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No. 14-0721

IN THE SUPREME COURT OF TEXAS

USAA TEXAS LLOYDS COMPANY,
Petitioner,

v.

GAIL MENCHACA,
Respondent.

On Petition for Review form the Thirteenth Court of Appeals,
Case No. 13-13-00046-CV

BRIEF OF UNITED POLICYHOLDERS AS AMICUS CURIAE IN SUPPORT OF RESPONDENT GAIL MENCHACA

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United Policyholders ("UP") respectfully submits this brief as *amicus curiae* in support of Plaintiff-Respondent Gail Menchaca ("Menchaca"). The Defendant-Petitioner is USAA Texas Lloyds Company ("USAA"). No person other than the *amicus curiae*, its members, or its counsel made a monetary contribution intended to fund its preparation or submission.

STATEMENT OF INTEREST OF AMICUS CURIAE

United Policyholders is a non-profit 501(c)(3) organization founded in California in 1991 and is a voice and information resource for insurance consumers in all 50 states, whether businesses or individuals. UP is dedicated to educating individuals and businesses about insurance issues and consumer rights. UP protects the interests of policyholders and advocates for them through participation as *amicus curiae* in insurance claim and coverage cases throughout the country. Donations, foundation grants, and volunteer labor support UP's work. UP does not accept funding from insurance companies.

UP's work is divided into three program areas: *Roadmap to Recovery*™ (disaster recovery and claim help for victims of wildfires, *e.g.*, the 2011 Bastrop County Complex Fire), *Roadmap to Preparedness* (insurance and financial literacy and disaster preparedness), and *Advocacy and Action* (advancing pro-consumer laws and public policy). UP hosts a library of tips, sample forms, and articles on commercial and personal lines insurance products, coverage, and the claims

process at www.uphelp.org. Texas home and business owners use UP's "Ask an Expert" forum and disaster recovery resources. UP interfaces with Texas Insurance Commissioner Mattax in proceedings of the National Association of Insurance Commissioners, where UP's Executive Director serves as an official consumer representative of insurance policyholders. UP also works with the Texas Office of Public Insurance Counsel on consumer initiatives.

Through a network of volunteers and advisers throughout the country and a small staff in California, UP offers assistance to state and federal courts as *amicus curiae*. Information and arguments in UP's briefs on issues, including fair claims standards, have been cited by the U.S. Supreme Court as well as by numerous state and federal appellate courts.[1] UP has participated as *amicus curiae* in more than 400 cases throughout the United States involving important insurance issues affecting homeowners and businesses, including a significant number of insurance claim and coverage matters adjudicated in Texas state courts and the United States Court of Appeals for the Fifth Circuit.[2]

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[1] *See, e.g., Humana, Inc. v. Forsyth*, 525 U.S. 299 (1999).

[2] *See, e.g., U.S. Metals, Inc. v. Liberty Mut. Ins. Co.* 490 S.W.3d 20 (Tex. 2016); *In re Universal Underwriters of Tex. Ins. Co.*, 345 S.W.3d 404 (Tex. 2011); *Gilbert Texas Constr., L.P. v. Underwriters at Lloyd's London*, 327 S.W.3d 118 (Tex. 2010); *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Crocker*, 246 S.W.3d 603 (Tex. 2008); *Excess Underwriters at Lloyd's, London v. Franks Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42 (Tex. 2008); *Fairfield Ins. Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653 (Tex. 2008); *Pendergest-Holt v. Certain Underwriters at Lloyd's of London*, 600 F.3d 562 (5th Cir. 2010); *Citigroup Inc. v. Fed. Ins. Co.*, 649 F.3d 367 (5th Cir. 2011); *Advanced Env. Recycling Tech. Inc. v. Am. Int'l Specialty*

In this brief, UP seeks to fulfill the "classic role of *amicus curiae* by assisting in a case of general public interest, supplementing the efforts of counsel, and drawing the court's attention to law that escaped consideration." *Miller-Wohl Co. v. Commissioner of Labor & Indus.*, 694 F.2d 203, 204 (9th Cir. 1982). As commentators have stressed, an *amicus curiae* is often in a superior position to "focus the court's attention on the broad implications of various possible rulings."[3] UP's 25 years of experience working with victims of natural disasters make it uniquely positioned to assist in this case. UP knows all too well that a thorough investigation of a claim can make the difference in whether the insured receives a fair settlement. When an insurer fails to conduct such an investigation, it must be held accountable. This case presents an opportunity to clarify the consequences for failing to abide by Texas's statutory fair claims standards.

Lines Ins. Co., 399 F. App'x 869 (5th Cir. 2010); *Motiva Enters., LLC v. St. Paul Fire & Marine Ins. Co.*, 445 F.3d 381 (5th Cir. 2006).

[3] Robert L. Stern et al., *Supreme Court Practice 570-71* (6th ed. 1986) (quoting Bruce J. Ennis, *Effective Amicus Briefs*, 33 CATH U. L. REV. 603, 608 (1984)).

ISSUES ADDRESSED

In this brief, *amicus curiae* United Policyholders addresses the following issues raised by this appeal:

1. When a jury has found that an insurer has committed an unfair or deceptive act or practice by refusing to pay a claim without conducting a reasonable investigation, can the insured recover damages in the amount of the policy benefits wrongfully withheld?
2. Should this Court reject the "independent injury" rule urged by USAA and its amici given that (1) the rule is contrary to precedent from this Court, (2) the Texas Legislature has refused to adopt the rule, and (3) adopting the rule would be bad policy that would harm insureds and give an additional unfair advantage to insurers?

INTRODUCTION

A battle between an insurance policyholder and its insurer is generally a battle between David and Goliath. This is particularly true when the insured is an individual, but is often true even when the insured is a business. The playing field is skewed even further when the insured has just experienced a horrific event like a tornado, a hurricane, a fire, or a diagnosis of cancer. The time when an insured most needs its benefits is precisely when the insurance company has the most leverage over the insured. An unscrupulous insurer can coerce an insured into accepting less than the insured is entitled to by threatening to deny a claim entirely based on a sloppy investigation or by drawing out the investigation for so long that the insured is forced to accept a pittance.

Both this Court and the Texas Legislature have recognized the unequal nature of the relationship between an insured and its insurer. And both have taken steps to level the playing field. Decades ago, this Court held that a special relationship exists between an insurer and its insured, and also recognized a bad-faith tort in the context of that relationship. The Legislature likewise has imposed statutory duties on insurers. Neither this Court nor the Legislature has adopted the "independent injury" rule that USAA is advocating in this case, and UP – on behalf of Texas policyholders – urges the Court not to do so now. Adopting that rule

would, to a large extent, undo the actions that this Court and the Legislature have taken to mitigate the enormous advantage that an insurer has over its insured.

The potential harm is particularly great where – as here – the "unfair or deceptive act or practice" found by the jury consists of "[r]efusing to pay a claim without conducting a reasonable investigation with respect to [the] claim." That finding necessarily means that at the time the insurer refused to pay the claim, ***the insurer did not know whether it was liable for the claim or not*** because it had not conducted the kind of reasonable investigation that would have revealed that information.

If this Court holds that a policyholder cannot recover damages in the amount of policy benefits where the insurer has refused to pay a claim without conducting a reasonable investigation, then this Court is authorizing insurers to conduct slipshod investigations in the hope that – after a trial on the merits – it will fortuitously turn out that the insurer had a legitimate basis for denying the claim after all. In other words, the Court will be encouraging insurers to roll the dice and deny claims without conducting reasonable investigations because if it happens that there was a legitimate basis for denying the claim, the insurer will not have to pay its insured anything for its unfair and deceptive practice of denying the claim without a reasonable investigation.

But such a result would not be in keeping with either the spirit or the letter of the law. If an insurer is going to deny a claim without conducting a reasonable investigation – which the law declares is an unfair or deceptive act or practice – then the insurer should be liable for policy benefits. After all, from the insurer's perspective, it is a mere fortuity that its refusal to pay turned out to be justified. If an insurer decides to play Russian roulette with the investigative process, it should not be the insured that ends up taking the bullet.

ARGUMENT

I. This Court Has Not Imposed an "Independent Injury" Requirement and Should Not Do So Now.

A. This Court Has Long Recognized the Special Relationship that Exists Between an Insured and its Insurer and the Related Bad-Faith Tort.

This Court first recognized the special relationship between an insured and its insurer nearly 30 years ago in *Arnold v. National County Mutual Fire Insurance. Co.*, 725 S.W.2d 165, 167 (Tex. 1987). There the Court explained that "[i]n the insurance context a special relationship arises out of the parties' unequal bargaining power and the nature of insurance contracts which would allow unscrupulous insurers to take advantage of their insureds' misfortunes in bargaining for settlement or resolution of claims." *Id.* The Court also recognized a bad-faith tort cause of action in the insurance context in *Arnold. Id.*

Texas courts have continued to recognize the bad-faith cause of action over the years. *See, e.g.*, *Rocor Int'l, Inc. v. Nat'l Union Fire Ins. Co.*, 77 S.W.3d 253, 259 (Tex. 2002); *Twin City Fire Ins. Co. v. Davis*, 904 S.W.2d 663, 666 (Tex. 1995); *Vail v. Tex. Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129, 132-35 (Tex. 1988); *Ramirez v. Transcontinental Ins. Co.*, 881 S.W.2d 818, 822-23 (Tex. App. – Houston [14th Dist.] 1994, writ denied). The courts have emphasized the bad-faith tort – based on the insurer's failure to deal fairly and in good faith with its insured – is separate and distinct from the contract claim for the breach of the underlying insurance policy. *See Davis*, 904 S.W.2d at 666; *Ramirez*, 881 S.W.2d at 823.

B. This Court Also Has Recognized Policy Benefits Can Be Actual Damages for the Breach of an Insurer's Duty of Good Faith.

In *Vail*, this Court explained that "an insurer's unfair refusal to pay the insured's claim causes damages as a matter of law in at least the amount of the policy benefits wrongfully withheld." 754 S.W.2d at 136. In other words, the amount of benefits under the policy can also provide the measure of bad-faith tort damages (if causation is established, as the jury found in this case). USAA interprets *Vail* to mean policy benefits can constitute damages for bad faith only if there has been a breach of the underlying insurance policy, but that is not what *Vail* says. When an insurer has refused to pay a claim without a reasonable investigation, its "refusal to pay the insured's claim" is "unfair." And where an insurer withholds benefits without conducting a reasonable investigation, the

benefits are being "wrongfully withheld." Thus, under *Vail*, policy benefits can be damages for an insurer's breach of its duty of good faith.

The Court emphasized this point in *Twin City Fire Insurance Co. v. Davis*, 904 S.W.2d 663 (Tex. 1995). There the Court held that "policy benefits wrongfully withheld [are] indeed actual damages" for an insurer's breach of its duties of fairness and good faith to its insured. *Id.* at 666. Once again, policy benefits are "wrongfully withheld" when they are withheld without a reasonable investigation as well as when they are withheld in violation of the terms of an insurance policy.

C. It Is Vitally Important for this Court to Make Clear that an Insured Can Recover on a Bad-Faith Claim Even if the Only Damages Are Based on Policy Benefits.

At the very least, *Vail* and *Twin City* mean that policy benefits alone can constitute the actual damages necessary to support a bad-faith claim or a claim based on unfair or deceptive acts or practices. In other words, if an insured proves that its insurer violated its duty of good faith or engaged in unfair or deceptive acts or practices, then the insured can recover on those claims – even if the insured did not suffer any "independent injury" separate and apart from the loss of policy benefits. This is an important point because recovery for bad faith or unfair or deceptive acts or practices carries with it the potential for the recovery of exemplary or treble damages, while recovery for the mere breach of an insurance contract does not.

In *United National Insurance Co. v. AMJ Investments, LLC*, 447 S.W.3d 1, 11-12 (Tex. App. – Houston [14th Dist.] 2014, pet. dism'd), the insured obtained favorable jury findings both on its breach of contract claim and on its statutory bad-faith claim, but the jury awarded the same damages for each claim. The insurance company argued that "in the absence of an independent injury, 'judgment cannot be rendered under the Insurance Code ***for amounts owed under the policy.***" *Id.* at 11 (emphasis in original). The Fourteenth Court of Appeals rejected the insurance company's argument, holding that "the absence of an independent injury does not foreclose liability" for statutory bad-faith claims. *Id.*

The court explained, "If a property insurer fails to pay the full amount of the claim as a result of an unfair claim-settlement practice under the Insurance Code, the insured may elect to recover its damages under either a breach-of-contract or a statutory-violation theory." *Id.* At a minimum, this Court should hold that the Fourteenth Court of Appeals got the analysis right in concluding that an insured can recover for bad faith without proving an independent injury.

II. The Legislature Likewise Has Not Imposed an "Independent Injury" Requirement.

A. This Court Should Not Legislate from the Bench by Imposing a Requirement that the Legislature Did Not.

In addition to the common law development of the bad-faith tort, the Texas Legislature also enacted Chapter 541 of the Insurance Code to define and prohibit

specified unfair and deceptive acts and practices. *See* TEX. INS. CODE §541.001. The chapter allows recovery by a "person who sustains actual damages . . . caused by" another person who has engaged in unfair or deceptive acts or practices. TEX. INS. CODE § 541.151. The chapter also defines unfair or deceptive acts or practices to include refusing "to pay a claim without conducting a reasonable investigation with respect to the claim." TEX. INS. CODE § 541.060(a)(7).

Significantly, the statute never says damages are recoverable only if there has been a breach of the underlying insurance contract. Rather, the statute only requires that a person suffer actual damages because of an unfair or deceptive act or practice. Nor does the chapter prohibit the recovery of policy benefits as damages for unfair or deceptive acts or practices. Similarly, the chapter does not impose the "independent injury" requirement that USAA is urging in this case. It would be particularly inappropriate for this Court to impose such a requirement now given the Legislature enacted Chapter 541 against the backdrop of this Court's bad faith law and, like this Court, chose not to impose an "independent injury" requirement.[4]

[4] In addition, during the last legislative session, the insurance industry tried to convince the Texas Legislature to amend Chapter 541 to include the "independent injury" rule, but the Legislature refused to do so. *See* Brief of Amici Curiae, Texas Automobile Dealers Association, Brass Real Estate Funds, Texas Independent Automobile Dealers Association, and Texas Organization of Rural & Community Hospitals, filed with this Court in this proceeding on Sept. 23, 2016, at pages 12-17.

B. Because Plaintiff Menchaca Submitted Her Statutory Bad-Faith Claim in Accordance with the Statute, She Should Be Allowed to Recover on that Claim.

As noted, Section 541.151 of the Insurance Code provides that a "person who sustains actual damages . . . caused by" another can recover for unfair or deceptive acts or practices. TEX. INS. CODE § 541.151. Similarly, Section 541.152 provides for the recovery of "actual damages" by a plaintiff who has prevailed in an action under Section 541.151. TEX. INS. CODE §§ 541.151-152. These are the exact matters inquired about in Questions 2 and 3 of the jury charge. The charge did not limit damages to those that were separate and apart from damages for breach of the insurance policy because the applicable statutes do not contain that limitation. *See* TEX. INS. CODE §§ 541.151-152.

This Court has held that statutory causes of action should be submitted in accordance with the language of the statute. *See, e.g.*, *Felton v. Lovett*, 388 S.W.3d 656, 661 n.18 (Tex. 2012). That is exactly how Plaintiff Menchaca submitted her statutory claims in this case. If this Court were to hold that damages should have been limited to those that represent an "independent injury," then the Court would improperly be engrafting an additional requirement onto the statute.

III. Imposing an "Independent Injury" Requirement Would Be Bad Policy.

A. Imposing an Independent Injury Requirement Would Encourage Insurers to Conduct Shoddy Investigations.

Where a jury has found an insurer "[r]efus[ed] to pay a claim without conducting a reasonable investigation with respect to [the] claim," that necessarily means when the insurer denied the claim, ***the insurer did not know whether it was liable for the claim or not***. Instead of conducting a reasonable investigation to determine whether it should pay, the insurer just refused to pay without conducting a reasonable investigation.

If this Court holds that a policyholder cannot recover damages in the amount of policy benefits under those circumstances, then insurers will have an incentive to roll the dice instead of fulfilling their duty to investigate fully and fairly. After all, if it fortuitously turns out there was a legitimate basis for denying the claim, then the insurer will not have to pay the claim and also will not have to pay anything for its unfair and deceptive practice of denying the claim without conducting a reasonable investigation.

But insureds deserve better than that. Statutory and common law both provide that insureds are entitled to a reasonable investigation at the outset ***before*** the claim is denied. And if the insurer does not provide a reasonable investigation, then recoverable damages should include policy benefits. Any other ruling would encourage slipshod investigations by insurers.

B. An Independent Injury Requirement Would, in Effect, Wrongly Force Insureds to Bear the Cost of Investigation.

Under Texas law, insurers have a "duty to investigate claims thoroughly and in good faith." *Viles v. Sec. Nat'l Ins. Co.*, 788 S.W.2d 566, 568 (Tex. 1990). However, if, as discussed above, an insurer has an incentive ***not*** to investigate, then the insured's right to a thorough and fair investigation loses meaning. Where an insured is forced to take a case all the way to trial for a fair determination of whether its claim should be paid, then the insured has, in effect, wrongly been forced to bear the cost of the investigation that the insurer should have done in the first place.

The potential impact of such a situation is enormous. An insured suffering from a catastrophic loss already may be struggling to survive. Being forced to take a case to trial because the insurer refused to perform a reasonable investigation could well lead to the insured's demise.

C. An Independent Injury Requirement Would Be Contrary to the Goal of Leveling the Playing Field for Insureds.

At the heart of this Court's bad-faith jurisprudence is the goal of leveling the playing field for insureds when they are in disputes with insurers. As this Court explained in *Arnold*, without the risk of liability for bad faith, the parties' unequal bargaining power enables insurers to conduct subpar investigations and drag out proceedings until the insured is forced to accept a settlement that is far less than the

insured deserves. *See* 725 S.W.2d at 167. The more catastrophic the loss is, the greater the pressure is on the insured to accept an unfair and inadequate settlement.

If policy benefits are not generally available as damages for unfair or deceptive acts or practices, then insurers will have even less incentive to conduct reasonable investigations and treat insureds fairly. For the same reasons this Court originally recognized a bad-faith tort in the insurance context, the Court should refuse to impose an independent injury requirement. Insureds need level playing fields now just as much as they ever have.

D. An Independent Injury Requirement Would Eviscerate Common Law and Statutory Bad-Faith Claims.

On its face, the Insurance Code appears to provide a host of protections for insureds as well as a host of disincentives to prevent insurers from abusing their insureds. For example, Section 541.060 of the Insurance Code prohibits a laundry list of unfair settlement practices, including (among others): (1) misrepresenting a material fact or policy provision relating to coverage; (2) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim when liability has become reasonably clear; (3) failing to promptly provide a reasonable explanation of the basis for the denial of a claim; (4) failing to affirm or deny coverage of a claim within a reasonable time; and (5) refusing to pay a claim without conducting a reasonable investigation of the claim. The penalties for such

unfair practices appear to be stiff: Section 541.152 authorizes treble damages where an insurer has committed an unfair or deceptive act or practice knowingly.

But an independent injury requirement would take away much of what the Insurance Code appears to give. After all, policy benefits are the primary subject of disputes between insurers and insureds. Moreover, since the prohibited conduct all relates to claims under insurance policies and the resolution of those claims, it only makes sense that damages would include policy benefits.

Further, what kinds of damages would be available if this Court adopts USAA's independent injury rule? Mental anguish damages for the torment that an insured endures when his or her insurance company tries to save a buck by dragging out the process for as long as possible – even when the insured has just suffered a horrific loss, is under immense pressure, and is struggling to survive? Maybe, but mental anguish damages are notoriously difficult to prove and subject to extremely strict standards. Other possibilities include matters of limited financial value (such as single digit increases in material or labor costs caused by delays) or of fleeting duration (such as a diminution in value that is cured once repairs are completed, even if delayed). The truth is that the independent injury rule would create an impossible gateway because it would force the insured to prove something that is often unprovable in order to obtain treble damages on something that is often unmeasurable.

In its *amicus curiae* brief, the Chamber of Commerce warns that refusing to apply the independent-injury rule would put ***all*** contracts at risk. The Chamber is wrong. The Chamber treats insurance contracts like any other contracts and treats the relationship between an insured and its insurer like any other contractual relationship. But this Court long ago recognized that the relationship between an insured and its insurer is a special one that imposes special duties on the insurer.

A refusal by this Court to allow insureds to recover meaningful damages for the unfair practices of insurers would make the promise of the unfair practices statutes illusory. Such a refusal would encourage insurers to continue to ride roughshod over their insureds at the time of their greatest need.

E. Insurers Are in the Best Position to Conduct Reasonable Investigations, and It Is Their Duty to Do So.

Insurers are specialists in their industry and have expertise regarding claims and investigations that is far superior to that possessed by their insureds. It goes without saying that the purpose of insurance is to insure. Insurance is a means of risk transference by which a policyholder transfers the risk of loss or the responsibility for certain costs and expenses to an insurance company in exchange for the payment of a premium. *See* Alan I. Widiss, *Insurance Law*, at 11. Individuals and businesses buy insurance to protect themselves from devastating disasters. Liability insurance is purchased by virtually every business organization in the United States.

Insurance comes in the form of an agreement under which the insured gives valuable consideration for protection from and indemnification against loss, damage, injury, or liability. But insurance is about more than just protection. It also buys peace of mind and the expectation that if disaster strikes, the insurer will conduct a fair and thorough investigation and promptly pay the insured what is owed under the policy. That expectation is entirely reasonable given that the insurer owes its insured a duty of good faith and fair dealing under Texas law. It is the very nature of insurance that payment generally should be made without the need for litigation. No one buys insurance with the idea that it will be necessary to sue to get benefits.

A policyholder buys an insurance policy, pays premiums up front, and expects claims to be paid when made. There are, of course, instances when an insurer has the right to deny a claim. But in deciding whether to reject a claim, the insurance company must act in good faith and cannot deny the claim to advance its own selfish interests. *See Arnold*, 725 S.W.2d at 167. Because an "insurance company has exclusive control over the evaluation, processing and denial of claims" (*id.)*; has special expertise in those matters; and owes its insureds a duty of good faith and fair dealing, courts should enforce an insurance company's duty to conduct reasonable investigations before deciding whether to reject claims.

Moreover, courts should not hesitate to award policy-based damages when an insurance company fails to conduct such an investigation.

F. The Availability of Policy-Based Damages Would Discourage Insurers from Using Their Overwhelming Might to Crush Their Own Insureds.

An insurance company is a financial juggernaut with unparalleled resources and specialized expertise in insurance litigation. *See THE FACT BOOK 1998: Property/Casualty Insurance Facts*, 5 Insurance Information Institute (1998). Even 20 years ago, the insurance industry collectively had "responsibility for assets totaling $3.1 trillion," with $802.3 billion of that amount attributable to the "property/casualty segment of the business." *Id. See also* "A World View of Insurance Insolvency Regulation III," H. Subcomm., 103 Cong. (Comm. Print 1994) (describing insurance as "a $2.3 trillion financial industry.") And those figures – as astronomical as they are – undoubtedly have only gotten bigger over the years.

Exploiting the financial vulnerability of policyholders is a lucrative business for insurance companies. To start with, insurance companies earn investment income – a profit – during disputes with policyholders. This result is achieved by continuing to invest the policyholder's premiums and the reserves for as long as a dispute lasts.

In addition, insurance companies are bulk purchasers of legal services and incur proportionately lower litigation costs than their policyholders. While most insureds probably engage in litigation relatively rarely, litigation is the lifeblood of insurance companies. According to the Insurance Environmental Litigation Association, a trade association of major property and casualty insurers, "insurance companies have filed tens of thousands of briefs across the country in a number of courts and in a vast variety of contexts." [5] Many of those briefs were undoubtedly filed in litigation with the insurers' own insureds. As the former president of the Alliance of American Insurers put it, "The liability system is fuel for the insurance engine." Franklin Nutter, *Search for Stability: Industry Must Solve Problems that Undermine a Stable Market*, Bus. Inc., June 17, 1985, at 21).

No truer words were ever spoken. The insurance industry has admitted spending (conservatively) a billion dollars a year fighting their policyholders in court.[6] Claims for more than a million dollars are rarely resolved without a

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[5] *See* Brief and Appendix of Amicus Curiae Insurance Environmental Litigation Association (ILEA) in Support of Continental Insurance Co., Aetna Casualty and Surety Co., and Fireman's Fund Insurance Co. of Newark, N.J., at 25, n.21, *County of Columbia v. Continental Ins. Co.*, 595 N.Y.S.2d 988 (App. Div. 3d Dep't 1993 (No. 65588) (relevant excerpts attached hereto as Exhibit A).

[6] *See* Brief of Amicus Curiae American Ins. Assoc. at 3-4, *Affiliated FM Ins. Co. v. Constitution Reinsurance Corp.*, 626 N.E.2d 878 (Mass. 1994) (No. SJC-06165) (relevant excerpts attached hereto as Exhibit B). *See also* Leslie Schism, *Tight-Fisted Insurers Fight Their Customers to Limit Big Awards*, Wall St. J., 1996, at A1. Further, the $1 billion number includes only the amount that the insurance industry spends on property and casualty insurance litigation. When life and health insurance litigation expenditures are included, "the legal costs of coverage battles with policyholders may far exceed $1 billion." Robert H. Gettlin, *Fighting the Client*, Best's Rev. P/C, Feb. 1997, at 49, 50.

lawsuit.[7] The enormous collective resources and litigation expertise of the insurance industry permit that industry to wage wars of attrition against individual policyholders.[8]

A battle between an insured and its insurer truly is a battle between David and Goliath. There is no way that a policyholder can match the resources of the insurance industry. An insurance company has all the resources that it needs to conduct a reasonable investigation, so when it does not do so, it should pay the price. A policyholder who has been dragged through the litigation process and forced to trial in the absence of a reasonable investigation has lost much of the benefit that it paid its premiums to receive. Where a jury finds that the insurer committed an unfair or deceptive act or practice by refusing to pay a claim without conducting a reasonable investigation, the insured should be fully compensated for its losses, including through damages based on policy benefits wrongfully withheld. That is what this Court correctly held in *Vail* and *Twin City*. There is no reason for this Court to change its holding now and every reason for it not to do so.

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[7] *See* Richard A. Archer, *Preparing for a 'Mega-Loss'*, Bus. Ins., Oct. 10, 1994, at 23. Mr. Archer is the retired deputy chairman of Jardine Insurance Brokers, Inc. *See also* L. Brenner, *The Polluted Open Box*, Corp. Fin., June/July 1995 at 34, 35 ("No matter what the policy language, if there's a significant seven-digit claim, it's not going to be covered [by the policyholder's insurance company]."); Eugene R. Anderson, *et al.*, *Insurance Nullification by Litigation*, Risk Mgmt., Apr. 1994, at 46.

[8] *See* Eugene R. Anderson, *et al.*, *Insurance Nullification by Litigation*, Risk Mgmt., Apr. 1994, at 46; Eugene R. Anderson, *Is Something Wrong with Claims Handling? Plaintiff: Insurers Profit from Delay Litigation*, Claims (Apr. 1995), at 33.

CONCLUSION

For the foregoing reasons, amicus curiae United Policyholders respectfully requests this Court (1) refuse to impose the "independent injury" requirement urged by USAA and its amici, (2) allow damages for unfair or deceptive acts or practices or bad faith torts to be based on wrongfully withheld policy benefits, and (3) affirm the judgment of the Court of Appeals.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the typeface and word-count requirements set forth in the Texas Rules of Appellate Procedure. This brief has been prepared using Microsoft Word in 14-point Times New Roman font for the text and 12-point Times New Roman font for the footnotes. This brief contains 5,155 words, as determined by Microsoft Word's word count feature, excluding those portions of the brief that the Texas Rules of Appellate Procedure allow to be excluded.

/s/ *Marc S. Tabolsky*
Marc Tabolsky

CERTIFICATE OF SERVICE

I certify that a true and correct copy of this brief was served on all counsel of record on October 6, 2016, through the official electronic filing system in compliance with the Texas Rules of Appellate Procedure.

/s/ *Marc S. Tabolsky*
Marc Tabolsky

EXHIBIT A

Supreme Court Of The State Of New York
Appellate Division: Third Department

Third Department Index
No. 65599

THE COUNTY OF COLUMBIA, NEW YORK,

Plaintiff-Appellant,

against

CONTINENTAL INSURANCE COMPANY, AETNA CASUALTY & SURETY COMPANY and FIREMEN'S INSURANCE COMPANY OF NEWARK, N.J.,

Defendants-Appellees.

BRIEF AND APPENDIX OF *AMICUS CURIAE* INSURANCE ENVIRONMENTAL LITIGATION ASSOCIATION IN SUPPORT OF CONTINENTAL INSURANCE COMPANY, AETNA CASUALTY & SURETY COMPANY AND FIREMEN'S INSURANCE COMPANY OF NEWARK, N.J.

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August 24, 1992

INTEREST OF AMICUS CURIAE

The Insurance Environmental Litigation Association ("IELA") is a trade association of major property and casualty insurers. IELA was formed, in part, to appear as amicus curiae in environmentally-related insurance coverage cases and to assist courts in the determination of important insurance coverage questions presented in such litigation. IELA members have entered into insurance contracts in New York and throughout the nation containing provisions similar to those at issue in the instant case. IELA is therefore vitally interested in the judicial interpretation of these coverage provisions.

Because of its members' extensive experience with the interpretation and application of the contract provisions before the Court, IELA has a unique perspective on the issues presented. Drawing on this experience, IELA's brief will show that enforcing the terms of insurance contracts as written is essential to the integrity of the insurance underwriting process and to the promotion of long-term environmental goals.

IELA files this brief on behalf of Allstate Insurance Co., American International Group, Chubb Group of Insurance Companies, CIGNA Property & Casualty Companies, Crum & Forster Corporation, Fireman's Fund Insurance Companies, Hanover Insurance Company, Hartford Insurance Group, Home Insurance Company, Liberty Mutual Insurance Company, Maryland Insurance Group, Prudential Reinsurance Company, Royal Insurance Co., St. Paul Companies, Selective Insurance Group of America, State Farm Fire & Casualty Company, The Travelers Insurance Companies, and United States Fidelity & Guaranty Company. Appellees Aetna Casualty & Surety Co. and Continental Insurance Co. are IELA members; this brief is not submitted on their behalf.

in favor of coverage." Brief of Opposing Amici at 21-23. Aetna, Continental, and Firemen's had *nothing whatsoever* to do with these briefs, nor is there any indication of the factual contexts of these cases or the policy provisions involved.[19] Claiming "judicial estoppel,"[20] Opposing Amici assert that the Insurers should not be allowed to "contradict themselves." Brief of Opposing Amici at 30-33.

The doctrine of judicial estoppel, however, applies only to factual positions. Expressions of opinions and legal conclusions — the type of "pro-coverage" statements alleged here — do not trigger application of the doctrine. *See, e.g., Bates v. Cook, Inc.*, 615 F. Supp. 662, 672 (M.D. Fla. 1984) (judicial estoppel generally does not apply to legal conclusions). Besides, most of these alleged "pro-coverage" statements were made by entities other than Aetna, Continental, and Firemen's. The doctrine of judicial estoppel can apply only to prior statements made by parties, not by nonparties (such as the "insurance industry" continually referred to by Opposing Amici).[21]

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19 Both the County and Opposing Amici argue that, because a drafting committee allegedly did not make certain revisions to a so-called standard policy, the "insurance industry" reached the conclusion that the pollution exclusion does not apply to personal injury coverage. County Brief at 40-41; Brief of Opposing Amici at 12-13. Of course, neither the committee nor the "insurance industry" ever made such an affirmative statement.

20 The doctrine of judicial estoppel does not encompass "widely recognized principles," as Opposing Amici assert. Brief of Opposing Amici at 30. Instead, judicial estoppel is recognized as a "rather vague" doctrine. 1B Moore's Federal Practice, ¶ .405[8] (Bender 1988).

21 Considering that insurance companies have filed tens of thousands of briefs across the country in a number of courts and in a vast variety of contexts, it would not be surprising if Opposing Amici were able to find a few briefs from the "insurance industry" asserting contrary positions to the ones taken here by Aetna, Continental, and Firemen's. This is mere gamesmanship. The purpose of judicial estoppel is to promote "common law views of fair dealing." 18 Wright, Miller & Cooper, *Federal Practice and Procedure*, Jurisdiction 2d § 4477 (1981). In the instant case, there is no indication that Aetna, Continental, and Firemen's have not dealt honestly and fairly with the County.

EXHIBIT B

(4) COPY

Commonwealth of Massachusetts

CLERK'S COPY

Supreme Judicial Court for the Commonwealth

No. SJC-06165

Norfolk County

AFFILIATED FM INSURANCE COMPANY

Plaintiff, Appellant

v.

CONSTITUTION REINSURANCE CORPORATION

Defendant, Appellee

On Appeal From A Judgement Of The Superior Court

BRIEF OF *AMICUS CURIAE* AMERICAN INSURANCE ASSOCIATION

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5/19/95. A True Copy: Attest: Assistant Clerk, pro tem., Supreme Judicial Court for the Commonwealth

INTEREST OF AMICUS CURIAE

The American Insurance Association ("AIA") is a national trade organization representing 252 companies writing property and casualty insurance contracts in every state and jurisdiction of the United States. These companies together write more than $60 billion in combined premiums annually.[1] Together, AIA member companies are affiliated with thousands of independent insurance agents nationwide. A substantial portion of AIA member companies' business is commercial liability insurance. This form of coverage enables American businesses to provide the goods, services, jobs, and investments vital to the country's economic health. In addition, AIA member companies employ more than 145,000 people and contribute $2.2 billion in state taxes and fees (including payroll taxes) to state governments each year.

AIA's purposes include promoting the economic, legislative and public interests of its members and the insurance industry, providing a

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[1] All financial figures are from 1990, the most recent year for which figures are available.

forum for discussion of problems that are of common concern to its members, and serving the public interest through appropriate activities including the promotion of safety and security of persons and property.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

Whether a reinsurer is contractually obliged to pay a proportionate share of the litigation expenses incurred by the reinsured company in opposing an insured's demand for coverage.

STATEMENT OF THE CASE

Amicus incorporates by reference the Statement of the Case set forth in the Brief of the Plaintiff-Appellant Affiliated FM Insurance Company ("Affiliated") on pages 2-4..

STATEMENT OF THE FACTS

Amicus adopts the Statement of Facts set forth on pages 4-9 of Affiliated's brief.

SUMMARY OF ARGUMENT

This case presents a single question: whether a reinsurer is contractually obliged to pay a proportionate share of the litigation expenses incurred by the reinsured company in successfully opposing an insured's demand for coverage? Ignoring the plain language of the applicable agreement, an unbroken line of authority in both this country and Great Britain (including a seminal decision by this Court), the uniform view of treatise writers, and an ancient and heretofore unquestioned practice between and among reinsurers and reinsured, the trial court answered that question in the negative. (Pp. 10-20.)

The Superior Court's conclusions were more than merely erroneous. If permitted to stand, the decision is likely to have staggering consequences for the domestic insurance industry. While the sums at issue in this case are relatively minor, direct (i.e., primary and excess) insurers spend (conservatively) a billion dollars a year in so-called "coverage litigation," typically in the

form of declaratory judgment actions. Permitting reinsurers to escape paying their fair share of these costs confers an unwarranted and historically unprecedented windfall while saddling reinsureds with massive, completely unanticipated costs that inevitably will be borne by policyholders in the form of increased premiums. (Pp. 20-26.)

Such a radical reorientation of the relationship between reinsurers and reinsured has no basis in law. As a result of the historical tradition that reinsurance transactions are a matter of the "utmost good faith between the parties," reinsurance contracts are remarkably short and notably lacking in the legalisms that characterize other complex commercial arrangements. (Pp. 10-12.) Accordingly, from the very advent of reinsurance several centuries ago, dispute resolution has always centered around the guiding principle of "good faith" as informed by the historic customs and traditions of the business. (Pp. 12-13.)