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UPDATE ON EXTRACTRACTUAL CAUSES OF ACTION

I. Introduction

II. First-Party Claims

A. Breach of the Duty of Good Faith and Fair Dealing

1. *Lias v. State Farm Mut. Auto. Ins.*, 45 S.W.3d 330 (Tex. App. – Dallas 2001)

This is a UIM case. Lias, the Plaintiff, was involved in an accident in which he incurred $8,760.64 in medical expenses and $2,700.00 in loss wages. He sued the at fault driver and recovered the $25,000.00 liability policy limits and $2,500.00 in PIP benefits under his own State Farm policy. He then made an underinsured motorist claim on January 26, 1995. On April 19, 1995 he demanded the $25,000.00 UM limit under his policy with State Farm. A couple of months later, State Farm made offers of $1,500.00 and $3,000.00, respectfully, then in August 1995, State Farm sent Lias a check for $11,000.00. Apparently, State Farm was questioning the Plaintiff's disability rating under the AMA guidelines. Lias had apparently provided evidence of a disability rating but State Farm determined that the rating was not calculated in accordance with the AMA guidelines and sought a new rating according to AMA standards.

Lias filed suit for a breach of contract and extra-contractual damages in March 1996. State Farm moved for separate trials on the contract and extra-contractual damages. That motion was granted. When the breach of contract claim was called to trial, Lias non-suited that claim, electing to pursue only his extra-contractual claims. State Farm then filed a "no evidence" motion for summary judgment arguing that it had acted reasonably in contesting the amount of the claim because there were questions about Lias contributory negligence and impairment rating. State Farm also argued that since Lias had non-suited his contract claim, Lias was precluded from making a claim for breach of the duty of good faith and fair dealing. The trial court granted State Farm's Motion for Summary Judgment without specifying the basis.

On appeal, the court first rejected State Farm's argument that summary judgment on the extra-contractual claims was proper because Lias had non-suited his contract claims. The court pointed out that a non-suit of the contract claim was not equivalent to a finding of no breach of contract and that the contract and extra-contractual claims were separate

and independent causes of action. The court noted that Lias still had the opportunity to establish coverage in the trial on the extra-contractual claims. The court then proceeded to address the evidence supporting Lias' claim of breach of the duty of good faith and fair dealing and affirmed the summary judgment for State Farm. The court held that there was a bone fide dispute as to of Lias' disability and, therefore, State Farm did not breach the duty of good faith and fair dealing by only offering $11,000.00 in settlement while Lias was demanding the full $25,000.00 policy limits. The court pointed out that there was no evidence that State Farm had ever evaluated the UIM claim at being worth $25,000.00. Instead, the evidence showed that the highest evaluation that State Farm ever made internally of the claim was that it was worth $11,000 and State Farm had offer that in settlement.

2. *Wellisch v. USAA,* 75 S.W.3d 53 (Tex. App. – San Antonio 2002)

This is a UIM case. Jessica Wellisch was riding as a passenger in a car driven by Salinas. Salinas crashed at over 80 mph killing Salinas and her son and severely injuring Jessica. Jessica eventually died. The Wellisches eventually recovered $1,000,000.00 the liability coverage of Salinas. Wellisch then made a claim on their own UIM coverage which had limits of $300,000.00. On November 25, 1998, USAA denied the claim. The Wellisches filed suit against USSA.

The trial court ordered separate trials on the contract and extra-contractual claims. At the trial on the contract claim, the jury found liability on the part of Salinas and awarded damages of $1,000,000.00. On the same day that the trial court entered judgment on the contract claim, USAA paid the UIM policy limits of $300,000.00. The Wellisches then proceeded to prosecute their extra-contractual claims arguing that USAA had breached the duty of good faith and fair dealing by initially denying their UIM claim. The trial court rendered summary judgment for USAA on the extra-contractual claims. The Wellisches appealed.

In affirming the summary judgment for USAA, after recounting several Texas cases that have so held, the court of appeals held that Texas law is clear that a UIM insurer is not obligated to pay UIM benefits until there has been a settlement with the at fault party or an actual judicial determination on the issue of liability and damages. Thus, the court held an insurer has the right to withhold payment of UIM benefits until the insured has established that they are legally entitled to recover from the at fault party and has established the amount of damages.

Additionally, the court noted that there was no evidence that USSA's alleged failure to properly investigate the claim caused any damages independent of the claim itself. The court noted that the

Plaintiffs' testimony raises the possibility that they sustained mental anguish as a result of the denial of their claim but there was no evidence tying any mental anguish to USAA's alleged failure to properly investigate the claim. Relying on the Texas Supreme Court's opinion in *Castaneda*, the court, therefore, also affirmed the summary judgment on the ground that there was no evidence of any damages as a result of the alleged failure to properly investigate the claim separate and apart from the claim itself.

3. *Mid-Century Ins. Co. v. Boyte,* 80 S.W.3d 546 (Tex. 2002)

This is a UIM case. As stated by the Texas Supreme Court in its "per curium" opinion, the issue in this case was whether an insurer's common law and statutory duties of good faith and fair dealing extend beyond entry of judgment in favor of the insured. The court of appeals held that the duty of good faith and fair dealing did extend beyond the trial court rendition of a money judgment against the insurer. The Texas Supreme Court reversed, holding that under *Stewart Titled v. Aiello*, 941 S.W.2d 68 (Tex. 1997) good faith and fair dealing did not extend beyond entry of judgment against the insurer.

Boyte sustained injuries to his back in an automobile accident in 1992. He settled with the at fault party's insurer for the $100,000.00 liability policy limits and then filed a UIM claim with Mid-Century. Mid-century valued his claim $120,000.00 and accordingly, tendered the $20,000.00 difference in settlement. Boyte, however, contended that his damages exceeded his UIM policy limit of $200,000.00. At the trial of the UIM claim in October 1995, the jury found that Boyte was entitled to the remaining $80,000.00 in policy benefits and rendered judgment accordingly.

After judgment was rendered against Mid-Century in the UIM trial, Boyte informed Mid-Century that he was in urgent need of back surgery but could not afford to pay for it. Mid-Century offered to pay for the surgery and for follow-up therapy up to an amount of $23,400.00 but refused to pay the full $80,000.00 judgment while its appeal was still pending. Boyte never scheduled the surgery. Ultimately, the Court of Appeals affirmed the UIM judgment against Mid-Century for the full $80,000.00. After the Texas Supreme Court denied review in March 1998, Mid-Century then paid the $80,000.00 judgment. Boyte then filed a new suit against Mid-Century alleging extra-contractual claims based on Mid-Century's failure to immediately pay the full $80,000.00 once the trial court has rendered judgment against Mid-Century for that amount.

The Texas Supreme Court rejected Boyte's argument that Mid-Century, by superceding execution on the judgment and refusing the pay it

while its appeals were pending, created a gross disparity in bargaining power that required the continued application of the duty of good faith and fair dealing. The court following *Aeillo* held that the insurer's duty of good faith and fair dealing ends when the only legal relationship between the parties, following entry of judgment, is one of creditor and debtor. Accordingly, an insurer can not be held liable for breaching the duty of good faith and fair dealing simply because it elects to appeal an adverse verdict against it for policy benefits. The insurer is entitled to exhaust all of its appeals without risk of incurring further "bad faith" liability.

4. *Allison v. Fire Ins. Exchange*, 98 S.W.3d 227 (Tex. App. – Austin 2002)

This is now the infamous mold case that resulted in a $30,000,000.00 judgment against Farmers in Travis County. The Court of Appeals held that there was factually sufficient evidence to uphold the jury's findings that Farmers has breached the duty of good faith and fair dealing. The court found no evidence, however, to support the jury's finding that Farmers' breach was committed knowingly and, therefore, the court reversed the awards of punitive damages and mental anguish damages.

The Court of Appeals opinion is factually intensive and provides a good road map for Plaintiffs to use in attempting to identify evidence of the insurer's claims handling practices that will support a finding of breach of the duty of good faith and fair dealing.

The evidence cited by the court as supporting the jury's finding of breach of the duty of good faith and fair dealing included the following:

A. An adjuster misrepresented that a "complete" plumbing test had been performed on the house even though the adjuster secretly thought that there might be other leaks:

B. Even though the adjuster admitted at trial that Farmers had all of the information needed to evaluate the claim by then, the adjuster wrote a letter to Ballard on February 8 asking for a 45 day extension in order to "complete our claim investigation" only to pay the claim then on February 24, 1999 less than three weeks after the letter:

C. Farmers made piecemeal payments for remediation of the mold damage that were insufficient and untimely even though the evidence showed that it had all of the information it needed:

D. Farmers bared its inadequate payments on sham fraudulent bids that Farmers received from contractors who then subsequently refused to perform the work for the amount of the bids:

E. Farmers waited until after mediation had failed to resolve the claim to invoke the appraisal provision of the homeowner's policy.

5. *Fiess v. State Farm Lloyds,* 2003 WL 21659408 (S.D. Tex. 2002)

This case involves a mold claim submitted under a homeowners' policy Magistrate Crone rendered summary judgment for State Farm. This case is interesting only in that Magistrate Crone first determines that the mold claim is not covered by the insurance policy in question but nevertheless proceeds to discuss the Plaintiff's various extra-contractual theories. The lack of coverage for the claim was fatal to all of the extra-contractual theories but the opinion is a good starting point for anyone who wants to read a treatise-like discussion of the current State of Texas law with regard to all extra-contractual theories of recovery.

6. *Vaughan v. Hartford Cas. Ins. Co.,* 2003 WL 21991334 (N.D. Tex. 2003)

This is a federal district court summary judgment opinion by Judge McBride concerning a UIM claim.

The Plaintiff, Vaughan, sustained injuries as a passenger while riding in a vehicle insured by Hartford. Vaughan recovered the limits of the liability of coverage of the at fault driver and, on November 30, 2000, made a claim on the Hartford UIM coverage. Settlement of Vaughan's UIM claim with Hartford took some time because Hartford questioned whether it had all of the applicable medical bills and records. Then Vaughan, through counsel, demanded that Hartford pay the full remaining limits of coverage under its UIM coverage, $825,000.00. Ultimately, however, Vaughan and Hartford agreed to settle Vaughan's UIM claim for $200,000.00. Hartford sent a "full and final release of all claims" form for Vaughan to sign. Vaughan, with the advice of counsel, executed the release but inserted language reserving his extra-contractual claims against Hartford. Upon receipt of the modified release, the Hartford adjuster wrote "void" on each page of the release and sent it back to Vaughan and his counsel. Ultimately, however, Vaughan executed a new release in settlement of his UIM claim. Judge McBride interpreted the scope of the release actually signed as only including Vaughan's contractual claim for UIM benefits. The court determined that the release did not, by its terms, encompass Vaughan's extra-contractual claims, including his claim for the breach of the duty of good faith and fair dealing.

Judge McBride rendered summary judgment for Hartford on the good faith and fair dealing claims, nonetheless, because there was no evidence that Vaughan had sustained any damages as a result of any delay by Hartford in paying the UM claim. Judge McBride notes that Vaughan had not presented any evidence that he had suffered mental anguish as a result of Hartford's handling of the claim. The court held that there was no evidence linking Hartford's alleged and improper handling of the claim to any amount of actual damages over and above the actual claim itself. Accordingly, even if Hartford breached the duty of good faith and fair dealing, there were no damages separate and apart from the claim attributable such breach. Accordingly, the court rendered summary judgment for Hartford.

B. Article 21.21

1. *Wellisch v. USAA,* 75 S.W.3d 53 (Tex. App. – San Antonio 2002)

Plaintiffs alleged that USAA had violated Article 21.21, §4(10)(ii),(iv) and (viii) as well as the DTPA because USAA unreasonably denied their claim because there was no reasonable investigation into the claim. USSA moved for summary judgment on the grounds that the Wellisches did not suffer economic damages as a result of its actions because they ultimately recovered the $300,000.00 UIM policy limits, which were paid by USAA following trial of the negligence/contract claims. The Wellisches contended, however, that they sustained separate damages in the form of mental anguish and that, accordingly, they were entitled to recover the mental anguish under their Article 21.21 claims.

The evidence showed that Mr. Wellisch had been taking medication for panic disorder for about 15 years and that he had sought some counseling for a brief time after his daughter's death. The evidence showed that there was nothing that the dispute with USAA caused him or his wife to be unable to do. He testified that it had been an "extrodinary mental drill" because his family has a contract with USAA that it failed to honor and he testified that he thought USAA considered his daughter's life worthless and that he did not understand what he had ever done to deserve the way he was treated by USAA. He testified that USAA's conduct had caused him a great deal of anguish, pain, confusion, frustration and embarrassment. Ms. Wellisch testified that she was under a doctor's care and had been on medication for depression and anxiety since her daughter's death. She could not, however, separate her physical maladies resulting from Jessica's death from the dispute with USAA. She testified that the dispute with USAA was part of the problem, and that the process of going through the trial against USAA was very draining and emotionally taxing.

The Court of Appeals held that this type of evidence raised the possibility that the Wellisches sustained mental anguish from the initial denial of their claim but not as a result of any allege failure to investigate their claim. Accordingly, there was no fact issue to defeat USAA's entitlement to summary judgment.

2. *Mid-Century Ins. Co. v. Boyte,* 80 S.W.3d 546 (Tex. 2002)

For the same reasons that the court rejected a continuing duty of good faith and fair dealing once the underlying insurance claim has been reduced to judgment, thereby creating a relationship of judgment creditor and judgment debtor, the court also rejected the insured's claims under section 4 of Article 21.21. Noting that the statutory "bad faith" standard of "failing to attempt in good faith to effectuate a prompt, fair and equitable settlement of the claim with respect to which the insured's liability has become reasonably clear" is identical to the common law bad faith standard when the court held that the insurer was entitled to summary judgment on the Article 21.21 claims.

3. *Doctor's Co. v. McDonough,* 2002 WL 2024260 (Tex. App. Houston [1st Dist.] 2002)

This case involves a health insurer's denial of health benefits based on a pre-existing condition exclusion.

The jury found that the claim was covered and not a "pre-existing condition" and awarded $42,380.00 for breach of the insurance contract. The Court of Appeals affirmed the award of policy benefits.

The jury also found that the insurer had violated Article 21.21 and the DTPA by "representing that an agreement confers or involves rights remedies or obligations which it does not have or involved", making or causing to be made any statement misrepresenting the terms benefits or advantages of the insurance policy, misrepresenting to a claimant of a material fact or policy provision relating to the coverage at issue and failing to attempt in good faith to effectuate a prompt fair and equitable settlement of the claim when the insurer's liability has become reasonably clear.

As to the denial of the claim, the Court of Appeals held that the insurer could not be held liable for statutory "bad faith" under Article 21.12 because, even though the court ultimately affirmed the finding of coverage, the insurer had reasonable basis for denying the claim based on some of the Plaintiff's physicians records which indicated that the lump in the Plaintiff's neck may have been there before she applied for the policy.

Accordingly, the court held that the insurer reasonably, albeit incorrectly, concluded that the Plaintiff had received medical advice concerning the cancerous lump in her neck before the policy was issued. According to the court, this case involved nothing more than a "bone fide coverage dispute".

As to the misrepresentation claims under Article 21.21, the Plaintiff pointed to four specifically actionable misrepresentations:

1. The insurer invited the Plaintiff to apply for "valuable coverage" which turned our to be worthless;

2. The definition of pre-existing condition in the policy was vastly different from that in the application;

3. The insurer promised that it would investigate her claim and represented that she had the right to appeal any denial of coverage;

4. The insurer promised that it would have its medical director review the pre-existing condition issue.

The appellate court noted that the third and forth alleged misrepresentation occurred, if at all, only after Plaintiffs sustained her loss or were made during the claim process. Accordingly, they could not be any producing cause of damages.

As to the first and second misrepresentations, the court noted that they were pre-loss representations. The court noted that a policy, however, is not "valueless" simply because it excludes coverage for a particular claim. Further, the alleged disparity between the definition contained in the policy and that as contained in the application did not support any misrepresentation claim. The court noted that the application did not even include a definition of "pre-existing conditions" but simply says that "pre-existing conditions" will be excluded. The court held that the insured got what she had applied for. i.e. a policy that excluded "pre-existing conditions" and as the insured is deemed to know the contents of the policy, she was on notice of how the policy defined "pre-existing condition". Accordingly, the court reversed the verdict to the extent that it was based on violations of Article 21.21.

4. *Allison v. Fire Ins. Exchange*, 98 S.W.3d 227 (Tex. App. – Austin 2002)

The Court of Appeals found, based upon the same evidence discussed above in connection with the good faith and fair dealing cause

of action (see supra), that there was evidence to support the jury's findings that Farmers failed to attempt in good faith to effectuate a prompt, fair and equitable settlement after liability had become reasonably clear in violation of Article 21.21 §4(10)(a)(ii).

5. *Performance Auto. v. Mid-Continent Cas. Co.*, 322 F.3d 847 (5th Cir. 2003)

This case stands for the unremarkable proposition that, having found no coverage for the first-party claim in question, summary judgment was also appropriate on the insured's Article 21.21 claims.

6. *West v. Mendota Ins. Co.*, 2003 WL 21321066 (N.D. Tex. 2003)

This case involves a first-party claim submitted by the insured under his automobile insurance policy. The insurer moved for summary judgment on all claims, including both contract and extra-contractual.

As to the contract claim, Judge Cummings granted the insurer's Motion for Summary Judgment because the evidence showed that the insurer had properly given notice of its intent to cancel the policy for nonpayment of premium and that the insured failed to tender premium owing by the stated date. Accordingly, the court rendered summary judgment that the policy had been validly cancelled prior to the accident in question.

However, the insured also asserted claims under Article 21.21 and the DTPA. Specifically, the insured alleged that on April 17, 2002, he spoke with an employee of the insurer about whether he could pay his overdue premium payment late. The insurer employee allegedly told him he could pay late without disrupting his insurance coverage. Allegedly in reliance on this misrepresentation, accordingly, the insured sent his premium payment in on April 19, 2002 even though the policy had been otherwise cancelled effective April 18, since the insured had not sent his premium payment in by April 18.

Judge Cummings holds that Plaintiff need only show that the Defendant engaged in an unfair insurance practice that was a producing cause of damage and need not show, under the statutory claims, that the person with whom the insured spoke had actual or apparent authority to extend the grace period. Analogizing the representations made about paying the premium late to the representations about coverage there were an issue in *Celtic Life v. Coats* and *Royal Globe v. Bar Consultants*, Judge Cummings held that the Plaintiff had presented sufficient evidence to raise a fact issue concerning whether or not the employees statements were misrepresentation in violation of Article 21.21 and the DTPA.

7. *Fiess v. State Farm Lloyds,* 2003 WL 21659408 (S.N. Tex. 2002)

In this case, as already noted above, the court ultimately held that there was no coverage for the claim under the homeowner's policy in question. Addressing the insured's Article 21.21 and DTPA claims, the court notes that when an insured joins claims under the Texas Insurance Code and DTPA with a bad faith claim, all asserting a wrongful denial of policy benefits, if there is no merit to the bad faith claim there can be no liability on either of the statutory claims. Accordingly, since there was no coverage, which meant there was no viable breach of the good faith and fair dealing claim, there also could be no viable Article 21.21 or DTPA claim based on the insurer's denial of the claim.

8. *Vaughan v. Hartford Cas. Ins. Co.,* 2003 WL 21991334 (N.D. Tex. 2003)

This case, as already noted above, involves a UIM claim. The insured settled and released his claim for actual UIM benefits but Judge McBride, as already noted above, construed the release signed by the insured to not encompass the insured's extra-contractual claims.

In rendering summary judgment for Hartford on the insured's Article 21.21 claim, Judge McBride notes that actual damages are a required element under an Article 21.21 or DTPA claim. Judge McBride then notes that there was no summary judgment evidence that the insured suffered any actual damages beyond those damages that were released by virtue of the release (i.e. the UIM claim itself). Accordingly, since there was no evidence linking Hartford's alleged improper handling of the claim to any amount of actual damages suffered as a result thereof, Judge McBride rendered summary judgment on Hartford on the Article 21.21 and DTPA claims.

C. <u>DTPA</u>

1. *Fiess v. State Farm Lloyds,* 2002 WL 21659408 (S.N. Tex. 2002)

In addition to the other extra-contractual claims already discussed, the insured in this first-party homeowners mold claim case specifically alleged "unconscionability" under the DTPA. Specifically, the insureds argued that State Farm's sale of the policy and failure to compensate them fully for their mold loss was unconscionable. In affect, it appears that the insured argued that it was unconscionable for State Farm to sell a policy that completely excluded all mold related claims.

In rejecting the insureds' arguments, Magistrate Crone held that it was undisputed that the mold exclusion was clearly set forth in the policy and that the insureds admitted at deposition that no one had lied to them about anything in the policy. She further noted that, while State Farm refused to pay the entire mold remediation claim, it did pay in excess of $34,000.00 notwithstanding the presence of the mold exclusion. State Farm viewed some costs as closely related to pre-existing non-flood leaks. Accordingly, there was no basis to conclude that State Farm has taken advantage of the policy holders to the degree that the resulting unfairness was noticeable, flagrant, complete or unmitigated. Thus, absent any evidence of misrepresentation or bad faith, there was no evidence to support a finding of unconscioniability. State Farm's Motion for Summary Judgment was granted.

D. Article 21.55

1. *Lias v. State Farm Mut. Auto. Ins.*, 45 S.W.3d 330 (Tex. App. – Dallas 2001)

This is an uninsured motorist claim case. Lias notified State Farm of his UIM claim on January 26, 1995. Then in April, 1995, Lias demanded the $25,000 UIM limits. State Farm, because it was questioning the extent of Lias' impairment rating, made offers of $1500.00 and $3000.00 at various points in time prior to August, 1995. State Farm requested further information about the insured's impairment rating. State Farm received the information requested on July 19, 1995 and sent Lias a check for $11,000.00 on September 9, 1995, i.e. within the 60 days established by Article 21.55. Accordingly, the court affirmed summary judgment on the Article 21.55 claims because State Farm complied with all applicable time periods.

2. *Allstate Ins. Co. v. Bonner*, 51 S.W.3d 298 (Tex. 2001)

The issue in this case is whether an insurer that did not comply with the claim acknowledgement deadlines of Article 21.55 must pay the insured's attorney fees when the insured is awarded UM benefits that are less than the PIP benefits previously paid by the insurer under the policy. Of course, where the insurer has paid PIP benefits, the amount of PIP benefits must be offset against any subsequent UIM award. The issue restated, is whether an insured is entitled to recover attorney fees for violations of Article 21.55 where the insured would have been entitled to UM benefits but for the PIP benefit offset.

The trial court entered a take nothing judgment against the insured but awarded attorney fees under Article 21.55 because Allstate had not

timely acknowledged the claim. The court of appeals affirmed. The Texas Supreme Court reversed.

Bonner was injured in a car wreck in October 1997. She immediately submitted a claim for PIP benefits along with a medical bill in the amount of $1802.00. Allstate then paid $1619.00 in PIP benefits after reducing the bill somewhat. Bonner then submitted a UM claim on December 11, 1997. Allstate received the claim on December 15, 1997 but did not acknowledge receipt of it until January 16, 1998, i.e. more than 15 days as required by Article 21.55.

The trial court jury found that the uninsured motorist was at fault and awarded $1,000.00 for medical bills but nothing for physical pain and suffering. The jury also awarded $7500.00 for attorney's fees. Because the $1619.00 in PIP benefits exceeded the $1000.00 UM damage award, the trial court rendered judgment that Bonner take nothing declined to award attorney fees and taxed costs against Bonner. The court appeals affirmed the take nothing judgment on the UM benefits but reversed the trial court's denial of attorneys fees and accessed all costs of court for trial and appeal against Allstate.

Allstate argued that the 21.55 should not be construed as imposing a penalty on an insurer for failing to timely acknowledge a claim unless the insurer ultimately is liable for the claim. Allstate relied on *Blizzard v. Nationwide Mutual Fire Insurance Company*, 756 S.W.2d 808 (Tex. App. – Dallas 1998, no writ) which denied attorney fees to an insured who established damages that were less than the total amount the insurer had already paid. Bonner countered that an attorney fee award was proper because she did have a valid claim that required Allstate to follow Article 21.55's acknowledgement procedures and time frames.

Siding with Allstate, the Texas Supreme Court held that Allstate's payment of $1619.00 in PIP benefits was a policy defense to the claim. In other words, Allstate completely defeated Bonner's UM claim under the policy terms. Accordingly, even though Allstate failed to acknowledge the claim within 15 days, Bonner was not entitled to recover attorney fees under Article 21.55.

3. *Wellisch v. USAA,* 75 S.W.3d 53 (Tex. App. – San Antonio 2002)

This is also UIM case. As previously discussed above, USAA did not pay the insured's UIM claim until the conclusion of the trial of the UIM issues. The jury awarded $6,000,000 in wrongful death damages and placed liability on the underinsured motorists. USAA paid the UIM claim up to its policy limits on the same day the trial court entered judgment.

The Court of Appeals cites numerous Texas cases that have held that an insurer is not obligated to pay UIM benefits until the insured becomes legally entitled to those benefits, which generally requires either a settlement with the tortfessor or a judicial determination following trial on the issue of the tortfessor's liability. Accordingly, the Court of Appeals says "an insurer has the right to withhold payment of UIM payments until the insured's legal entitlement is established". Applying these principles to Article 21.55, the court held that USAA's liability on the UIM claim did not arise on the date of the accident which resulted in the death of the Plaintiff's daughter. Instead, USAA's liability arose on the date the trial court entered final judgment following a determination that the uninsured motorist's caused the accident and returned a verdict favorable to the insured in the amount of $6,000,000. Because USAA paid the UM claim on the same day the trial court entered judgment, the court of appeals held that USAA did not violate Article 21.55 and affirmed the trial court's summary judgment in favor of USAA.

4. *Certain Underwriters, et al v. Smith,* 77 S.W.3d 859 (Tex. App. – Houston [14th Dist] 2002)

This case involves a dispute over who the beneficiary of a life insurance policy was when the policy was purchased by national convenience store chain covering its employees in the event that the employees were killed while on the job. Policies were written to pay NCS $250,000 upon the accidental death of any of its employees who were killed during the course and scope of employment. NCS was not a subscriber to worker's compensation.

Following William Smith's death, NCS submitted a claim and received the $250,000 in proceeds. Mr. Smith's widow subsequently learned of the payment and filed suit arguing that NCS did not have an insurable interest in the life of her husband and sought reformation of the policy so that she could be deemed the lawful beneficiary of the policy that she sought damages in the form of the $250,000 proceeds from both NCS and Lloyds of London the carrier.

The Court of Appeals held that the employer had no insurable interest in the life of its employees and that, accordingly, it held the policy proceeds and constructive trust for the wife of the employee. However, the court did not impose liability on Lloyds who, according to the court, discharged its responsibilities by paying the proceeds to the employer.

Smith argued that since the policy had been reformed so that she was the only lawful beneficiary, she was also entitled to Article 21.55 penalties. Rejecting this argument, the Court of Appeals acknowledged that Article 21.55 is to be liberally construed. However, the statute applies

to beneficiaries that are "named in the policy or contract". The court noted that the legislature meant "named" beneficiary and not a lawful, yet unnamed beneficiary. To hold otherwise, according to the court, would create a windfall for beneficiaries that only become known through the process of litigation. Accordingly, the court held that reformation of a policy could not be used to impose liability on a carrier under Article 21.55. The statute only applies to the beneficiary or insured actually named in the policy itself even if the policy is later reformed to change the beneficiary to a lawful beneficiary.

5. *Menix v. Allstate,* 83 S.W.3d 877 (Tex. App. – Eastland 2002)

This is a UIM case. Menix settled her claim for the liability policy limits of the at fault party prior to trial of the UIM case, Allstate and Menix stipulated to the liability of the other driver, the payment of the liability limits and that Allstate has tendered $2,500 in PIP benefits to Menix and would be, therefore, liable for all damages over $22,500 up to $42,500. Menix's UIM policy limits were $20,000. The jury awarded actual damages in the amount of $27,800. Menix requested pre-judgment interest and attorney's fees. Allstate objected. The trial court denied Menix's motion for interest and attorney's fees and entered judgment awarding damages of $27,800 by it allowing a settlement credit of $22,500 for the liability limits and PIP benefits already received. Accordingly, the court entered judgment in favor of Menix for $5300. Allstate promptly tendered the $5300 to Menix when the trial court rendered judgment.

On appeal, Menix argues that Allstate is liable for attorney's fees and penalties under Article 21.55. Relying on *Bonner*, (see discussion above) the court rejected Menix's arguments, holding that until there had been a judicial determination that the other driver was liable and a determination of the total amount of damages sustained, Allstate had no duty to pay any UIM benefits. By tendering payment to Menix immediately after the trial court entered judgment, Allstate complied with Article 21.55.

6. *Ozor v. CNA Ins. Co.,* 2002 WL 31059790 (N.D. Tex. 2002)

This is a life insurance case. The issue presented was what period of limitations applies to a claim for interest and attorney's fees under Article 21.55.

Federal Magistrate Sanderson noted that Article 21.21 §16(d) provides that all actions under that article (i.e. Article 21.21) must be brought within two years. (The court appears to treat a Article 21.55 as falling under Article 21.21). The court holds that the two year statute of

limitation under Article 21.21 governs the Article 21.55 claim. However, the court's opinion notes that the Plaintiff did not dispute that proposition as urged by the insurer. Having held that the two year statute applied, the court then held that the cause of action accrued, at the latest, when the insurer denied the Plaintiff's claim for death benefits following the death of his wife. Accordingly, the claim was barred.

7. *Keeling, et al v. State Farm Lloyds,* 2002 WL 31230804 (N.D. Tex. 2002)

This is a first-party homeowner's insurance policy case involving a alleged foundation damage.

There was a dispute about whether or not the foundation damage was caused by a covered cause of loss or not. The insurer eventually paid the Plaintiffs $4734.70 to repair structural damage to their home but Plaintiffs sought an additional $35,000 for foundation repairs and related expenses. Plaintiffs eventually filed suit. Then the insurer moved for summary judgment seeking a ruling that the claim was excluded other than what the insurer had already paid and the Plaintiffs were not entitled to penalties under Article 21.55.

The court first holds that there are fact questions on coverage precluding the summary judgment for the insurer. With regard to the insurer's argument that it could not be held liable for Article 21.55 penalties, the court notes that the Plaintiffs notified Defendant of their loss on or about January 26, 1999 and that the insurer had only offered to pay $4734.20 and rejected the remainder of the claim. Accordingly, the court held that if the Plaintiffs ultimately established that the claim was covered and, therefore wrongfully denied, the Defendant will be liable for additional penalties and attorney's fees under Article 21.55.

Accordingly, this case treats a denial of claim, even if it done in a timely manner and in accordance with the Article 21.55 time frames as the equivalent of a failure to pay in a timely manner. So, any time you have a denial that turns our to be wrongful, the Plaintiff will be able to recover penalties.

8. *Protective Life Ins. Co. v. Russell,* 2003 WL 203240 (Tex. App. – Tyler 2003)

This is a life insurance case.

The insured died on January 27, 1999. On February 11, 1999, the insured's wife completed and signed a claim form and gave it to the agent who, in turn, mailed it to the insurer. 137 days later, on June 29, 1999, the

insurer denied the claim on grounds that the insured's health and insurability had changed from the time he filled out the application and the date that he physically obtained the policy. The insured's wife then filed suit. Both sides moved for summary judgment. The trial court denied the insured's motion and granted the insurer's motion on her claims for benefits under the policy and damages under Article 21.55.

On appeal, the Court of Appeals first upheld that summary judgment for the actual policy benefits because the insurer did not comply with the time constraints regarding providing notice of alleged misrepresentations to be used as a policy defense. See Article 21.17. With regard to the award of attorney's fees and interest under Article 21.55 the court agrees with the insurer's contention that it should not be held liable for Article 21.55 penalties simply because it denied the claim. In this connection, this case stands in contrast to the *Keeling* case just discussed above. However, the court notes that the insurer failed to notify Ms. Russell within 15 days after the date she turned in all of the documents required as to whether the insurer would accept, reject or needed additional time to process, her claim. The evidence showed that the only contact with the Plaintiff was when the insurer denied her claim by letter dated June 29, 1999, i.e. 137 days after the claim was submitted. The court says that "we must emphasize that PLIC's violation of Article 21.55 was not due to its decision to deny Ms. Russell's claim. Nothing in Article 21.55 suggests that an insurance company cannot dispute and deny a claim.

Next, the court had to decide when the Article 21.55 interest penalties begin to accrue and notes that under Article 21.55, damages begin to accrue on the earlier of 180 days after the date the insurer receives written notice of a claim or the date suit is filed. The court then holds that the date the insurer received written notice of the claim was the date the insurer's agent received the claim form from Ms. Russell. "Notice of claim" means any notification in writing to an insurer by a claimant that reasonably apprises the insurer of the facts related to the claim. Notice to the agent will apparently suffice. Accordingly, since the agent received the notice of the claim on February 11, interest begin to accrue on August 11, 1999.

9. *Republic v. Mex-Tex, Inc.,* 106 S.W.3d 174 (Tex. App. – Amarillo 2003)

This is first-party commercial property loss claim case. The issue is whether the Article 21.55 interest penalties accrue on the entire amount of the claim that is ultimately found to be owing if the insurer has earlier tendered less than the total amount of the claim.

Following a hail storm, the owner of a shopping mall submitted a claim to its insurer for the roof. Initially there was a dispute as to the possible existence of pre-existing damages. However, eventually the insured and the insurer agreed that the roof would be replaced and that the insurer would pay for it. However, in the interim, while that dispute was being resolved, the insured went ahead and replaced the roof in order to avoid further injury to its tenants as a result of any other rains. The cost of the roof procured by the insured was in excess of $200,000. The insureds submitted a claim for $179,000 after deducting the cost of insulation. The insurer balked because it concluded that it could have replaced the roof with one identical make for approximately $145,000. The trial court ruled that the $179,000 claim by the insured was within the coverage of the policy.

On appeal, the court first affirms the trial court ruling that the insurer was liable for the full amount of the claim submitted by the insured. The insurer argued, however, that nevertheless, the award of Article 21.55 penalties must be reversed because it had complied with the time periods mandated by the statute. The court rejected this argument. It applied a strict liability approach to Article 21.55 in the event that the carrier has denied, even in part, the claim. Since the carrier failed to pay the full claim in the amount of $179,000 and since the court had found that claim to be valid, the carrier violated Article 21.55.

The court considered the insurer's argument that the penalty should only be calculated on the portion of the total claim that the insurer balked at, rather than calculating the penalty on the entire amount of the claim since the insurer had offer to pay $145,000 towards a new roof. Purporting to apply the literal terms of the statute, the court rejected this argument and noted that the 18% penalties run on the "claim". The court noted that the "claim" submitted was for $179,000, not the difference between $179,000 and $145,000. Tender of a lesser amount than is actually owed does not toll the accrual of interest under a tender theory. Since the insurer was obligated to tender the entire sum that it owed, and since it did not, the penalties accrued on the entire amount of the claim.

The court noted that the result might be different had the insurer initially tendered the partial payment with the stipulation that it was without prejudice to the rights of the insured to pursue the balance. Under those circumstances, applying the law of tender, a tender tolls the accrual of penalty or interest on the sum that is actually tendered. Here, however, the partial payment offers were not accompanied by such a stipulation. Instead, the offer was made in the context of being all that the insurer believed that it owed.

III. Third Party Claims

A. Stowers/Article 21.21/DTPA

1. *Rocor Intl., Inc. v. National Union Fire Ins.*, 77 S.W.3d 253 (Tex. 2000)

The issue in this landmark Texas Supreme Court opinion was whether Article 21.21, *as it existed prior to the September 1, 1995 amendments,* affords the insured a cause of action for unfair claims settlement practices in the third-party liability context. Specifically, the issue was whether the insured had a cause of action under Article 21.21 for costs that the insured incurred in defending a lawsuit while the excess carrier delayed settling the claim. There was no excess judgment. As noted, the issue was simply the insured's additional defense costs and expenses incurred due to the carrier's alleged delay in getting the case settled.

Prior to the 1995 amendments, Article 21.21 §16(a) allowed insureds to bring claims under Article 21.21 through the State Board of Insurance board orders, which in turn, allowed the insured to bring claims under other sections of the insurance code, including Article 21.21-2. Article 21.21-2 defined as an unfair practice "not attempting in good faith to effectuate prompt, fair and equitable settlements of claim submitted in which liability has become reasonably clear". See Article 21.21-2, §2(b)(4). Although Article 21.21-2 does not itself give rise to a private cause of action, the Texas Supreme held in *Vail* that conduct violating Article 21.21-2 was actionable under Article 21.21 through Board Order 18663.

National Union relied upon the language in *Garcia* holding that an insured has no cause of action under Article 21.21 for the insurer's fail to settle a third-party claim. In *Garcia* the court held that breach of the *Stowers* duty did not constitute a violation of Article 21.21. Moreover that the *Garcia* court distinguished *Vail* because *Vail* involved a first-party property insurance claim. In *Rocor*, the Texas Supreme Court, in effect, repudiates those statements. The *Rocor* court held that nothing in Article 21.21 supports a conclusion that the legislature intended the limit Article 21.21 the first-party claims when the insured has sustained actual damages.

The court then turned to defining the applicable standard to be applied. *Rocor* holds that, in order to trigger an insurer's statutory duty to reasonably attempt settlement of a third-party claim against its insured, the policy must cover the claim and the *insured's* liability to the third-party must be reasonably clear. Additionally, as with a common law *Stowers*

claim, claimant must have made a proper settlement demand within policy limits such that an ordinarily prudent insurer would have accepted it. If these elements are met, then the insured has a cause of action for unfair claims settlement practices in the third-party liability context, even if there has not been any excess judgment, provided that the insured can prove that the insurer's conduct caused the insured to suffer damages.

The importance of the fact that *Rocor* was dealing with the pre-1995 version of Article 21.21 and the *Vail* scheme there under cannot be over emphasized. As the *Rocor* court pointed out in footnote three to its opinion, Article 21.21 was amended in 1996 to specifically make certain unfair claim settlement practices directly actionable under Article 21.21 itself without having to resort to the links that the *Vail* court went to in order to get to the non-privately actionable violations under Article 21.21-2. Article 21.21, §4 now defines unfair settlement practices as including:

> * (ii) failing to attempt in good faith to effectuate a prompt, fair and equitable settlement of a claim with respect to which the *insurer's* liability has become reasonably clear. (emphasis added).

Note that in *Rocor*, in dealing with the pre-1995 version of Article 21.21 where the standard was settlement of claims "in which liability has become reasonably clear", the *Rocor* court construed the reference to "reasonably clear" liability to refer to the *insured's* liability. However, under the current version of Article 21.21, by the statutes own terms, it is not the *insured's* liability that must be clear, but is instead the *insurer's* liability.

Query: Does the *Rocor* standard apply to the post-1995 amendments to Article 21.21 which speak in terms of the *insurer's* liability being clear versus Rocor's interpretation of the pre-1995 statute as calling for the insured's liability to the third-party being clear?

What if the *insured's* liability to the third-party is clear but there are serious unresolved coverage questions thereby making the *insurer's* liability unclear? Under the current version of Article 21.21, a literal reading of the statute would require that not only must the insured's liability to the claimant be clear, but the insurer's coverage obligation must also be clear. Otherwise, the *insurer's* liability is not clear, which is what the current version of the statute requires.

2. *Nationwide Mut. Ins. v. Chaney,* 2002 WL 31178068 (N.D. Tex. 2002)

This case involves the elements of a proper "*Stowers*" demand and offers a discussion of the use of the turnover statute by the Plaintiff to acquire the *Stowers* claim.

The settlement demand in question was for $32,000 and referred to the Plaintiff's $25,245.90 in medical expenses which included expenses that the Plaintiff had occurred at Laird Memorial Hospital. However, the demand did not explicitly offer to release the hospital lien or any other potential claims against the insured. The Plaintiff later obtained a significant excess verdict against the insured. In attempting to collect the full judgment via a turnover of the *Stowers* claim, the Plaintiff admitted that the settlement offer did not expressly offer to release the insured from any potential claims, but contended, nevertheless, that it did contain an "implied release" sufficient to satisfy the full release requirements of *Trinity v. Bleeker.* In rejecting this argument, the court held that it could not infer that there was ever an offer to fully release the insured from any potential claims. The settlement demand made no reference to the hospital lien. Moreover, even though the Plaintiff's attorney had sent a letter of protection to the hospital, there was no reference to the letter of protection in the demand letter and the demand did not propose to be a "final settlement". Accordingly, there was no effective *Stowers* settlement demand.

In a footnote, the court notes that even if the insured had a valid *Stowers* claim, the claim would not be subject to turnover because the insured never attempted to assert the claim and his testimony established that he refused to pursue or assign any claim that he might have had against Nationwide and was satisfied with Nationwide's handling of the lawsuit despite the fact that he remained fully exposed on the excess judgment. Testimony apparently was to the effect that he believed that he would be better off without an assignment of the claim if that meant further representation by Nationwide in the turnover and collection proceedings and any bankruptcy proceedings that he might ultimately have to file than he would have been had he assigned the claim to the Plaintiff and had no representation. Apparently Nationwide had agreed to full representation of the insured, even in the context of bankruptcy proceedings if he chose to file bankruptcy. Under these circumstances, Judge Lindsay concluded that, under *Charles v. Tamez,* a turnover would be inappropriate.

3. *Gulf Ins. Co. v. Jones,* 2003 WL 22208551 (N.D. Tex. 2003)

This case follows up on *Rocor* and purports to apply it.

The underlying claim was a medical malpractice case against a podiatrist, Bloom. Gulf defended Bloom in the lawsuit. It was tried and the jury

returned a verdict in favor of the Plaintiff for $2,125,000. After remittitur, judgment was entered in favor of the Plaintiff against Bloom for $1,100,000 plus pre-judgment and post-judgment interest.

Gulf contended that its coverage was limited to the "per person" policy limit of $500,000 plus post-judgment interest on that amount. On March 27, 2000, Gulf paid the Plaintiff the $500,000 per person limit plus post-judgment interest on that amount through the date of payment. Gulf then filed the present declaratory action seeking a ruling that it had no duty to indemnify its insured further and that it had no extra-contractual liability under *Stowers*. The insured and the Plaintiff filed counterclaims for breach of contract, negligence, *Stowers* violations and violations of the Insurance Code.

On June 27, 2001, the Plaintiff and the doctor settled their differences and entered into an agreement whereby the doctor agreed to pay the Plaintiff $200,000 in exchange for the Plaintiff's agreement to only seek satisfaction of the remaining amount owed on the judgment from Gulf and from the proceeds of a malpractice case that the insured intended to bring against his defense lawyers. The insured specifically alleged that defense counsel failed to properly evaluate and settle the lawsuit within the policy limits and failed to inform him of his rights and the consequences of failing to settle within limits.

As to the common law *Stowers* claim, it was undisputed that there had been a pre-trial settlement demand for the $500,000 per person policy limits. However, when the insured was informed of the offer, he stated that he did not want to settle the case even though the policy did not require that the doctor give his consent to settle. The insured was also advised of his rights to hire personal counsel but did not do so. The settlement offer was refused. Nonetheless, the insured contended that Gulf's adjustor was negligent by not fully appreciating the weaknesses in the defense. The court pointed out, however, that the evidence showed that the claims adjustor was aware of and considered the possible exposure in the case including the opinions of the Plaintiffs and defense experts. The insured had testified in deposition that he thought it was reasonable for the insurance company to believe that the case was defensible.

Second, the insured contended that the claim adjustor erred by mistakenly concluding that she needed his consent to settle. The court pointed out that the insured was adamant that he did not want to settle and communicated his position in that regard to Gulf. The evidence showed that Gulf did not believe that the lawsuit was worth the policy limits and, therefore, Gulf would not have settled even if it had known that the insured did not have to consent. The court points out that the insurer has no *Stowers* obligation to make or solicit settlement offers. Based on all of

the facts, the court held that Gulf was entitled to summary judgment on the *Stowers* claim.

With regard to the Article 21.21 claims, Gulf, relying on *Maryland Insurance v. Head*, argued that the insured had no statutory bad faith claims for failing to settle beyond the common law *Stowers* claim. However, the court noted that, at the time suit was filed in *Head,* Article 21.21 had not been amended to include §4(10) which permits an insured to bring a claim against its insurer for "failing to attempt in good faith to effectuate a prompt, fair and equitable settlement of a claim with respect to which the *insurer's* liability has become reasonably clear". Then, the court cites *Rocor's* discussion of the elements of a statutory failure to settle claim even though *Rocor* was construing the pre-1995 version of Article 21.21 which did not include §4(10) and which merely spoke in terms of a claim on which "liability was clear". The court specifically acknowledged that the opinion in *Rocor* did not purport to interpret §4(10) but characterized the pre-1995 language "virtually identical" to the language in §4(10). Since there was no valid *Stowers* claim, and *Rocor* had adopted the *Stowers* elements as the elements of an Article 21.21 claim, at least under the pre-1995 statute, the court held that the insured had no cause of action under the post-1995 version of Article 21.21.

In this case, the difference in the pre-1995 statutory language construed in *Rocor* and the post-1995 amended language of Article 21.21 made no difference in the end since the court found that the insured had no viable *Stowers* claim. It is significant, however, that the court treats the old language as construed by *Rocor* to be "virtually identical" to the language to the post-1995 statute involved here.

4. *Travelers v. Page,* 2002 WL 1371065 (Tex. App. – Amarillo 2002)

This case discusses extra-contractual damages under Article 21.21 and the DTPA and arises out of an underlying construction defect dispute.

In January 1989, the owners of the project notified the insured, the general contractor, and its surety company of the alleged defects in the project and alleged that the insured had breached its contract that the owners intended to file suit. The insured promptly notified three insurance carriers of the demand letter but did not demand coverage or a defense under the policies at that time.

The owners filed suit in New Mexico against the insured and its surety company on June 12, 1989 alleging breach of contract. The insured failed to provide Travelers with the petition or request a defense, however, until May 1990. On October 12, 1990, Travelers agreed to assume the insured's defense under reservation of rights. Eventually, on March 11,

1992, the insured, the owners, and the bonding company settled. The bonding company paid $950,000 to the owners. In turn, the bonding company sought $1,092,000 in reimbursement from the insured. In a letter dated June 17, 1992, the insured demanded that Travelers and two other carriers reimburse the insured for the full amount sought by Safeco, the bonding company, as well as $158,000 in incurred defense costs. Travelers rejected this request, contending that there was no coverage under the policies it issued because there was no property damage within the policy period. It also declined to pay additional defense costs because it contended that they were incurred before it was notified of the suit.

In July 6, 1992 the insureds filed suit against Travelers and two other carriers, Maryland Casualty and Employer's Casualty, in Potter County seeking a declaration that the policies provided coverage and asserting causes of action for breach of contract, breach of the duty of good faith and fair dealing, negligence and violations of Article 21.21 and the DTPA.

Employer's Casualty was then put into receivership and had minimal further involvement in the litigation. On October 27, 1992, Maryland settled with the insured for $250,000, $150,000 to be paid to the insured and Safeco to settle coverage claims and $100,000 to the insured and Safeco for extra-contractual claims.

The insured moved for summary judgment against Travelers the issue of coverage and breach of contract. Travelers responded by asserting late notice, lack of coverage and various other exclusions and affirmative defenses. Travelers also file its own motion for summary judgment.

The trial court denied Travelers' motion and granted the insured's motion for partial summary judgment, holding that Travelers had a duty to defend the insured and that the policy provided coverage for the property damage but did not cover the cost of repairing certain faulty construction. The trial court found that there were questions of fact on the issue of damages and reserved those issues for trial. The court also then severed the extra-contractual claims.

Then, at the trial on damages, the court rendered judgment in favor of the insured for breach of contract, awarding $907,000 in actual damages $250,000 in pre-judgment and interest and $170,000 in attorney's fees. That judgment was appealed and the Court of Appeals reversed and rendered judgment for $50,000 in loss of use damages and $62,246 in defense costs plus attorney's fees and interest.

Then, trial proceeded on the extra-contractual claims resulting in a judgment adverse to Travelers finding that it had violated the DTPA and Article 21.21. Specifically, the trial court found that Travelers had:

- Represented that its insurance contract involved obligations which it did not have or involved;
- Represented its insurance services had characteristics or benefits which they did not have;
- Made statements misrepresenting the terms, benefits or advantages of the policies;
- Made assertions, representations or statements with respect to the insurance that were untrue, deceptive or misleading;
- Made misrepresentations relating to its insurance policy by making untrue statements of material fact, failing to state material facts that were necessary to make other statements not misleading and making statements in such a manner as to mislead a reasonably prudent person to a false conclusion.

Additionally, the trial court found that Travelers did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims submitted to which liability had become reasonably clear in violation of Article 21.21, failed within a reasonable time to affirm or deny coverage of the claim in violation of Article 21.21, and refused to pay a claim without conducting a reasonable investigation in violation of Article 21.21.

In reviewing these findings, the Court of Appeals characterized the gist of the insured's complaint as Travelers asserting that there was no coverage under the policy when they knew there was coverage for loss of use of the premises, even though the loss of use may have occurred well after the policy, and by continuing to deny that coverage, Travelers delayed payment of defense costs, refused to pay costs that it represented that it would pay and otherwise refused to assist its insured in the defense of the case. Travelers' basic argument in response was that there was a bone fide dispute about coverage under its policy, and that the alleged misrepresentations complained of were nothing more than Travelers interpreting its policy one way and the insured interpreting a different way.

The Court of Appeals first considered whether a bone fide dispute on coverage defense applied and if it did, did Travelers denial of coverage arose from a bone fide dispute as to the insurance coverage or as the result of deliberate of misrepresentations or conscious indifference. The court held the bone fide dispute defense applied and that it was not until the court's decision in the coverage suit that Travelers actually knew that the loss of use occurring outside it's policy period was covered. The alleged misrepresentations were nothing more than a coverage dispute.

The Court of Appeals reversed and rendered that the insured take nothing on its extra-contractual claims.

5. *Chickasha v. Houston General Ins.*, 2002 WL 1792467 (Tex. App. – Dallas 2002)

This case deals with the *Rocor* court's analysis of the pre-1995 Article 21.21 versus the post-1995 Article 21.21 §4(10) language.

Chickasha was sued by hundreds of claimants for air, ground and water pollution in Commerce Texas. The suits were filed in various counties, and implicated that Chickasha's coverage from 1946 to 1986. Chickasha contacted all of the carriers it could find and tendered the cases to them for defense. Chickasha could not find any policies before 1972. Chickasha's carriers after 1972 denied coverage. Chickasha sued for declaratory judgment that the policies covered claims. Additionally, Chickasha brought claims for breach of the duty of good and fair dealing and violations of Article 21.21. As of October 1, 1999 Chickasha had spent more than $7,000,000 in defense costs and settlement of the underlying claims.

The first issue was whether Chickasha had adequately proven the existence of and the terms of pre-1972 insurance policies. The court, in an interesting discussion of the proof and evidence problems when old polices cannot be found, concluded that the evidence established the existence of and coverage under pre-1972 policies. The court upheld the trial court's summary judgment on that point.

Next, the Court of Appeals addressed the trial court's summary judgment in favor of the carrier on the extra-contractual claims. Claims were asserted under Article 21.21 §4(10). Since Chickasha's suit was filed in 1998, the post-1995 Article 21.21 applied. The court addresses *Rocor* and states that the pre-1995 language that the *Rocor* court interpreted is "virtually identical" to the language in §4(10)(ii). It fails to note any distinction between the insured's liability to the third-party claimant being clear, which was the standard applied by the *Rocor* court under the pre-1995 language, and the insurer's liability being clear, which

is the language of the post-1995 Article 21.21. The Chickasha court holds simply that the elements of the cause of action as set out in *Rocor* are applicable to a cause of action under §4(10)(ii).

Then, the court addresses the carriers' argument that the insurer's liability was not clear because coverage for the underlying claims was not "reasonably clear". The court dismisses this argument out of hand with the following statement:

> "Reasonable clarity of coverage is not one of the elements under *Rocor* and §4(10)(ii).

However, the court also noted that the carriers did not include this particular argument in their motion for summary judgment, and, therefore, assert it for the first time on appeal. The summary judgment for the carriers was reversed.

This case is significant in that the court applied the *Rocor* elements blindly to the post-1995 Article 21.21 language and even went so far as to specifically state that clarity of coverage is not one of the elements even though the post-1995 language requires that the insurer's liability be clear. This would certainly suggest that there has to be clear coverage.

6. *Herrin, M.D. v. Medical Protective Co.*, 89 S.W.3d 301 (Tex. App. – Texarkana 2002)

This case involves Article 21.21 and DTPA claims based on alleged misrepresentations.

Dr. Herrin had medical malpractice coverage through Medical Protective. The policy required that Dr. Herrin give his consent to any third-party settlement. Herrin contended that Medial Protective promised him that, in connection with a particular settlement, if he would give his consent for a $300,000 settlement, it would not in any way affect his liability coverage. Accordingly, Herrin consented to settle a malpractice case for $300,000 in 1995. The claim was paid in early 1996 and in April 1997 Medical Protective refused to renew his policy.

This, ultimately, resulted in Dr. Herrin retiring prematurely from the practice of medicine because he could not get the necessary insurance coverage to continue his surgical practice. The trial court rendered summary judgment for Medical Protective.

The Court of Appeals reversed the summary judgment. It, interestingly, found the existence of an "informal fiduciary relationship" bared on the fact that Medical Protective's representative that had made

the representations and Dr. Herrin had worked together for approximately 15 years. The court further found fact issues as to whether Medical Protective representations constituted actionable misrepresentations under Article 21.21 and reversed summary judgment on that ground as well.

B. Article 21.55

1. *UTICA v. Tex. Prop.& Cas. Guar. Fund*, 110 S.W.3d 450 (Tex. App. – Austin 2003)

Among a host of issues, one issue involved in this case is whether the insured's defense costs incurred in defending a liability claim constitute a first-party claim" so as to governed by Article 21.55. The court held that they were not.

2. *Northern Co. Mut. Ins. Co. v. Davalos,* 84 S.W.3d 314 (Tex. App. – Corpus Christi 2002)

This case, contrary to *Utica*, assumes, without expressly discussing the issue that Article 21.55 *does* apply to defense costs incurred by an insured under a liability policy.

Davalos was injured in an automobile accident on October 10, 1995 in Dallas. He sued the driver of the other car in Matagorda, County Texas. The other driver sued Davalos in Dallas County, Texas. Davalos hired his own counsel to defend the Dallas County action. The counsel filed an answer and an immediate motion to transfer venue of the Dallas County case to Matagorda County. Davalos then notified his insurer requesting that it defend him in the Dallas County case. The insured responded by requesting that Davalos allow the carrier chosen attorney to substitute in as Davalos counsel and also asked Davalos to withdraw the motion to transfer to Matagorda County. Davalos refused to comply with these requests and kept the attorney that he selected. The carrier eventually settled the Dallas County case. Davalos then sued the carrier in Matagorda County alleging that it had breached the insurance policy and engaged in unfair methods of competition and unfair or deceptive acts of practices in violation of Article 21.21 and had violated the Article 21.55 by failing to undertake his defense.

Both parties moved for summary judgment. The trial court granted Davalos motion for summary judgment and awarded Davalos $15,000 plus 18% penalties under Article 21.55.

The court first held that there was a clear conflict of interest between Davalos and his insurer in that the insurer wanted the case to stay in Dallas wherein Davalos wanted the case to be transferred to Matagorda

County where he lived and was familiar with the community. Because of this conflict of interest, the carrier forfeited its right to control the defense and breached its duty to defend by refusing to pay Davalos defense costs.

With regard to Article 21.55 penalties, the court noted that the carrier notified Davalos of its receipt of the claim by letter of January 9, 1997. However, the carrier neither accepted not rejected the claim and did not otherwise meet the time periods for doing so. Accordingly, the court held that Article 21.55 penalties were appropriate. The court did not discuss the more fundamental question as to whether or not defense costs incurred in connection with a third-party liability claim qualify as a "first-party" claim under Article 21.55.

3. *Mt. Hawley Ins. Co. v. Steve Roberts,* 215 F. Supp.2d 783 (F.D. Tex. 2002)

This case also holds that Article 21.55 applies to the insured's incurred defense costs in defending against a third-party liability claim.

After holding that the carrier had a duty to defend its insured builder in the context of a construction defect lawsuit, the court then considers whether or not Article 21.55 applied. The court examines the various conflicting decisions on whether defense costs incurred under a liability policy qualify as a "first-party" claim for the purposes of Article 21.21. The court followed those cases such as *Rubalcava*, *Jentury v. Greenleaf* and *Ryland v. Travelers* in holding in that Article 21.55 did apply to the insured's' expenditure of defense cost.

4. *Atofina Petro., Inc. v. Evanston,* 104 S.W.3d 247 (Tex. App. – Beaumont 2003)

This case addresses whether there is a "good faith mistake" defense under Article 21.55.

At issue was the payment by Atofina of a $5,750,000 settlement of a wrongful death claim. Atofina sought reimbursement from its carrier, Evanston, but Evanston defined coverage. With regard to Article 21.55, there is no indication that Evanston even argued that reimbursement of a wrongful death settlement did not qualify as a "first-party" claim for purposes of Article 21.55. The argument that Evanston made, instead, was that its coverage defenses were raised in good faith and, as such, the penalties should not apply. Citing several reported cases, the court held that an insurer's failure to comply with Article 21.55 results in an imposition of statutory penalties even if delay is made in "good faith".

5. *Primrose v. National American Ins. Co.*, 2003 WL 21662829 (N.D. Tex. 2003)

This case deals with the proper calculation of the 18% interest penalty under Article 21.55.

That issue was the carrier's refusal to provide Primrose with the defense in the some underlying litigation. The insured incurred approximately $183,000 in defense costs that were covered under its policy. The insured sought additional Article 21.55 penalties. The dispute was mainly over whether the penalties are calculated as simply interest or, instead, as compound interest and as to whether the damages must be determined to have accrued as the defense fees were earned or, instead, are all deemed to have occurred as of the dates of the Defendant's Article 21.55 violation. Finally, there was an issue as to pre-judgment interest could be awarded on the statutory penalties.

The carrier received the claim on August 6, 2001. Accordingly, under Article 21.55 the carrier was required to acknowledge receipt of the claim and, commence any investigation, request all needed items etc. on or before August 21, 2001. The jury found that the carrier failed to do so, and therefore, violated Article 21.55. The court holds that the dated of accrual of the 18% penalty was August 22, 2001 when the carrier first violated the statutory time frames.

The court further held that Article 21.55 penalties were in the nature of punitive damages, not actual damages, because they were designed to penalize the insurer without any reference to harm suffered by the insured. Accordingly, since no pre-judgment interest can be awarded on exemplary damages, no pre-judgment interest can be awarded on the 18% penalties either.

IV. Miscellaneous

A. *In re Trinity,* 64 S.W.3d 463 (Tex. App. – Amarillo 2001)

This is a UIM case where the insurer petitioned for writ of mandamus to compel the trial court to sever contractual UIM claims from insured's claims for penalties under Article 21.55. The Court of Appeals held that the carrier was entitled to mandamus.

In so holding, the court had to address the insured's argument that under *Lusk v. Puryear*, 896 S.W.2d 377 (Tex. App. – Amarillo 1995 orig. proc.) a claim for breach of contract and a claim for statutory damages under Article 21.55 are one cause of action and severance is, therefore, is improper. The court distinguished *Rusk* on the grounds that it involved

PIP benefits rather than UIM benefits. The court further noted that under *Allstate Insurance v. Bonner* (see discussion above), the claimant must first establish liability and damages against the at fault driver before having a ripe UIM claim. Accordingly, the court held that severance was appropriate since the UIM claim did not mature until the claimant that establishes the negligence of the UIM motorist and the amount of damages sustained. The court held that trial court abused its discretion in denying the severance.

B. *Vargas v. State Farm Lloyds,* 216 F.Supp.2d 643 (S.D. Tex. 2002)

This is a first-party homeowners claim case discussing the issue of individual liability on the part of an adjustor.

Following report of a water damage claim allegedly resulting in structural and cosmetic damage as the result of plumbing leaks, State Farm, through its adjustor, Bruce, hired a plumbing company to test the plumbing lines. The homeowners argued that adjustor knowingly hired a biased engineer. Based upon an unfavorable report from the engineer, State Farm ultimately denied coverage in a letter issued and signed by Bruce. The homeowners responded with a letter back to Bruce challenging the engineer's methodology and conclusions and requesting additional information about his findings. Bruce eventually arranged a telephone conference with the insureds and the engineer to allow the insured the opportunity to question the engineer. State Farm continued to deny the claim.

Homeowners sued in state court for a breach of contract, breach of the duty of good faith and fair dealing and violations of Article 21.55. Additionally, they lodged claims against Bruce for violations of Article 21.21 and the DTPA. The specifically alleged that Bruce was personally liable for engaging in a slew of "unfair insurance practices," including hiring a biased engineer to determine the cause of foundation damage, failing to disclose the engineer's relationship with the insurance industry, failing to effectuate a prompt, fair and equitable settlement of Vargas' claim, and failing to conduct a reasonable investigation of Vargas' claim.

State Farm removed the case to federal court based on diversity jurisdiction arguing that Bruce had been fraudulently joined.

Judge Kent first notes that it is well settled under Texas law that an insurer's agent cannot be held liable for breach of contract or breach of the duty of good faith and fair dealing. However, after *Liberty Mutual v. Garrison Contractors*, the Supreme Court has not exempted insurer's agents or employees from liability under Article 21.21. The court then examined the job description of an insurance adjustor and noted that they

are engaged in the "business of insurance" by investigating, processing, evaluating, approving and denying claims. Accordingly, they cannot be classified as merely clerical or janitorial employees. The court also noted that the text of Article 21.21 itself specifically lists adjustors among those individuals that are included under the statutes definition of "person". Judge Kent acknowledged, however, that there is a split among the federal courts in Texas as to whether insurance adjustors can be held personally liable under Article 21.21. The court also gave considerable weight to the fact that Bruce appeared to have assumed responsibility for the investigation and the denial of the claim and that he was the one who had signed the denial letter. Ultimately, the court held that Bruce may have contributed to the investigation to the claim, therefore, he had not been fraudulently joined.

C. *In re Republic Lloyds,* 104 S.W.3d 354 (Tex. App. – Houston [14th Dist.] 2003)

This is a first-party homeowners case dealing with severance of the contract and extra-contractual claims when there has been an "offer to settle". The insurer sought severance and the trial court denied it. The insurer then filed a petition for writ of mandamus.

In the trial court, the insurer argued that a settlement offer had been made on the entire breach of contract claim and, in support of this argument, offered into evidence a sworn statement in proof of loss executed by the homeowners and a check issued by the insurer for the full amount referenced on the sworn statement. But, the homeowners argued that the check only covered the undisputed portion of the claim, plumbing leaks but not the foundation damage portion of the claim and that, therefore, the insurer had not actually made an offer to settle the entire claim.

Noting that the insurer had to show that the trial court had abused its discretion the Court of Appeals noted that at the evidentiary hearing on the motion to severance, the insurer did not introduce any testimonial evidence on the nature of the offer made by the insurer. They only introduced the proof of loss and a copy of the check. There was no evidence showing when or if the check was actually tendered to the homeowners, or whether it was tendered in response to the proof of claim, which was dated almost five months after the check was issued. Further the check did not contain any release language or indicate that is was payment in full for the claim. Accordingly, the proof of loss was not conclusive. The homeowners explanation that the check was only tendered as partial payment, not as settlement of the entire claim, went unrebutted. Accordingly, the insurer did not show abuse of discretion.

Justice Yates dissented that he believed that the check was tendered as a partial settlement or as settlement of the whole claim was immaterial and that, in any event, such evidence would be prejudicial to the carrier in the trial of the breach of contract action.

D. *In re Allstate Ins. Co.,* 2003 WL 21026877 (Tex. App. – Houston [1st Dist.] 2003)

This is an automobile case also dealing with severance and "settlement offers".

In this case, the evidence showed that Allstate offered to settle the breach of contract case for $1200 following a hit-and-run accident. In contrast to *Akin*, where the Supreme Court held that severance and abatement were not required in a case where settlement negotiations involved only the payment by the insurer of the undisputed portion of a claim, the evidence here was that Allstate had made a settlement offer on the entire claim, not merely the undisputed portion of it. Accordingly, the court issued a writ of mandamus requiring severance of the contract and extra-contractual claim.

E. *Mauskar v. Hardgrove,* 2003 WL 21403464 (Tex. App. – Houston [14th Dist.] 2003)

This is a statute of limitations case discussing the fraudulent concealment and discovery rules as applied to alleged misrepresentations of insurance policies.

The Plaintiff claimed that he told his insurance agent that he wanted to purchase life insurance polices that were similar to policies that he had purchased in India and England which ran for a definite term and, through dividends and bonuses during the life of the policies, generated a return of premiums plus interest and ultimately would pay two to three times the death benefit when the insured reached age 65. (Sounds like a good product; where can I get one?) The agents allegedly represented to him that the policies sold to him met his requirements.

On September 13, 1997, the insured turned 65 but he did not cash in his policies at that time. He alleged that on July 9, 1998, he began becoming aware that the policies offered no retirement income and that premium payments would continue as long as the policies were in effect until the age of 95 years. He crashed the polices in 1999. On July 5, 2000, the insured sued the agents and the insurance companies involved for negligent procurement, misrepresentation, fraud and violations of the DTPA and insurance code. The Defendants responded with a motion for summary judgment based on the statute of limitations. The insured argued

the discovery rule and fraudulent concealment, among other things. The insured argued that his claims did not accrue until he actually cashed in the policies in 1999 and discovered that he did not receive the return that he had been promised. The court held that his causes of action accrued at the time he purchased the polices because when he purchased them he received written descriptions of the polices and also received the polices themselves that clearly disclosed how the premiums were to be paid and for how long. Had the insured read the polices at the time he purchased them, he would have immediately known that the polices where not what were allegedly represented to him. In response to the discovery rule, the court noted that for the rule to apply, the nature of the injury must be inherently undiscoverable. The insured could have discovered his injury by reading the policies. It held that an insurance agent has no duty to explain the policy terms to the insured. The court also rejected the insured's fraudulent concealment arguments and held that there was no fiduciary relationship between the insurer or its agents and the policy holder that would give rise to some sort of an affirmative duty to disclose what is otherwise shown in the policies. Accordingly, all of the insured's claims were barred.

F. *In re Hochheim Prairie Farm Mut. Ins.*, 2003 WL 22024269 (Tex. App. – Beaumont 2003)

This case involves the attempted use of a Rule 202 pre-suit deposition to discover whether the insured has a potentially viable *Stowers* cause of action against his insurer so that the carriers' liability will not be limited to policy limits in the event of a successful suit.

The underlying claim involved a fatality accident and $25,000 limits of liability on the at fault party's policy. The parents of the deceased extended a settlement offer to settle for policy limits which the carrier did not respond to within the stated time. The Plaintiffs then filed suit against the estate of the at fault driver, who died. That litigation had not yet proceeded to trial.

While the underlying accident case was pending, the Plaintiffs filed a verified petition for pre-suit depositions under Rule 202 to take the deposition of the insurer's claims adjustor that investigated the accident and a claims supervisor. Plaintiffs wanted to get discovery on what had occurred in response to their settlement demand. Then sought documents concerning the settlement offer. The trial court granted the petition without conducting a hearing and ordered that the testimony and documents obtained in the Rule 202 discovery could not be used in the underlying wrongful death action. The carrier filed for a writ of mandamus.

In granting the writ of mandamus, a majority of the court noted that the Plaintiffs conceded that they would not be entitled to the discovery that they were seeking if they sought that type of discovery in the underlying litigation while the suit was still pending. The court further noted that the cause of action to which the discovery related, i.e. a "*Stowers*" claim had not yet even accrued since the underlying wrongful death case was still pending. Finally, the court held that the insurance company would suffer irreparable prejudice by having to produce its employees for deposition prior to conclusion of the underlying litigation. The benefit of the discovery sought to the real parties, at least at this point in time, was only marginal. Accordingly, the court granted the mandamus.

Justice Burgess dissented arguing that whether or not there would be prejudice to the insurer by having to submit its employees for deposition was not the proper test to be applied in a mandamus context. He would have deferred to the trial judge's decision in balancing the harm versus the benefit of the discovery sought.

G. *Hussey v. State Farm Lloyds Ins. Co.*, 2003 WL 21919357 (E.D. Tex. 2003)

This case deals the scope of discovery concerning an expert in the context of a bad faith claim.

The underlying claim was a first-party water damage claim under a homeowner's policy. State Farm hired an engineer, Purdue, to determine whether the damage was caused by a water leak. Purdue rendered his opinion that it was not, and based on the opinion, State Farm denied the claim for foundation damages. The homeowners sued for contractual and extra-contractual damages.

The Plaintiffs served a notice of intent to take the deposition of State Farm on written questions with a subpoena deuces tecum requesting that it produce "any and all engineering reports prepared by Perdue for the past five years on residential foundation claims where damage was alleged to be caused by a plumbing leak".

State Farm contended that discovery of an expert witnesses' filed unconnected with the case at hand and solely for use of as impeachment was impermissible where the expert's creditability had not been put in issue. State Farm also made burdensome and undue expense arguments. The homeowners countered that five years worth of reports were relevant to determining whether State Farm breached its duty of good faith and fair dealing by knowingly hiring a biased engineering firm.

Significantly, State Farm apparently provided no evidence, affidavit or otherwise, that the production of Purdue's expert reports would cause undue burden. Ultimately, federal Judge Davis (Tyler) allowed the discovery to proceed and denied the motion for protective order.

V. Conclusion