, they oversimplify legal sufficiency review. There are circumstances in which we must consider evidence contrary to the verdict for a specific purpose within our constitutional limitations. To identify those exceptions, it is helpful to recall the circumstances in which a legal insufficiency challenge succeeds.

We will sustain a legal sufficiency point when:

- (a) there is a complete absence of evidence of a vital fact, (b) the court is barred by rules of law or of evidence from giving weight to the only evidence offered to prove a vital fact, (c) the evidence offered to prove a vital fact is no more than a mere scintilla, or (d) the evidence conclusively establishes the opposite of a vital fact.

*Merrell Dow Pharms., Inc.*, 953 S.W.2d at 711. When there is an absence or mere scintilla of evidence to support jury findings, a no-evidence point should be sustained regardless of evidence to the contrary. Thus, in the first and third situations, considering evidence contrary to the verdict serves no legitimate purpose.

In the second situation, it may be necessary to consider evidence unfavorable to the verdict to know that certain offered evidence is incompetent. For example, a witness may reveal on voir dire that prior testimony was hearsay or otherwise incompetent.

In the fourth situation, obviously it is impossible to conclusively establish the opposite of a vital fact without considering evidence contrary to the verdict. A reviewing court first looks for evidence supporting the jury's failure to find, disregarding all evidence to the contrary. If there is no such evidence, then the court may look to the entire record to decide if the proposition is established as a matter of law. *See Holley v. Watts*, 629 S.W.2d 694, 696-67 (Tex. 1982).

Finally, we have had to particularize our review to certain issues which are not amenable to standard no-evidence rules. A finding of bad-faith is one such issue, at least as we defined the tort before 1997, because it must be supported by some evidence of a complete absence of a reasonable basis for denying the claim. *See Lyons v. Millers Cas. Ins. Co.*, 866 S.W.2d 597, 600 (Tex. 1993), *modified by Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48 (Tex. 1997) (redefining the tort of bad faith). We concluded that the only way an appellate court can determine if there was a complete absence of a reasonable basis for denial is to first identify the possible bases raised by the facts of the case, before applying traditional no-evidence rules:

A legal sufficiency analysis requires the reviewing court to give weight only to evidence supporting the judgment for the insured and reject all evidence to the contrary. However, only after an appellate court has determined what potential basis an insurance company may have had for denying a claim can the court conduct a meaningful review of whether the insured has presented evidence that the insurer lacked a reasonable basis for denying or delaying the claim. The court may then apply the traditional rules of legal sufficiency review, giving weight only to evidence in support of the judgment.

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

Thus, at least for pre-*Giles* cases, there are three steps for reviewing bad-faith findings. First, we must isolate the possible reasonable bases the insurer may have had for denying the claim. This inquiry requires that we look at all evidence, whether it favors the judgment or not. Second, we must

determine if the insured presented evidence that the insurer lacked a reasonable basis for denying the claim and that it knew or should have known it had no reasonable basis for its actions. It is at this point that we must return to “traditional rules of legal sufficiency review, giving weight only to evidence in support of the judgment.” *Dominguez*, 873 S.W.2d at 376. Third, we review whether the insurer has conclusively established the opposite of a vital fact.

In this case, the facts, circumstances, and pleadings suggest three possible bases for denying the claim, all arising from the policy. They are the insuring clause, which defined a covered sickness as one manifesting more than thirty days after the effective date, the exclusion for diseases involving the gallbladder, and the exclusion of preexisting conditions. The second step is to review whether Ms. Castañeda presented evidence that Provident lacked a reasonable basis for denying or delaying the claim, and that it knew or should have known that it lacked a reasonable basis. Provident’s own witnesses testified that they denied the claim without a reasonable basis. They contradicted each other about why the claim was denied, when it was denied, or even if it ever had been denied at all. The evidence most favorable to the verdict is that a low-level clerk erroneously rejected the claim in October 1991. By December, Provident knew its error but asserted a new excuse for denying the claim, even though it knew it did not have enough information to legitimately deny on that basis. Although it promised to reconsider, it simply turned a deaf ear to all further attempts by the insured to get a straight answer.

The Court justifies giving no weight to evidence supporting the verdict by considering what it calls “unchallenged” and “undisputed” evidence to the contrary. As one example, it says that the testimony of Laurie Haggard, who said she authorized denial of the claim when the file would not justify denial, if put in “context,” shows that she concluded that the claim was not covered, and that

additional information received afterwards did not show the HS manifested “during the three-day window.” Haggard’s testimony, in essence, is that she had a hunch the claim was deniable which would be borne out if the company ever received the records of a “Dr. Juarez.” While Provident received additional letters and records, they were largely duplicative of what it already had. Haggard already knew about the maternal uncle and that Ms. Castañeda had a history of jaundice in the past. The Court does not say what information Provident learned after December 17 that made the difference between a reasonable and unreasonable denial.

Haggard’s testimony that the information in the company’s file was insufficient to deny the claim is, I would think, some evidence that Provident violated the duty of good faith, defined in the charge as “[d]enying a claim or delaying a claim without a reasonable basis or fail[ing] to determine whether there is any reasonable basis of the denial or delay. . . .” If the Court today cannot recognize the evidence of bad faith in this case, I am not sure what quantum of evidence it will take in the future for this Court to affirm a judgment based on the tort of “bad faith.”

The Court appears to view the above evidence as merely sloppy claim handling practices that caused no harm. Instead of analyzing whether there is evidence of bad faith as defined in the charge, it gives the impression that Ms. Castañeda was required to prove when HS manifested within an artificially created three-day window between the thirtieth day of the policy and the day HS was diagnosed. I agree that a claim that is *in fact* not covered by the policy will not support a bad faith suit even if the insurer gave the wrong reason. *See Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995). However, Provident’s brief to us does not argue that it conclusively established lack of coverage. It does not challenge the jury’s failure to find that HS manifested within 30 days from the effective date of the policy which the Court now holds was established as a matter of law.

Provident cites *Stoker* only in its overall argument that the company had a reasonable basis for denial.

### III

I would hold that Ms. Castañeda's condition was covered because it had not manifested within the thirty-day exclusionary period. Our Court has not written on the subject, but a secondary authority has defined a general rule for when an illness has its inception: "an illness is deemed to have its inception when it first becomes manifest *or* active *or* when there is a *distinct* symptom or condition from which one learned in medicine can *with reasonable accuracy* diagnose the illness." John C. Williams, Annotation, *Construction and Application of Provision in Health or Hospitalization Policy Excluding or Postponing Coverage of Illness Originating Prior to Issuance of Policy or Within Stated Time*, 94 A.L.R.3d 990, 998 (1979) (emphasis added). Another authority agrees that there is a general rule for *inception* of disease, but does not agree that *manifest* has a uniform meaning:

While the general rule [about inception of disease] is widely if not unanimously recognized, there is no unanimity as to exactly what constitutes manifestation of a disease. The rule varies state to state, if not from case to case.

WILLIAM F. MEYER, LIFE AND HEALTH INSURANCE LAW § 17:6 (1972). An examination of state supreme court cases reveals that Meyer is correct, and that any semblance of a majority rule for manifestation is illusory. It is important to note not only how a court in a particular case defines insuring clauses and pre-existing condition exclusions but how it applies the definitions to the facts of the case.

For example, in a 1975 case, the Supreme Court of Mississippi adopted the standard

formulation, that a “disease will ordinarily be deemed to exist when a distinct symptom, ailment or condition manifests itself from which a doctor can with reasonable accuracy diagnose the disease.”

*Blue Cross & Blue Shield v. Mosley*, 317 So.2d 58, 61 (Miss. 1975). In a later case, it clarified:

[A] disease or condition would have had to manifest itself in some way to the insured in order for the insurer to deny coverage. Not only must the physical condition or disease exist prior to the effective date of coverage under such an exclusion, it was also for the insurer to show a manifestation of it to the insured prior to date of becoming insured.

*Mississippi v. Carper*, 545 So.2d 1, 2-3 (Miss. 1989).

The Supreme Court of Washington has held that “a condition does not become manifest until it is known.” *Hovis v. Industrial Hosp. Ass’n.*, 426 P.2d 976, 977 (Wash. 1967). In that case a major medical and hospital policy provided coverage for “physical illnesses, unless specifically excluded, which become manifest or have their original date of onset after Membership hereunder has been continuously effective for thirty or more days.” *Id.* The insured underwent surgery for vascular disease about a year after the effective date of the policy. However, the insured had suffered with pain and cramps in his legs and hips for several years. An expert testified that if the insured had been examined by a vascular specialist five years earlier, the condition would have been discovered, but without such an expert examination it would not. The defendant argued that the test should be whether one learned in medicine could have diagnosed the condition with reasonable accuracy. The supreme court approved of the trial court’s answers to the argument:

To adopt any other rule would make this type of coverage substantially worthless. When the company doesn’t require a medical examination as a condition precedent it would put the burden upon the insured to have his own medical examination, at his own risk, and I don’t think that’s the intention of these policies at all.

....

[I]t is inconceivable and would shock conscience that a health insurance company could escape liability in that way, and I can’t believe it’s the law. There’s some

language in some decisions in other states that might be taken to indicate that, but I don't think that is the law, I don't think it would be intended to go this far.

*Id.* at 977.

The Supreme Court of Oregon has focused on whether the insured knew or should have known of a pre-existing condition. *See Evans v. Investors Ins. Corp.*, 536 P.2d 506 (Or. 1975). The policy in that case defined a covered sickness as one “which first manifests itself 30 or more days after this policy has been in force.” *Id.* at 507. Within 30 days of the effective date, the insured was told by an army doctor at a preinduction physical that he had a slight varicocele of his left testicle, although the doctor said he was not sure. The insured later had surgery for an inflamed varicocele, and the insurance company rejected the claim. The Oregon court defined manifest as meaning “to show plainly” or “to put beyond question or doubt,” and held that the army doctor’s equivocal diagnosis did not constitute a manifestation of the condition. *Id.* at 508.

The Supreme Court of Nebraska has applied a reasonable-insured test. *See Fuglsang v. Blue Cross*, 456 N.W.2d 281 (Neb. 1990), *overruled on other grounds*, 545 N.W.2d 727, 800-01 (Neb. 1996). Several months before the effective date of the policy, the insured in that case complained to the family physician that she had difficulty swallowing, chewing, and moving her tongue and weakness in her arm and leg muscles. She was diagnosed after the policy date with myasthenia gravis by a Tensilon test. The court upheld the jury’s verdict for the insured, holding that “A condition, not otherwise diagnosed, is manifest when the insured knew or should have known of the existence of his illness because he was experiencing symptoms that would lead a reasonable person to seek a medical diagnosis.” *Id.* at 556 (quoting *American Sun Life Ins. Co. v. Remig*, 482 So.2d 435 (Fla. App. 1985)).

In *Kissil v. Beneficial National Life Insurance Co.*, 319 A.2d 67, 70 (N.J. 1974), the Supreme Court of New Jersey did not formulate a test but held that a disease would be “contracted and commencing” only if symptoms manifest themselves with reasonable certainty. In that case a child was born and immediately diagnosed with a condition of meconium ileus and presumptively diagnosed with cystic fibrosis. After the coverage date fifteen days later, he was conclusively diagnosed with cystic fibrosis, an inherited disease present at birth. The defendant’s medical expert testified that meconium ileus is conclusively indicative of cystic fibrosis. The plaintiff’s expert testified that not all babies born with meconium ileus become cystic. The supreme court held that the issue of whether cystic fibrosis commenced prior to coverage was an issue properly left to the jury because of the conflicts in the evidence and inferences that could be drawn from it. *Id.*

A number of courts have adopted what appears to be a broad definition of manifestation, but it is not clear how they would rule on facts such as those in the case before us today. In most of those cases, the insureds appear to have been suffering from symptoms from which they knew they had an illness. In *Dirgo v. Associated Hosps. Serv., Inc.*, 210 N.W.2d 647 (Iowa 1973), the policy excluded existing conditions. The year before the effective date of the policy, the insured began experiencing lower abdominal discomfort which continued after surgery for a prostate infection. After the policy date, the condition was diagnosed as diverticulitis using standard medical procedures. The court upheld the trial court decision in favor of the insurer on a substantial evidence analysis. *Id.* at 651.

In *Bishop v. Capitol Life Insurance Co.*, 545 P.2d 1125 (Kan. 1976), the issue was also whether a condition existed on the policy date. For several years before the policy date, the insured had suffered chest pains and shortness of breath. After the policy date, he was diagnosed with

arteriosclerotic heart disease, and tests revealed an old scar on the wall of the heart. The court held that the heart condition was active or manifest to one learned in medicine. *Id.* at 1129.

The issue in *Southards v. Central Plains Ins.Co.*, 441 P.2d 808 (Kan. 1968), the issue was whether a kidney condition commonly known as Bright's disease was contracted before the policy date. The insured had been diagnosed with Bright's disease before and after the policy date, although the insured did not learn of that fact until afterwards. *Id.* at 813.

The policy in *Dowdall v. Commercial Travelers Mut. Accident Ass'n*, 181 N.E.2d 594 (Mass. 1962), covered sicknesses "originating" more than 30 days after the effective date of the policy taken out in 1952. Although the facts are not explicit, the insured said he had experienced "trouble" with his arms and legs since 1944. The cause of his disability was multiple sclerosis. His physician testified that the symptoms appeared in 1944, that he "had reasonable cause" to believe that the condition was MS when he treated the insured in 1947 and 1948, but did not tell him he had the disease in 1952, and that a definite diagnosis was made in 1955. *Id.* at 595.

Finally, in *Richards v. American Sec. Life Ins. Co.*, 303 P.2d 1110 (Okla. 1956), the policy only insured "sickness the cause of which originates while the policy is in force . . . ." *Id.* at 1111. Before the policy date, the insured had a cataract removed from his right eye, and his left eye was only 20/30 due to sclerosis of the lens. After the policy date, he had a cataract removed from the left eye and made a claim for the medical expenses. The defense expert testified that a sclerosis is the same as a beginning cataract. The court held that it would not overturn a jury verdict for the defendant when there was a conflict in the medical testimony. *Id.* at 1112.

Insurance policies are subject to the same rules of construction as other contracts. *See Trinity Universal Ins. Co. v. Cowan*, 945 S.W.2d 819, 823 (Tex. 1997). It must be considered as a whole

and effect given to each part if reasonably possible. *National Sec. Life & Cas. Co. v. Davis*, 257 S.W.2d 943, 944 (Tex. 1953). The plain, ordinary, and generally accepted meaning of words is preferred unless the policy itself shows that the terms have been used in a technical or different sense. *See Ramsay v. Maryland Am. Gen. Ins. Co.*, 533 S.W.2d 344, 346 (Tex. 1976). If an insurance contract can be given more than one meaning, it is ambiguous, and the interpretation that most favors coverage will be adopted. *See Grain Dealers Mut. Ins. Co. v. McKee*, 943 S.W.2d 455, 458 (Tex. 1997). An intent to exclude coverage must be expressed in clear and unambiguous language. *See State Farm Fire & Cas. Co. v. Reed*, 873 S.W.2d 698, 699 (1993).

In the future, we should follow the lead of those courts that have applied the common meaning of manifest and conclude that a disease is manifest when it is apparent, obvious, or plain. *See, e.g., Ross v. Western Fidelity Ins. Co.*, 872 F.2d 665, 669 (5<sup>th</sup> Cir. 1989), *clarified on rehearing*, 881 F.2d 142 (5<sup>th</sup> Cir. 1989). In *Ross*, the Fifth Circuit Case interpreted an insuring clause virtually identical to the one in Provident's policy in which the insurer agreed to pay for medical expenses "resulting from sickness, which first manifests itself more than 30 days after the effective date. . . ." *Id.* at 669. In that case, an infant had been born with respiratory problems and was subjected to a number of diagnostic tests, including cardiac tests. Later, after the effective date of coverage, it was discovered the child had a congenital heart murmur. The court held:

To be manifest, a sickness must be apparent, obvious, or plain. The heart defect here did not manifest itself during the excluded time frame. Despite the presence of symptoms that may have been caused by the heart defect, the heart defect itself was not diagnosed and therefore was not apparent, obvious, or plain.

*Ross*, 872 S.W.2d at 669. In our case, Dr. Gutierrez was unable to diagnose Guillermo Castañeda, Jr., after the policy coverage date. No doctor Denise had ever seen before Dr. Canales even

suspected HS, and to the contrary, she seemed perfectly healthy.

As one justice has stated:

It appears quite unfair to hold that when one takes out an insurance policy when one is unaware of any symptoms and has no symptoms manifest to the average person and later when one becomes ill, for the insurance company to refuse to pay because the company can get a medical expert or physician to testify that the insured has had a condition for many years prior to the effective date of the policy, which results in his present sickness or disability, and therefore, under the terms of the policy, the insured is not covered. ”

*Mutual Hosp. Ins. Inc. v. Klapper*, 312 N.E.2d 482, 484 (Ind. 1974). Another court has observed that “a medical insurance system that covers only well persons and those sick persons who have not vigilantly monitored their health makes sense only if viewed through the looking glass.” *Hardester v. Lincoln Nat’l Life Ins. Co.*, 33 F.3d 330, 339 n.5 (4<sup>th</sup> Cir. 1994) (Hall, J., dissenting) *dissenting opinion adopted on rehearing in banc*, 52 F.3d 70 (4<sup>th</sup> Cir. ), *cert. denied*, 516 U.S. 864 (1995).

As noted before, most courts require a *distinct* condition so that a diagnosis can be made with *reasonable accuracy*. What is the distinct symptom here? It is clear that Dr. Canales’s diagnosis hinged on the fact that Denise Castañeda’s maternal uncle has the genetic condition. Yet her uncle’s condition is not Denise Castañeda’s “distinct symptom or condition.” With a pen stroke the Court denies coverage to insureds who, unbeknown to them, suffer genetic or other congenital conditions. In this age of gene-mapping, we are rapidly reaching the point that a genetic condition is diagnosable from birth if enough diagnostic tests are run.

The policy does not state to whom the sickness must manifest itself. There is nothing in the policy to indicate that the word has the more technical meaning of being capable of diagnosis by a medical expert. We need to interpret the term manifest in a way that makes insuring for unknown risks possible, because virtually every latent illness is a “physical condition” which could be

diagnosed through sophisticated testing. An insured would have to pay for every sophisticated test in existence to know what the policy actually covers.

A reasonable interpretation is that a condition is covered unless it is at least apparent to a reasonable insured that she is sick. Such an interpretation would effectuate the purposes of the insuring clause. As one court has commented,

[W]hile insurance companies need protection from unscrupulous applicants who would fraudulently attempt to gain coverage for an illness of which they are already aware, such protection need not go so far as to consider a disease to exist at the time of its medical inception. Furthermore, to consider a disease to exist at a time when the victim is blissfully unaware of the medical “seeds” visited upon his body, is to set a trap for the unwary purchaser of health insurance policies.

*Klapper*, 288 N.E.2d at 282. While this does not necessarily mean a condition must be diagnosed to be manifested, sometimes latent diseases are not manifest until diagnosis. Certainly, a disease is not manifest when the patient does not even know he or she is sick.

I would hold that a disease has not manifested itself until the insured suffers from *distinct* symptoms from which a diagnosis can be made with reasonable accuracy, *and* the symptoms are such that a reasonable insured would seek medical treatment. The evidence shows that Ms. Castañeda was healthy and active in school and sports. Her physician said that she was asymptomatic except for a yellow tint to her skin, the same as her father. It was her maternal uncle who the Castañedas learned had HS. Thus, whether Ms. Castañeda’s HS had manifested within the policy period should be a question of fact. The jury’s finding that the disease had not manifested should be sustained.

#### IV

I agree with the Court that it is not bad faith for an insurance company simply to make a

mistake and deny a claim for the wrong reason. We so held in *Republic Insurance Company v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995). However, *Stoker* does not apply because the evidence of coverage is conflicting, and should be resolved in favor of the verdict.

The Court ignores the ample evidence that Provident violated its duties to Ms. Castañeda. The *Stoker* exception does not apply because the claim was in fact covered. While policy benefits do not support the entire judgment for actual damages, I agree that the award should not be set aside for the reasons set forth by the court of appeals. 914 S.W.2d at 280-82.

## V

In summary, I disagree with the Court's conclusion that the evidence only shows "less than exemplary" claims practices or merely a bona fide coverage dispute. The record is more than adequate to support jury findings that Provident American Insurance Company violated the DTPA and the Texas Insurance Code and breached its duty to deal in good faith. I therefore would affirm the judgment of the court of appeals in all respects.

There is ample evidence from which the jury could conclude that Provident decided to deny the claim from the beginning, and asserted a series of pretextual reasons for not paying the claim. This case has serious implications well beyond the present parties. The Court's opinion may very well eviscerate the bad-faith tort as a viable cause of action in Texas. If the evidence in this case is not good enough to affirm judgment, I do not know what character or quantity of evidence would ever satisfy the Court in this kind of case.

Raul A. Gonzalez  
Justice

OPINION DELIVERED: December 31, 1998