

# **Current Trends in Bad Faith in Health Insurance**

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**TABLE OF CONTENTS**

I. Introduction ..... 1

II. Breach of Contract and the Misrepresentation Defense ..... 1

    A. The Materiality Requirement ..... 2

    B. The “Intent to Deceive” Requirement ..... 5

III. Bad Faith Claims & Establishing a Reasonable Basis for Denial ..... 7

IV. Improper Joinder & Removal Issues ..... 9

V. Conclusion..... 11

**TABLE OF AUTHORITIES**

**CASES**

*Bundick v. National Life and Accident Ins. Co.*,  
509 F.Supp. 584 (W.D.Tex. 1980).....5

*Horne v Charter National Insurance*,  
14 S.W.2d 182 (Tex.Civ.App.—Ft. Worth, 1981).....5

*Lee v. National Life Assurance Co. of Canada*,  
635 F.2d 516 (5th Cir. 1981) .....6

*Harrington v Aetna Casualty and Surety Co.*,  
489 S.W.2d 171 (Tex.Civ.App.—Waco, 1972) .....4, 5

*Aetna Life Insurance Co. v. Shipley*,  
134 S.W.2d 342 (Tex.Civ.App. Fort Worth 1939, writ dismiss'd) .....3

*Bates v. National Life Ins. Co.*,  
927 F.Supp. 1015 (S.D.Tex. 1996).....7, 8

*Bettes v. Stonewall Ins. Co.*,  
480 F.2d 92 (5th Cir. 1973) .....3

*Cartusciello v. Allied Life Ins. Co. of Tex.*,  
661 S.W.2d 285 (Tex.App.—Houston [1st Dist.] 1983, no writ).....6

*Crowder v. National Life & Accident Ins. Co.*,  
90 S.W.2d 267 (Tex.Civ.App., 1936, writ dismiss.).....4

*Estate of Diggs v. Enterprise Life Ins. Co.*,  
646 S.W.2d 573 (Tex.App.—Houston [1st Dist.] 1982, writ ref'd n.r.e.).....6

*Druker v. Fortis Health*,  
No. 06-00052 (S.D.Tex., July 17, 2006).....10

*Fidelity Union Fire Ins. Co v. Pruitt*,  
23 S.W.2d 681 (Tex.Comm'n App. 1930) .....3

*First Texas Prudential Ins. Co. v. Pipes*,  
56 S.W.2d 203 (Tex.Civ.App. El Paso 1933, writ dismiss'd) .....3

*Flanders v. Fortis Insurance Company*,  
No. 05-0726 (W.D.Tex., Nov. 14, 2005).....10

*Flowers v. United Insurance Co. of America*,  
807 S.W.2d 783 (Tex.App.Houston [14th Dist.] 1991, no writ).....6

*Garcia v. John Hancock Variable Life Ins. Co.*,  
859 S.W.2d 427 (Tex.App.—San Antonio 1993, writ denied)..... 1, 2, 6

*Gorman v. Jefferson Standard Life Ins. Co.*,  
275 S.W. 248 (Tex.Civ.App., 1925) .....4

*Griggs v. State Farm Lloyds*,  
181 F.3d 694 (5th Cir. 1999) .....9, 10, 11

*Hajdik v. Fortis Insurance*,  
No. 06-2348 (S.D.Tex. Jan. 11, 2007) .....10, 11

*Indiana and Ohio Live Stock Ins. Co. v. Smith*,  
157 S.W. 755 (Tex.Civ.App. Austin, 1913, writ ref'd.) .....3

*Inter-Ocean Insurance Company v. Ross*,  
315 S.W.2d 71 (Tex.Civ.App., 1958, no writ hist.) .....4

*Jackson v. National Life and Accident Ins. Co.*,  
161 S.W.2d 536 (Tex.Civ.App. Dallas 1942, writ ref'd w.o.m.) .....3

*Johnson-Ramirez v. Araiza et al.*,  
No. 05-0990 (W.D.Tex. Nov. 15, 2005) .....10

*Kirk v. Kemper Investors Life Insurance Company*,  
448 F.Supp.2d 828 (S.D.Tex. 2006) .....7

*Mayes v. Massachusetts Mut. Life Ins. Co.*,  
608 S.W.2d 612 (Tex.1980) .....1, 6

*National Life & Acc. Ins. Co. v. Dickinson*,  
115 S.W.2d 1180 (Tex.Civ.App.El Paso 1938, writ dismiss'd.) .....3

*Odom v. Insurance Company of the State of Pennsylvania*,  
441 S.W.2d 584 (Tex.Civ.App.—Austin, 1969) .....4, 6

*Ohio Casualty Ins. Co. v. Stewart*,  
76 S.W.2d 873 (Tex.Civ.App., 1934, writ dismiss.) .....4

*Republic Ins. Co v. Stoker*,  
903 S.W.2d 338 (Tex.1995) .....7, 8

*Robinson v. Reliable Life Ins. Co.*  
554 S.W.2d at 231 (Tex.Civ.App.—Dallas, 1977), *affd.*, *Robinson v. Reliable Life Ins. Co.*, 569 S.W. 2d 28 (Tex. 1978)

*Smallwood v. Ill. Cent. R.R. Co.*,  
385 F.3d 568 (5th Cir. 2004) .....9

*Southern Life & Health Ins. Co. v. Grafton*,  
414 S.W.2d 214 (Tex.Civ.App. Tyler 1967, writ ref'd n.r.e.) .....3

**CURRENT TRENDS IN BAD FAITH IN HEALTH INSURANCE**

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*St. Paul Fire & Marine Ins. Co. v. Huff*,  
172 S.W. 755 (Tex.Civ.App.—Texarkana, 1915) .....4

*Standard Fire Ins. Co. v. Rominger*,  
827 F.Supp. 1277 (S.D.Tex. 1993) .....8

*State Farm Lloyds, Inc. v. Polasek*,  
847 S.W.2d 279 (Tex.App—San Antonio 1992, writ denied).....8

*Transportation Ins. Co. v. Moriel*,  
879 S.W.2d 10 (Tex. 1994).....8

*Trinity Reserve Life Ins. Co. v. Hicks*,  
297 S.W.2d 345 (Tex.Civ.App. Dallas 1956, no writ) .....3

**STATUTES**

28 U.S.C. 1332(a).....9

Texas Insurance Code §705.004.....2

## I. INTRODUCTION

The existence of misrepresentations on an application for an individual health insurance policy presents a unique set of legal challenges. The discovery of a misrepresentation immediately triggers questions about the actions that should be taken in response. Does the misrepresentation call for a rider excluding the condition? Does the misrepresentation warrant rescission of the policy? It is critical for insurers facing such questions to have a complete understanding of the potential claims that can be asserted against an insurer following the denial of benefits under a policy.

This paper will address the scope of the misrepresentation defense and analyze its applicability to the claims typically asserted in response to the denial of insurance benefits, namely: breach of contract, bad faith, Insurance Code violations, and Texas Deceptive Trade Practices Act (DTPA) violations. As explained below, the misrepresentation defense is not easy to establish. It requires insurers to prove, *inter alia*, that the insured had the “intent to deceive” when they made the misrepresentation, and that the misrepresentation was “material” to the risk assumed. Both the materiality requirement and the intent to deceive requirement involve fact issues that generally preclude summary judgment. However, an insurer is only required to establish all of the elements of a misrepresentation defense in response to a breach of contract claim. Claims for bad faith, Insurance Code violations, and DTPA violations are subject to other defenses that do not include the procedural hurdles of the misrepresentation defense. Thus, it is important to recognize that an insurer’s potential exposure is highly dependant on the claims asserted.

Finally, this paper will touch on an issue that out-of-state insurers often face in bad faith litigation: the improper or fraudulent joinder of local insurance agents to defeat diversity jurisdiction. Recent cases

out of the federal courts in Texas have upheld, and re-emphasized, the longstanding principle that plaintiffs cannot defeat diversity in a wrongful denial of benefits lawsuit by incorporating nebulous claims against an insurance agent in their Petition. As a result, insurers should keep in mind when assessing whether to remove benefit denial lawsuits to federal court that the joinder of an insurance agent does not necessarily defeat diversity jurisdiction.

## II. BREACH OF CONTRACT AND THE MISREPRESENTATION DEFENSE

When an insured brings suit for the wrongful denial of benefits under their insurance policy, they frequently allege that the insurer is liable for breach of contract. Ultimately, this amounts to a claim that the insurer violated the terms of the insurance policy by failing to provide covered benefits. Of course, when an insurer denies benefits following the discovery of a misrepresentation on the insured’s policy application, the insurer has a valid defense. Under the common law, insurers are not liable for breach of contract if they rescind an insurance policy based on the existence of a “material misrepresentation” in the policy application.<sup>1</sup> However, the insurer must prove the following elements to establish the misrepresentation defense:

- (1) the making of a representation;
- (2) the falsity of the representation;
- (3) reliance on the misrepresentation by the insurer;
- (4) the intent to deceive on the part of the insured in making the mis-representation; and

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<sup>1</sup> *Mayes v. Massachusetts Mut. Life Ins. Co.*, 608 S.W.2d 612, 616 (Tex.1980); *Garcia v. John Hancock Variable Life Ins. Co.*, 859 S.W.2d 427, 431 (Tex.App.—San Antonio 1993, writ denied).

(5) the materiality of the misrepresentation.<sup>2</sup>

The effect of misrepresentations has also been addressed, to a limited extent, by the Texas legislature in Section 705.004 of the Insurance Code.<sup>3</sup> This section provides:

- (a) An insurance policy provision that states that false statements made in the application for the policy or in the policy make the policy void or voidable:
  - (1) has no effect; and
  - (2) is not a defense in a suit brought on the policy.
- (b) Subsection (a) does not apply if it is shown at trial that the matter misrepresented:
  - (1) was material to the risk; or
  - (2) contributed to the contingency or event on which the policy became due and payable.
- (c) It is a question of fact whether a misrepresentation made in the application for the policy or in the policy itself was material to the risk or contributed to the contingency or event on which the policy became due and payable.<sup>4</sup>

Thus, section 705.004 of the Insurance Code reinforces the materiality requirement established in the common law, which has traditionally been, along with the intent to deceive requirement, one of the most heavily litigated areas of the

misrepresentation defense. As a result, the following subsections will explore the scope and application of those requirements.

**A. The Materiality Requirement**

The principle question an insurer faces after identifying a misrepresentation on an application for health insurance is whether that misrepresentation was “material.” However, the vague phrase found in the Insurance Code – “material to the risk” – does not suitably describe the scope of “materiality.” While it may be clear that an insured’s failure to report their proper home address is unlikely to constitute a material misrepresentation, more difficult questions arise when an insured misrepresents a health condition that would not necessarily have precluded them from receiving coverage had the condition been disclosed. If the insured subsequently makes a claim for benefits that is completely unrelated to the undisclosed condition, an insurer faces significant questions about whether it may only issue a rider excluding coverage related to the undisclosed condition, rather than rescind the policy altogether. Before addressing this question it is necessary to distinguish misrepresentations that are “material to the loss” from those that are “material to the risk.” Even though the distinction has been recognized by the Texas Supreme Court for some time, confusion about it still persists in misrepresentation cases.

***(i) Material to the Risk vs. Material to the Loss***

In a majority of states, the materiality requirement is satisfied if the condition misrepresented is material to the risk assumed, even if loss sustained was unrelated to that condition. In other words, if an applicant fails to disclose a heart murmur, that misrepresentation is material even if the applicant never makes a claim for medical benefits relating to the heart condition. Although the misrepresentation was not material to the loss, it was material to the risk assumed by the insurer when it

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<sup>2</sup> See *id.*

<sup>3</sup> Formerly Insurance Code Article 21-16.

<sup>4</sup> Texas Insurance Code §705.004; similarly, section 705.051 provides: “A misrepresentation in an application for a life, accident, or health insurance policy does not defeat recovery under the policy unless the misrepresentation: (1) is of a material fact; and (2) affects the risks assumed.”

agreed to provide the applicant medical coverage.

Even though the Texas Supreme Court clarified its position on this issue almost thirty years ago, where it adopted the majority view, plaintiff's attorneys frequently argue that there must be a causal connection between the fact misrepresented and the loss sustained. Because that argument has some intuitive appeal and is supported by a handful of outdated cases, it is important to review the Supreme Court's landmark decision in *Robinson v. Reliable Life Insurance Co.*<sup>5</sup>

The plaintiff in *Robinson* brought suit against an insurance company that denied him payment on a life insurance policy following the death of his son on the basis that there were false representations in the insurance application.<sup>6</sup> The trial court found that the application contained misrepresentations (including the failure to report that the insured had been hospitalized within the past five years), and that the false statements were material to the risk assumed.<sup>7</sup> The plaintiff appealed, arguing that the false statements were not material to the risk, as a matter of law, because there was no evidence demonstrating that the facts misrepresented caused the boy's death.<sup>8</sup>

The plaintiff's argument seemed to be directly contradicted by the statutory definition of materiality found in the predecessor to Section 705.004, which stated that recovery would not be barred by a misrepresentation unless "the matter or thing misrepresented was material to the risk **or** actually contributed to the contingency or event on which said policy became due and payable...."<sup>9</sup> The disjunctive "or" explicitly distinguishes materiality to the risk from

materiality to the loss. However, there was a substantial amount of precedent supporting the plaintiff's reading of the statute. Between 1933 and 1967 no less than four Texas appellate courts held that an insurer may only deny coverage based on a misrepresentation if the fact misrepresented actually contributed to the loss.<sup>10</sup>

Nonetheless, the Court of Appeals rejected the plaintiff's reading of the statute, holding:

We do not consider that these decisions are sound insofar as they seem to hold that a condition existing at the time of the issuance of the policy is not material to the risk unless it actually contributes to the loss. The concept of a condition material to the risk assumed by the insurer is quite distinct from the cause of the loss, as the better reasoned cases in Texas and elsewhere have recognized. Thus, there is a well-defined line of cases supporting the insurer's contention that under [the predecessor to §705.004 of the Insurance Code] the materiality of the risk must be viewed as of the time of the issuance of the policy, rather than at the time the loss occurred, and that the principal inquiry in determining materiality is whether the insurer would have accepted the risk if the true facts had been disclosed.<sup>11</sup>

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<sup>5</sup> 554 S.W.2d 231 (Tex.Civ.App.—Dallas, 1977), *aff'd.*, *Robinson v. Reliable Life Ins. Co.*, 569 S.W.2d 28 (Tex.1978).

<sup>6</sup> *Robinson*, 554 S.W.2d at 232.

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.* at 233.

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<sup>10</sup> *See, e.g.*, *Southern Life & Health Ins. Co. v. Grafton*, 414 S.W.2d 214, 218 (Tex.Civ.App. Tyler 1967, writ ref'd n.r.e); *Trinity Reserve Life Ins. Co. v. Hicks*, 297 S.W.2d 345 (Tex.Civ.App. Dallas 1956, no writ); *National Life & Acc. Ins. Co. v. Dickinson*, 115 S.W.2d 1180, 1183 (Tex.Civ.App.El Paso 1938, writ dism'd); *First Texas Prudential Ins. Co. v. Pipes*, 56 S.W.2d 203, 204 (Tex.Civ.App. El Paso 1933, writ dism'd).

<sup>11</sup> *Robinson*, 554 S.W.2d at 233; *see, e.g.*, *Fidelity Union Fire Ins. Co v. Pruitt*, 23 S.W.2d 681 (Tex.Comm'n App. 1930); *Jackson v.*

The Supreme Court affirmed on appeal, concluding, in a brief opinion, that because the word “or” should not be read as conjunctive, “materiality to the risk must be viewed as of the time of the issuance of the policy, rather than at the time the loss occurred.”<sup>12</sup>

As a result, in Texas, a misrepresentation does not have to be material to the loss in order to satisfy the materiality requirement. However, the Supreme Court’s decision in *Robinson* raises additional questions about materiality. For instance, although it is clear that materiality must be “viewed as of the time of the issuance of the policy,” that principle does not clarify what impact the misrepresented fact must have had on the underwriting decision to be considered material. Clearly, if a specific misrepresented fact would have led an insurer to reject coverage altogether, there is strong case to be made that the misrepresentation would be considered material. However, what if the misrepresented fact merely would have caused the insurer to charge the applicant a higher premium, had it been disclosed on the application?

***(ii) What Facts Are Material to the Risk?***

Unfortunately, the Texas Supreme Court has given very little guidance on an issue that frequently arises in the context of misrepresentation cases: whether the materiality requirement is satisfied if the fact misrepresented would have influenced the premiums paid, but would not have precluded issuance of the policy. To make matters worse, the appellate courts that have

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National Life and Accident Ins. Co., 161 S.W.2d 536, 537-38 (Tex.Civ.App. Dallas 1942, writ ref’d w.o.m.); Aetna Life Insurance Co. v. Shipley, 134 S.W.2d 342, 347 (Tex.Civ.App. Fort Worth 1939, writ dism’d); Indiana and Ohio Live Stock Ins. Co. v. Smith, 157 S.W. 755, 756 (Tex.Civ.App. Austin, 1913, writ ref’d); Bettes v. Stonewall Ins. Co., 480 F.2d 92, 95 (5<sup>th</sup> Cir. 1973).

<sup>12</sup> Robinson, 569 S.W.2d at 30.

addressed the issue have reached conflicting results.

In cases dating back to 1915, a number of courts have followed the proposition that “the test of materiality is...whether knowledge of the true facts would have influenced a prudent insurer in determining whether to accept the risk, **or in fixing the amount of premiums.**”<sup>13</sup> More recently, however, Texas Appellate courts have rejected that rule and held that an undisclosed fact that would have simply influenced the premiums paid would not be material to the risk.

In 1972, the Waco Court of Appeals explicitly addressed this question in *Harrington v. Aetna Casualty and Surety Company*.<sup>14</sup> The insured in *Harrington* was denied coverage under an automobile insurance policy on the basis that he misrepresented material facts on his application.<sup>15</sup> Specifically, the insured represented that his car would not be used for business, when in fact it was used primarily for that purpose.<sup>16</sup> The insurance company argued that it would not have issued the policy “at the stated premium,” had it known about the facts misrepresented at the time of issuance.<sup>17</sup> The Court, however, rejected the insurer’s argument:

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<sup>13</sup> Odom v. Insurance Company of the State of Pennsylvania, 441 S.W.2d 584, 587 (Tex.Civ.App.—Austin, 1969); *see also*, St. Paul Fire & Marine Ins. Co. v. Huff 172 S.W. 755, 756 (Tex.Civ.App.—Texarkana, 1915); Gorman v. Jefferson Standard Life Ins. Co. 275 S.W. 248, 251 (Tex.Civ.App., 1925); Ohio Casualty Ins. Co. v. Stewart, 76 S.W.2d 873, 877 (Tex.Civ.App., 1934, writ dism.); Crowder v. National Life & Accident Ins. Co. 90 S.W.2d 267, 270 (Tex.Civ.App., 1936, writ dism.); Inter-Ocean Insurance Company v. Ross, 315 S.W.2d 71, 73 (Tex.Civ.App., 1958, no writ hist.).

<sup>14</sup> 489 S.W.2d 171 (Tex.Civ.App.—Waco, 1972).

<sup>15</sup> *Id.* at 174.

<sup>16</sup> *Id.*

<sup>17</sup> *Id.* at 175.

Aetna says that, within the meaning of [the predecessor to §705.004 of the Insurance Code], a misrepresentation in an application for insurance is ‘material to the risk’ if, had the true facts been known, the insurer would have charged a higher premium for the policy issued. There is dicta in a number of cases which supports Aetna’s position; but we believe the rule to be that the misrepresentation is not ‘material to the risk,’ as that phrase is used in the statute, unless it actually induced the insurance company to assume the risk. We therefore sustain plaintiff’s 17<sup>th</sup> point of error and hold that, under the record, there is no evidence to support the court’s finding that Harrington’s misrepresentation was material.<sup>18</sup>

Remarkably, the validity of the Waco Court of Appeals’ decision in *Harrington* has not been thoroughly examined by the Texas Supreme Court or the Texas appellate courts. *Harrington* was followed by the Western District of Texas, in *Bundick v. National Life and Accident Insurance Company*,<sup>19</sup> however, the *Bundick* court’s decision does not address the conflict in the law. Instead, in a brief opinion denying a motion for new trial, the Court cited *Harrington* and held that the following jury instruction comports with Texas law:

A misrepresentation in an application for insurance is not material to the risk simply because, had the true facts been known, the insurer would have charged a higher premium for the policy issued.<sup>20</sup>

Similarly, in *Horne v. Charter National Insurance*,<sup>21</sup> the Fort Worth Court of Appeals overturned the trial court’s ruling that a misrepresentation was material to the risk as a matter of law because the evidence merely showed that the insurer would have charged a higher premium had it known the facts misrepresented.<sup>22</sup> Although the Court referenced *Harrington* in its opinion, the Court’s ruling was primarily based on its observation that, pursuant to the Insurance Code, materiality is a question of fact.<sup>23</sup> Thus, the Court’s statements regarding the scope and applicability of *Harrington* are merely dicta. *Horne* does, however, highlight an important issue to keep in mind in misrepresentation cases: the Insurance Code explicitly states that materiality is a question of fact. As a result, it is extremely difficult to establish the misrepresentation defense as a matter of law through a dispositive motion. Barring extraordinary circumstances, an insurer must submit issues relating to materiality to the trier of fact.

Ultimately, the conflict among Texas on this issue has not yet been resolved. Given that the more recent opinions indicate that a misrepresentation is not material unless the undisclosed fact would have led the insurer to refuse coverage entirely, it would be prudent to process claims in accordance with their rulings.

#### **B. The “Intent to Deceive” Requirement**

Another aspect of the misrepresentation defense that is frequently litigated is the “intent to deceive” requirement. When faced with irrefutable evidence of their misrepresentation, plaintiffs will inevitably argue that it was inadvertent. Due to the inherent difficulty in assessing the subjective mental state of the insured, insurers frequently have a difficult

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<sup>18</sup> *Id.* at 177-178 (internal quotations omitted).

<sup>19</sup> 509 F.Supp. 584, 585 (W.D.Tex. 1980)

<sup>20</sup> *Id.*

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<sup>21</sup> 614 S.W.2d 182 (Tex.Civ.App.—Ft. Worth, 1981)

<sup>22</sup> *Id.* at 185.

<sup>23</sup> *Id.*

time establishing this element of the misrepresentation defense. As a result, insurers have often taken the position that the intent to deceive can be established as a matter of law, at least where the misrepresentations are particularly egregious. In support of that argument, insurers have traditionally cited the Texas Supreme Court's decisions in *Odom v. Insurance Company of the State of Pennsylvania*<sup>24</sup> and *Mayes v. Massachusetts Life Ins. Co.*<sup>25</sup>

In *Mayes*, an insurer brought a declaratory action seeking to rescind two life insurance policies based on material misrepresentations in the insured's application.<sup>26</sup> Although the jury found that the misrepresentations were material to the risk and relied on by the insurer, the jury concluded that the misrepresentations were not made with the intent to deceive.<sup>27</sup> The insurer argued that the intent to deceive was established as a matter of law.<sup>28</sup> The Supreme Court disagreed, arguing that facts of the case lent support to the beneficiary's contention that the misrepresentation was inadvertent.<sup>29</sup> Thus, the Supreme Court concluded its holding with the following cryptic statement, which seems to imply that fraudulent intent can, in some circumstances, be established as a matter of law:

We cannot say from this record that fraudulent intent was established as a matter of law.<sup>30</sup>

The Supreme Court's ruling in *Odom* also lends some support to the argument that the intent to deceive can be

established as a matter of law. The Supreme Court's strong, somewhat sarcastic, tone in the following passage from *Odom* is frequently referenced on this point:

While subjective evidence of the state of mind of [the insured] when he made application for this insurance is now impossible to obtain it is inconceivable that he did not know the falsity of the answers given by him to the questions shown above. If he was a normal human being, and there is no evidence that he was not, he could not have failed to remember that he was involved in two accidents and that he had been convicted of seven moving violations within the past thirty six months. Such answers were, therefore, knowingly false as a matter of law.<sup>31</sup>

Relying on *Mayes* and *Odom*, among other cases, insurers have frequently argued that fraudulent intent can be established as a matter of law. Although this reading of *Mayes* was supported by the Fifth Circuit Court of Appeals in *Lee v. Nat'l Life Assurance Co. of Canada*,<sup>32</sup> various Texas Courts of Appeal have held reach the opposite conclusion, holding that the intent to deceive cannot be established as a matter of law.<sup>33</sup> For instance, in *Cartusciello v. Allied Life Insurance Company of Texas*, the Houston Court of Appeals overturned summary judgment that was granted in favor of an insurer on the basis of misrepresentation, concluding that

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<sup>31</sup> *Odom*, 441 S.W.2d at 587.

<sup>32</sup> 635 F.2d 516, 517 (5<sup>th</sup> Cir. 1981).

<sup>33</sup> See, e.g., *Estate of Diggs v. Enterprise Life Ins. Co.*, 646 S.W.2d 573 (Tex.App.—Houston [1<sup>st</sup> Dist.] 1982, writ ref'd n.r.e.); *Flowers v. United Insurance Co. of America*, 807 S.W.2d 783, 786 (Tex.App.Houston [14<sup>th</sup> Dist.] 1991, no writ); *Cartusciello v. Allied Life Ins. Co. of Tex.*, 661 S.W.2d 285 (Tex.App.—Houston [1<sup>st</sup> Dist.] 1983, no writ); *Garcia v. John Hancock Variable Life Ins. Co.*, 859 S.W.2d 427 (Tex.App.—San Antonio 1993, writ denied).

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<sup>24</sup> *Odom v. Ins. Co. of the State of Penn.*, 441 S.W.2d 584 (Tex.Civ.App.—Austin 1969), aff'd, 45 S.W.2d 195 (Tex.1970).

<sup>25</sup> *Mayes v. Mass. Mut. Life Ins. Co.*, 608 S.W.2d 612 (Tex.1980).

<sup>26</sup> *Id.* at 614.

<sup>27</sup> *Id.* at 615.

<sup>28</sup> *Id.* at 616.

<sup>29</sup> *Id.*

<sup>30</sup> *Id.* at 617.

“intent to deceive or induce the issuance of an insurance policy can never be proved as a matter of law to establish the defense of misrepresentation.”<sup>34</sup>

In August of 2006, the Southern District of Texas cast even more doubt on the Fifth Circuit’s interpretation of *Mayes* in *Kirk v. Kemper Investors Life Insurance Company*,<sup>35</sup> In *Kirk*, another archetypal misrepresentation case where it was eventually discovered that the insured did not disclose all of her health conditions on her application for insurance, the Southern District provided an extensive analysis of the intent to deceive requirement and ultimately concluded that fraudulent intent cannot be established as a matter of law.<sup>36</sup> In doing so, the Southern District distinguished *Odom* on the basis that “*Odom* concerned violations of warranties rather than misrepresentations, and...involved strong evidence of collusion between the insured and the insurer’s agent.”<sup>37</sup> The *Kirk* court was also heavily influenced by the weight of Texas authority rejecting the Fifth Circuit’s interpretation of *Mayes*.<sup>38</sup> Ultimately, the court held that

[U]nder Texas law, an insured’s intent to deceive may not be proved by summary judgment evidence of the insured’s knowledge of their actual health condition or of even substantial disparity between the representations made on the insurance application and the insured’s knowledge.<sup>39</sup>

Thus, insurers should keep in mind that the argument that fraudulent intent can

be established as a matter of law is growing more and more difficult to make.

### III. BAD FAITH CLAIMS & ESTABLISHING A REASONABLE BASIS FOR DENIAL

The defense that applies to bad faith claims and claims brought under the Texas Insurance Code or the Deceptive Trade Practices Act is quite different from the misrepresentation defense that applies to breach of contract claims. As noted above, the misrepresentation defense is fairly difficult to establish, given the nebulous concepts of “materiality” and “intent to deceive,” and is all but impossible to establish on summary judgment. However, insurers are not required to prove the elements of the misrepresentation defense in response to bad faith, DTPA, or Insurance Code claims. Such claims are based on the insured’s alleged breach of its duty to “deal fairly and in good faith with their insureds,” which “emanates not from the terms of the insurance contract, but from an obligation imposed in law as a result of a special relationship between the parties governed or created by a contract.”<sup>40</sup>

When a court evaluates the scope of that duty, it holds an insurer “to that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business.”<sup>41</sup> As a result, in order to maintain a claim for bad faith against an insurer, an insured must prove:

- (1) that there was no reasonable basis for denying or delaying payment of the benefits of the policy and;

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<sup>34</sup> *Cartusciello*, 661 S.W.2d at 288.

<sup>35</sup> *Kirk v. Kemper Investors Life Insurance Company*, 448 F.Supp.2d 828 (S.D.Tex. 2006).

<sup>36</sup> *Id.* at 836-837,

<sup>37</sup> *Id.* at 836.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

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<sup>40</sup> *Bates v. National Life Ins. Co.*, 927 F.Supp. 1015, 1021 (S.D.Tex. 1996); *see also* *Republic Ins. Co v. Stoker*, 903 S.W.2d 338, 340 (Tex.1995).

<sup>41</sup> *Id.* at 1021.

- (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.<sup>42</sup>

In other words, the insured “must show either that the insurer had no reasonable basis for denying the claim or that the insurer failed to determine whether there was a reasonable basis for denying the claim.”<sup>43</sup>

In *Bates v. Jackson National Life Insurance Company*,<sup>44</sup> the Southern District of Texas examined this standard in detail, concluding that the first element “assures that a carrier will not be subject to liability for an erroneous denial of a claim as long as the reasonable basis for the denial of the claim exists.”<sup>45</sup> The Court noted that the second element, which is focused on what steps the insurer must take to investigate the claims, can only be met “by establishing that the carrier actually knew there was no reasonable basis to deny the claim..., or by establishing that the carrier, based on its duty to investigate, should have known that there was no reasonable basis for denial or delay.”<sup>46</sup>

The *Bates* court also highlighted the distinction between the misrepresentation defense and the defense applicable to bad faith claims:

Coverage is not the issue in a bad faith claim; rather, the focus is on the reasonableness of the insurer’s

conduct in rejecting the claim. It is not enough for the insured to show that the insurer should have known to pay the claim, or that there were other facts suggesting that the claim was valid. The insured must show that no reasonable basis existed for denying the claim. If the insured cannot prove the absence of a reasonable basis, the insurer is entitled to judgment on the bad faith claims as a matter of law.<sup>47</sup>

Thus, it is critical to recognize that, in a misrepresentation case, when an insurer is sued for bad faith stemming from the denial of a claim, the insurer does not need to prove that the misrepresentation was material and made with the intent to deceive. Those issues strictly relate to the insured’s claim for breach of contract. The defense applicable to bad faith claims is much broader, and, as the *Kirk* Court emphasized, can be established as a matter of law.

Moreover, the same defense is applicable to any derivative benefit denial claims brought under the Texas Insurance Code or the Deceptive Trade Practices Act. As the Southern District noted:

The Texas Insurance Code...is essentially a statutory codification of the already existing common law requirements. The breach of an insurance contract does not automatically give rise to liability under the Insurance Code. Rather, the ‘reasonableness’ requirements of common law good faith apply equally in the statutory context. Hence, in order to establish a statutory violation under the Insurance Code, the same elements necessary to establish an insurer’s breach of the common law duty of

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<sup>42</sup> *Id. see also*, *Transportation Ins. Co. v. Moriel*, 879 S.W.2d 10, 18 (Tex. 1994); *Standard Fire Ins. Co. v. Rominger*, 827 F.Supp. 1277 (S.D.Tex. 1993); *State Farm Lloyds, Inc. v. Polasek*, 847 S.W.2d 279 (Tex.App—San Antonio 1992, writ denied).

<sup>43</sup> *Id.*

<sup>44</sup> 927 F.Supp. 1015 (S.D.Tex. 1996).

<sup>45</sup> *Id.* at 1022.

<sup>46</sup> *Id.* (citing *Rominger*, 827 F.Supp. at 1278).

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<sup>47</sup> *Id.*

good faith and fair dealing must be proven.<sup>48</sup>

As a result, when misrepresentations result in the denial of coverage under an insurance policy, and the insured brings multiple claims against the insurer for failing to make proper payment, the parties should assess the viability of any bad faith and statutory claims apart from the breach of contract claim relating to the same set of facts. Under Texas law, the insured's available defenses can differ dramatically.

#### **IV. IMPROPER JOINDER & REMOVAL ISSUES**

After a wrongful denial of benefits lawsuit has been filed, out of state insurers must make a threshold determination about whether the case should be removed to federal court. When the insurance company is the only defendant in the lawsuit, the removal analysis is relatively straightforward: if the parties are diverse and there is more than \$75,000 in controversy, the case may be removed to federal court.<sup>49</sup>

More complicated questions arise when the plaintiff not only brings suit against their insurer, but also against the insurance agent who sold them the policy. When the local insurance agent resides in the same state as the plaintiff (i.e., is "nondiverse"), many insurers simply assume that diversity has been destroyed and the lawsuit cannot be removed to federal court. However, when a plaintiff joins an insurance agent in a wrongful denial of benefits case without advancing any specific allegations against them, it is possible that the insurance agent has been improperly joined as a defendant.

The doctrine of improper joinder permits a defendant to remove a case to federal court by establishing either "(1) actual fraud in the pleading of jurisdictional facts, or (2) inability of the plaintiff to

establish a cause of action against the non-diverse party in state court."<sup>50</sup>

Applying this standard, the Fifth Circuit has routinely rejected attempts to improperly join insurance agents in lawsuits that involve benefit denial claims against an insurer. The Fifth Circuit's opinion in *Griggs v. State Farm Lloyds* is instructive.<sup>51</sup> In *Griggs*, an insured brought suit against his homeowner's insurer for denying his claim for burglary-related losses.<sup>52</sup> The insured also sued the agent who sold him the policy, but made no specific allegations against the agent and merely alleged that "the Defendants" violated, *inter alia*, Article 21.21 of the Texas Insurance Code and the DTPA.<sup>53</sup> The insurer removed, arguing that the agent had been improperly joined. The District court agreed and denied the motion to remand.

On appeal, the Fifth Circuit affirmed, rejecting the plaintiff's argument that he successfully pleaded a viable cause of action against the agent because an agent *could* be held liable under Article 21.21 and the DTPA for making misrepresentations. The Court reasoned:

Griggs argues that the mere possibility that such a claim can be stated requires the conclusion that he has stated a valid claim in this case. We disagree...we have never held that a particular plaintiff might possibly establish liability by the mere hypothetical possibility that such an action could exist. To the contrary, whether the plaintiff has stated a valid cause of action depends upon and is tied to the factual fit between the plaintiffs'

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<sup>48</sup> *Id.* at 1026.

<sup>49</sup> 28 U.S.C. 1332(a)

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<sup>50</sup> *Smallwood v. Ill. Cent. R.R. Co.*, 385 F.3d 568, 573 (5<sup>th</sup> Cir. 2004) (en banc).

<sup>51</sup> *Griggs v. State Farm Lloyds*, 181 F.3d 694 (5<sup>th</sup> Cir. 1999), attached hereto as Exhibit C.

<sup>52</sup> *Id.* at 695.

<sup>53</sup> *Id.* at 699.

allegations and the pleaded theory of recovery.<sup>54</sup>

The Court also rejected the plaintiff's contention that his causes of action against the agent were viable because Texas law merely requires notice pleading.<sup>55</sup> The Court explained that the plaintiff's petition "allege[d] no actionable facts specific to [the agent]" and emphasized that, as in the instant case, "the only factual allegation even mentioning [the agent] merely states that 'Defendants, through its local agent, Lark Blum issued an insurance policy.'"<sup>56</sup> Thus, the Court concluded that the plaintiff had not alleged "any specific actionable conduct" against the agent, even under the liberalized pleading standards in the Texas Rules of Civil Procedure.<sup>57</sup>

Relying on the principles established in *Griggs*, district courts within the Fifth Circuit also have frequently held that vaguely pleaded allegations against all "Defendants" cannot defeat diversity, particularly in the context of insurance litigation. In 2005, the Western District of Texas issued two opinions - *Flanders v. Fortis Insurance Company*, and *Johnson-Ramirez v. Araiza et al.* - that applied the doctrine of improper joinder to claims against insurance agents.<sup>58</sup> In each case, the plaintiff brought factually unsupported claims against insurance agents alongside their benefit denial claims against the insurer and the insurer removed, arguing that the agents were improperly joined.<sup>59</sup> And in each case, the District Court (District Judges Furgeson and Rodriguez, respectively) denied remand, concluding that the plaintiff

had not stated a valid cause of action against the agent.<sup>60</sup>

Similarly, in July of 2006, the Southern District of Texas denied a motion to remand in an insurance dispute after concluding that insurance agents had been improperly joined.<sup>61</sup> The plaintiff in that case, like the plaintiff in *Griggs*, argued that he had stated a valid claim against the non-diverse insurance agents because agents can, in theory, be held liable under the Texas Insurance Code and the Deceptive Trade Practices Act.<sup>62</sup> The Court rejected those arguments, holding that because the plaintiff failed to provide factual support for his claims against the agents and merely pleaded them against "the defendants," the agents were improperly joined, and removal was appropriate.<sup>63</sup>

A few months ago, the Southern District of Texas issued an almost identical opinion on strikingly similar facts. In *Hajdik v. Fortis Insurance*, the plaintiff brought suit against the defendant for rescinding his policy.<sup>64</sup> He also joined the insurance agent, alleging violations of the DTPA and the Texas Insurance Code.<sup>65</sup> However, the plaintiff brought no specific factual allegations against the agent and merely pled his claims against all "Defendants."<sup>66</sup> Citing Fifth Circuit precedent, the Court held that such general allegations did not establish proper joinder.<sup>67</sup> The Court explained:

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<sup>60</sup> *Id.*

<sup>61</sup> *Druker v. Fortis Health*, No. 06-00052 (S.D.Tex., July 17, 2006), attached hereto as Exhibit G.

<sup>62</sup> *Id.*

<sup>63</sup> *Id.*

<sup>64</sup> *Hajdik v. Fortis Insurance*, No. 06-2348 (S.D.Tex. Jan. 11, 2007), attached hereto as Exhibit H.

<sup>65</sup> *Id.* at 2.

<sup>66</sup> *Id.* at 3.

<sup>67</sup> *Id.*

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<sup>54</sup> *Id.* at 701.

<sup>55</sup> *Id.* at 699.

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Flanders v. Fortis Insurance Company*, No. 05-0726 (W.D.Tex., Nov. 14, 2005), attached hereto as Exhibit E; and *Johnson-Ramirez v. Araiza et al.*, No. 05-0990 (W.D.Tex. Nov. 15, 2005), attached hereto as Exhibit F.

<sup>59</sup> *Id.*

Plaintiff argues that his Original Petition...states cognizable claims against Ms. Skolaut for violations of the DTPA and Texas Insurance Code. The Original Petition, however, references wrongdoing committed only by the “Defendants,” without specifying what role Ms. Skolaut played in the alleged wrongdoing other than selling the health insurance policy to Mr. Hajdik. **When there are no specific factual allegations made against the insurance agent, the Fifth Circuit has held that general allegations about the wrongdoing of “the Defendants” do not state a cause of action against the agent.**<sup>68</sup>

As a result, it is important for multi-state insurers to remember that, in the Fifth Circuit, the standard for improper joinder is clear: a plaintiff cannot defeat diversity by asserting unsupported causes of action against multiple “defendants,” even though there is a “hypothetical possibility” that such causes of action could exist.<sup>69</sup>

## V. CONCLUSION

Rescinding or denying payment on an insurance policy due to material misrepresentations made by the insured raises a host of difficult questions. When misrepresentations are discovered, it is critical for insurers to consider, among other things, the scope of their potential defenses should the denial of benefits lead to litigation. As emphasized above, the misrepresentation defense is relatively difficult to establish. However, the defense applicable to bad faith claims and statutory claims is much broader than the defense applicable to breach of contract claims. Thus, it is important to recognize that the viability of an insured’s breach of contract claim, and the potential exposure related to that claim, should be analyzed separately

from the viability of an insured’s remaining claims.

Moreover, once a lawsuit has been filed, insurers who are diverse from the plaintiff should keep in mind that the joinder of an insurance agent does not necessarily preclude removal to federal court. In the last two years, there has been a spate of opinions rejecting attempts to defeat diversity jurisdiction by the joinder of a nondiverse insurance agent. Ultimately, insurers should only make a decision about removal after carefully analyzing the claims pleaded against each party.

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<sup>68</sup> *Id.* (emphasis added)

<sup>69</sup> Griggs, 181 F.3d at 701.