

**STRATEGIES FOR APPROACHING
BAD FAITH LITIGATION**

TABLE OF CONTENTS

	Page
I. INTRODUCTION	1
II. INDEPENDENT INJURY RULE	1
A. <i>Provident American Insurance Co. v. Castaneda</i>	
B. Other Courts and <i>Castaneda</i>	
C. Application of the Independent Injury Rule	
III. STATUTORY BAD FAITH.....	3
A. Texas Insurance Code Chapter 541	4
1. Requirements for a cause of action	
2. Damages	
B. The Prompt Payment Of Claims	7
1. Acknowledgement	
2. Deadline to accept or reject the claim	
3. Deadline to pay valid claims	
4. Penalty for late payment of claims	
5. Traditional first party claims	
6. Defense costs in third-party actions	
7. Insured's delay and its effect on Prompt Payment	
C. No Double Dipping.....	13
IV. COMMON LAW BAD FAITH.....	13
V. CONCLUSION	

I. INTRODUCTION

When an insured is unhappy with an insurer's handling or denial of his claim, there are several causes of action available to pursue against the insurer. In the event that the insured believes he was wrongfully denied benefits owed to him under the policy, he may bring a breach of contract claim against the insurer in order to recover the amounts owed under the policy. Further, in many cases, the insured may bring extra-contractual causes of action, which are governed by various statutes as well as the common law. In most instances, the common law follows the statutes, but there are a number of differences.

The extra-contractual claims asserted by policyholders generally fall within two main categories: (1) breach of the common law duty of good faith and fair dealing (common law bad faith) and (2) violations of the Texas Insurance Code (statutory bad faith). Allegations of statutory bad faith are further broken down into (1) allegations of violations of the Texas Insurance Code Chapter 541 and/or Texas Deceptive Trade Practices – Consumer Protection Act (“DTPA”), *see* TEX. BUS. & COMM. CODE. § 17.41 *et seq.*, and (2) allegations of violations of the Texas Prompt Payment of Claims Statute, *see* TEX. INS. CODE Chapter 542.

This paper will provide an overview of extra-contractual claims available to a policyholder under the common law as well as Chapters 541 and 542 of the Texas Insurance Code, as well as provide strategies for defending against these causes of action.

II. INDEPENDENT INJURY RULE

Extra-contractual damages arise from the insurer's failure to properly handle an insured's claim, as opposed to contractual damages, which are benefits to which an insured may be entitled under an insurance policy. Although this distinction may seem fairly straight forward, it is important to keep these two concepts separated. In order for an insured to recover extra-contractual damages, the insured must show damages that are separate and distinct from the policy benefits. *Provident Am. Ins. Co. v. Castañeda*, 988 S.W.2d 189, 198-200 (Tex. 1998).

A. *Provident Am. Ins. Co. v. Castañeda*

In *Castañeda*, Denise Castañeda sought damages from her insurance carrier, Provident American, for alleged violations of the Insurance Code and the DTPA arising out of the handling of a claim under a health insurance policy and the ultimate denial of that claim. *Id.* at 91. Castañeda never sought any contractual relief. Accordingly, the only theories of liability in her case were extra-contractual.

The facts underlying the coverage dispute in *Castañeda* are as follows: Denise Castañeda and her father, Guillermo Castañeda, Sr., had medical insurance coverage with Provident American. Both Denise and Guillermo were diagnosed with hemolytic spherocytosis (“HS”), a condition that causes misshapen blood cells, and consequently, they had their spleens and gallbladders removed. The Castañedas then submitted a claim to Provident American,

which was denied. Denise Castañeda claimed that Provident American's handling and denial of her claim was wrongful, in part, because of an inadequate investigation and failure to acknowledge certain communications.

The trial court entered a judgment in Castañeda's favor in which it trebled her damages and added a twelve percent penalty for lost benefits; the court of appeals affirmed, except as to the twelve percent penalty. The court of appeals also held that the evidence was sufficient to support the award of \$50,000 for loss of credit reputation and loss of benefits. The Texas Supreme Court, however, reversed the court of appeals' decision, finding that there was not sufficient evidence of an injury that was separate and distinct from the denial of the policy benefits. *Id.* at 198–200.

Specifically, the Court held that Castañeda's allegations did not subject the insurer to liability. *Id.* at 198. Instead, the Court found that in order to recover on extra-contractual damages, an insured must show that the actions or inactions of the insurance carrier were the producing cause of damages that are *separate and apart* from those that would have resulted from a wrongful denial of the claim. *Id.* Moreover, the separate injury must flow from an "extreme act," because to hold otherwise would impose a strict liability on carriers that, like Provident American, may not have all the pertinent facts at the time a coverage position is determined. *Id.* at 200.

The *Castañeda* court reiterated that not every erroneous denial of a claim subjects an insurer to bad faith liability. *Id.* at 197. The court concluded that none of Provident American's actions or inactions were separate and apart from those that would have resulted from a wrongful denial of the claim and, therefore, *Castañeda* was not able to recover any extra-contractual damages. *Id.* at 198.

B. Other Courts and *Castañeda*

There is one narrow window of opportunity for an insured to recover policy benefits under an extra-contractual claim. *See generally Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129 (Tex. 1988). In *Vail*, the Court concluded an insurance carrier that was found to have *intentionally* failed to exercise good faith in processing the insureds' claim was liable for extra-contractual damages because the insurer's *unfair* refusal to pay the insured's claim caused damages as a matter of law. 754 S.W.2d 129, 136 (Tex. 1988). The *Castañeda* opinion does not expressly overrule *Vail*, but it does endorse a broad application of the independent injury rule without ever even mentioning *Vail*.

However, recent court of appeals cases on this issue have strictly adhered to *Castañeda* and ignored *Vail*. *See Wellisch v. United States Servs. Auto. Ass'n*, 75 S.W.3d 53, 60 (Tex. App.—San Antonio 2002, no pet.) (holding an insured may not recover extra-contractual damages unless the conduct complained of causes injury independent of the injury resulting from a wrongful denial of policy benefits); *United States Servs. Auto. Ass'n v. Gordon*, 103 S.W.3d 436 (Tex. App.—San Antonio 2002, no pet.) (holding an insured under a homeowner's insurance policy is not entitled to recover extra-contractual damages unless the complained of actions or omissions cause injury independent of the injury resulting from the wrongful denial of the

benefits); *see also Perrotta v. Farmers Ins. Exch.*, 47 S.W.3d 569, 575 (Tex. App.—Houston [1st Dist.] 2001, no pet.) (finding the insured’s extra-contractual claims failed as a matter of law because Farmers had a reasonable basis for denying the claim); *MacIntire v. Armed Forces Benefit Ass’n*, 27 S.W.3d 85, 92 (Tex. App.—San Antonio 2000, no pet.) (holding there is no bad faith as a matter of law because insurer did not breach a contractual duty to its insured).

Additionally, in 2008, the Texas First Court of Appeals reversed a judgment allowing recovery under extra-contractual theories because the claimed damages were the same as the damages for failing to pay timely under the policy. *DaimlerChrysler Ins. Co. v. Apple*, 265 S.W.3d 52, 70 (Tex. App.—Houston [1st Dist.] 2008), *aff’d in part and rev’d on other grounds in part, Chrysler Insurance Co. v. Greenspoint Dodge of Houston, Inc.*, 297 S.W.3d 248 (2009). The independent injury/damages requirement may also not be avoided by claiming non-recoverable forms of damages as damages separate from breach of contract claims. *See, e.g., Great Am. Ins. Co. v. AFS/IBEX Financial Serv.*, No. 3:07-CV-924-O, 2011 WL 3163605 (N.D. Tex. July 27, 2011) (mem. op.) (finding claims of lost profits, lost opportunity, lost employee wages, and loss of productivity were not claims that suffice as other damages to support an extra-contractual insurance claim); *see also Walker v. Federal Kemper Life Assur. Co.*, 828 S.W.2d 442 (Tex. App.—San Antonio 1992, writ denied) (six years before *Castañeda* affirming trial court’s refusal to submit Insurance Code/DTPA question to jury because insured presented no evidence of damages other than those that would have accrued from failure of insurer to promptly pay her claim).

C. Application of the Independent Injury Rule

There is a strong argument to be made that an independent injury is required, and the insured is not entitled to recover policy benefits in an extra-contractual claim without alleging some conduct on the part of the insurer which would amount to more than a simple breach of contract. In short, an insurer defending a bad faith action should always look to see if the insured has alleged and produced evidence of an independent injury and independent damages; if the insured has not, the insurer could prevail on any bad faith claims against it by filing a simple dispositive motion.

III. STATUTORY BAD FAITH

Texas has a set a high bar to prove that an insurer’s denial of a claim arises to the level of bad faith. “An insurer will be liable if the insurer knew or should have known that it was reasonably clear that the claim was covered.” *Universal Life Ins. Co. v. Giles*, 950 S.W.2d 48, 56 (Tex. 1997). Thus, if an insurer shows it had a reasonable basis for denying a claim, even if it is later found to be erroneous, the insurer is immune from statutory bad faith under the Texas Insurance Code and the Texas Deceptive Trade Practices Act. *MacIntire v. Armed Forces Benefit Association*, 27 S.W.3d 85, 92 (Tex. App.—San Antonio 2000, no pet.); *Avila v. Loya*, No. 07-0096-CV, 2005 WL 1902120 (Tex. App.—Amarillo Aug. 10, 2005, no pet.) (finding insured’s bad faith claim failed because insurer had reasonable basis for denying the claim); *see also Trahan v. Fire Ins. Exch.*, 179 S.W.3d 669 (Tex. App.—Beaumont 2005, no pet.) (granting

motion for summary judgment on extra-contractual damages because insurer disproved the breach of contract element of insured's claim).

In attempting to prove bad faith by an insurer, evidence of an incorrect denial of coverage is not enough. *Avila*, 2005 WL 192120, at *3. Rather, the insured must prove that the insurer had *no* reasonable basis for its denial of coverage. Therefore, even if the basis of the denial is proven to be erroneous, an insurer may still avoid bad faith liability. *Id.* (citing *MacIntire*, 27 S.W.3d at 92). Obviously, if the insurer is found to have properly denied coverage, any claim for bad faith would fail. *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995).

A. Texas Insurance Code Chapter 541

1. Requirements for a cause of action

Extra-contractual claims are tort claims and require a negligence-type standard that revolves around whether the insurer's actions were reasonable under the circumstances. Chapter 541.060 contains a "laundry list" of actions by an insurer that may give rise to a claim under the statute:

Sec. 541.060. UNFAIR SETTLEMENT PRACTICES.

- (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to engage in the following unfair settlement practices with respect to a claim by an insured or beneficiary:
 - (1) misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;
 - (2) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of:
 - (A) a claim with respect to which the insurer's liability has become reasonably clear; or
 - (B) a claim under one portion of a policy with respect to which the insurer's liability has become reasonably clear to influence the claimant to settle another claim under another portion of the coverage unless payment under one portion of the coverage constitutes evidence of liability under another portion;
 - (3) failing to promptly provide to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or offer of a compromise settlement of a claim;
 - (4) failing within a reasonable time to:

- (A) affirm or deny coverage of a claim to a policyholder; or
 - (B) submit a reservation of rights to a policyholder;
- (5) refusing, failing, or unreasonably delaying a settlement offer under applicable first-party coverage on the basis that other coverage may be available or that third parties are responsible for the damages suffered, except as may be specifically provided in the policy;
 - (6) undertaking to enforce a full and final release of a claim from a policyholder when only a partial payment has been made, unless the payment is a compromise settlement of a doubtful or disputed claim;
 - (7) refusing to pay a claim without conducting a reasonable investigation with respect to the claim;
 - (8) with respect to a Texas personal automobile insurance policy, delaying or refusing settlement of a claim solely because there is other insurance of a different kind available to satisfy all or part of the loss forming the basis of that claim; or
 - (9) requiring a claimant as a condition of settling a claim to produce the claimant's federal income tax returns for examination or investigation by the person unless:
 - (A) a court orders the claimant to produce those tax returns;
 - (B) the claim involves a fire loss; or
 - (C) the claim involves lost profits or income.
- (b) Subsection (a) does not provide a cause of action to a third party asserting one or more claims against an insured covered under a liability insurance policy.

Generally speaking, allegations under Chapter 541 have become considerably more difficult to prove in recent years. In order for a policyholder to prevail on an extra-contractual claim arising out of the denial of claim, he must show (1) the claim was denied; (2) there was no reasonable basis to deny the claim; and (3) the insurer knew or should have known that it had no justification for denying the claim. The threshold step – denying the claim – is obvious, but the remaining two elements are more difficult to establish. The standard basically provides that the insured must prove that there is no proposition in all of the universe which would constitute a reasonable basis for denying the claim.

In *MacIntire v. Armed Forces Benefit Association*, for example, Linda and Scott McIntire submitted a joint application for life insurance from the Armed Forces Benefit Association

("AFBA") in April of 1996. Originally, the policy was set up to have quarterly premium payments deducted from one of the MacIntires' bank account. For whatever reason, the automatic transfers never began. The MacIntires made some premium payments directly to AFBA, but several were missed. Several months later, Scott MacIntire was diagnosed with a terminal illness, and died in August 1998. Ms. MacIntire contacted AFBA to inquire about the insurance benefits under Mr. MacIntire's life insurance policy, and then she submitted the remaining delinquent premium payments. AFBA did not accept these late premium payments and denied the claim.

AFBA's position was that coverage on Mr. MacIntire's life insurance terminated in March of 1998 because of the failure to pay premiums after February 1998. Ms. MacIntire argued that she was never made aware that the policy was terminated until after she inquired about the benefits in September of 1998. Ms. MacIntire sued AFBA alleging, among other things, that it violated then Article 21.21 and the duty of good faith and fair dealing.

When considering the bad faith claims, the court noted that, "an insurer who proves it had a reasonable basis for denying a claim, even if the finder eventually determines that basis to be erroneous, enjoys immunity from statutory bad faith under the Texas Insurance Code and the Texas Deceptive Trade Practices Act." The court ultimately determined that the substantial factor in the lapse of coverage was the MacIntires' failure to pay the premiums, and Ms. MacIntire did not introduce any evidence that AFBA's failure to provide notice of the policy's status prevented or hindered her from making timely premium payments. The court further determined that AFBA did not have a duty to provide notices regarding the policy, and if the notices were provided, Ms. MacIntire failed to establish the causal link between the improper notices and her failure to maintain the policy.

The *MacIntire* case continues to stand for the proposition that an insurer who establishes a reasonable basis for denying a claim, even if that claim is erroneous, enjoys immunity from statutory bad faith under the Texas Insurance Code. Similarly, in *Perrotta v. Farmers Insurance Exchange*, a lawsuit arose out of a denial of a theft/loss claim filed by a homeowner's insurance policyholder. 47 S.W.3d 569 (Tex. App.—Houston [1st Dist.] 2001, no pet.). In September of 1996, Mr. Perrotta discovered several boxes of personal property missing from his residence. He reported the loss with his insurance agent who forwarded notice of the loss to Farmers. A Farmer's adjuster met with Mr. Perrotta and went over the items that were lost. Mr. Perrotta also mailed a proof of loss form to Farmers at the adjuster's request, but Farmers took exception to the proof of loss form because it did not detail the amount claimed and did not have a notary seal. Farmers sent Mr. Perrotta another proof of loss form and a separate authorization form, but Mr. Perrotta did not complete the forms. Mr. Perrotta did, however, attend an Examination Under Oath and provided nine photographs depicting the stolen items. But Mr. Perrotta never signed and returned the transcription of the examination to Farmers. Farmers ultimately denied Mr. Perrotta's claim.

Mr. Perrotta sued Farmers for breach of contract and extra-contractual claims. The court held that Farmers had a reasonable basis for denying the claim because of Mr. Perrotta's own breach of the policy. The court noted that when the underlying claim upon which an insured's extra-contractual claims are premised is found to have been properly denied, the extra-

contractual claims necessarily fail. More recently, in *Avila v. Loya*, 2005 WL 1902120 (Tex. App.—Amarillo, August 10, 2005, no. pet.), the Amarillo Court of Appeals noted:

[E]vidence that establishes a bona fide coverage dispute does not demonstrate bad faith [I]f an insurer has a reasonable basis for a denial of coverage, it retains the right to deny questionable claims without being exposed to extra-contractual tort claims which require the same predicate for recovery as bad faith claims. . . . Thus, an insurer who establishes a reasonable basis for denying a claim, even if that basis is shown to be erroneous, enjoys immunity from statutory bad faith under the Texas Insurance Code and the DTPA.

The *MacIntire* case and its progeny illustrate the difficult standard an insured faces when making an extra-contractual claim arising out of a denied claim.

2. Damages

A breach of Chapter 541 can result in trebled damages. Trebled damages equate to three times the economic damages; it does not equate to economic damages plus three times economic damages. Thus, if a jury awards a plaintiff \$100,000 in economic damages (not including mental anguish damages) and awards additional damages the total award will be \$300,000; it will not be \$400,000 or [\$100,000 + (\$100,000 x 3)]. Additionally, prejudgment interest should not be included in the amount trebled. Rather, it should be added after the additional damages are added to the economic damages. *Aetna Cas. & Surety Co. v. Garza*, 906 S.W.2d 543, 556 (Tex. App.—San Antonio 1995, writ denied).

An insured can also recover for mental anguish damages by establishing that the defendant acted “knowingly.” The Texas Supreme Court has clarified that a knowing violation of the Insurance Code occurs where the offending party has “actual awareness” of the deception. *St. Paul Surplus Lines Ins. Co. v. Dal-Worth Tank Co.*, 974 S.W.2d 51, 53-54 (Tex. 1998). The *St. Paul* court explained:

“Actual awareness” does not mean merely that a person knows what he is doing; rather it means that a person knows that what he is doing is false, deceptive, or unfair. In other words, a person must think to himself at some point, “Yes, I know this is false, deceptive or unfair to him, but I’m going to do it anyway.”

Id.; see also *Allison v. Fire Ins. Exch.*, 98 S.W.3d 227, 256 (Tex. App.—Austin 2002, pet. vac’d w.r.m.).

B. The Prompt Payment Of Claims

The Prompt Payment of Claims statute sets out rules for timing of communications and payments of first-party claims. TEX. INS. CODE § 542. In the liability policy context, the Texas Supreme Court has interpreted this to mean that claims concerning indemnity for third-party claims are not covered by the statute, but claims for the insured’s defense are included. See *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1, 16 (Tex. 2007). We outline the

statutory deadlines for the claims below and then discuss issues and concerns unique to traditional first party claims and defense costs for third-party claims.

1. Acknowledgement

Section 542.055 states:

Sec. 542.055. RECEIPT OF NOTICE OF CLAIM.

(a) Not later than the 15th day or, if the insurer is an eligible surplus lines insurer, the 30th business day after the date an insurer receives notice of a claim, the insurer shall:

- (1) acknowledge receipt of the claim;
- (2) commence any investigation of the claim; and
- (3) request from the claimant all items, statements, and forms that the insurer reasonably believes, at that time, will be required from the claimant.

(b) An insurer may make additional requests for information if during the investigation of the claim the additional requests are necessary.

(c) If the acknowledgment of receipt of a claim is not made in writing, the insurer shall make a record of the date, manner, and content of the acknowledgment.

Under the above-referenced statute, an insurer has 15 days after receiving notice of a claim by which to: (1) acknowledge receipt of the claim, (2) begin to investigate the claim, and (3) request additional information from the insured, if necessary. If the insurer is an eligible surplus lines insurer, then the deadline is 30 days.

2. Deadline to accept or reject the claim

Section 542.056 sets for the deadline to accept or reject the claim and states:

Sec. 542.056. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM.

(a) Except as provided by Subsection (b) or (d), an insurer shall notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date the insurer receives all items, statements, and forms required by the insurer to secure final proof of loss.

(b) If an insurer has a reasonable basis to believe that a loss resulted from arson, the insurer shall notify the claimant in writing of the acceptance or rejection of the claim not later than the 30th day after the date the insurer receives all items, statements, and forms required by the insurer.

- (c) If the insurer rejects the claim, the notice required by Subsection (a) or (b) must state the reasons for the rejection.
- (d) If the insurer is unable to accept or reject the claim within the period specified by Subsection (a) or (b), the insurer, within that same period, shall notify the claimant of the reasons that the insurer needs additional time. The insurer shall accept or reject the claim not later than the 45th day after the date the insurer notifies a claimant under this subsection.

After acknowledging and investigating the claim, the insurer must then notify the insured in writing no later than the 15th business day after it has received the items it requested under Section 542.055 as to whether it has accepted or rejected the claim. However, this deadline can be extended for an additional 45 days if the insurer notifies the insured, in writing, that it needs additional time to complete its investigation.

3. Deadline to pay valid claims

Next, under Section 542.057, if an insurer notifies the policyholder that it has accepted the claim, it must pay the claim no later than 5 business days after providing the insured that notice. This deadline is extended to 20 business days if the insurer is an eligible surplus lines insurer. If the payment is conditioned upon some action by an insured, then the insured must pay 5 days after the performance of that action.

4. Penalty for late payment of claims

Under Section 542.058, if an insurer fails to make payment on a valid claim for more than 60 days after receiving all items, statements and other requested information, then it is liable for the penalties set forth in Section 542.060, which states:

Sec. 542.060. LIABILITY FOR VIOLATION OF SUBCHAPTER.

- (a) If an insurer that is liable for a claim under an insurance policy is not in compliance with this subchapter, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.
- (b) If a suit is filed, the attorney's fees shall be taxed as part of the costs in the case.

Accordingly, an insurer who does not pay a valid claim within the 60 day statutory period is subject to an 18 percent interest penalty. Currently, there is no good faith exception to this rule, as several courts have stated that an insurer who wrongfully denies a claim should not be in a better position than one who delays, but ultimately pays, the claim. *See, e.g., Higginbotham v. State Farm Mut. Auto. Ins. Co.*, 103 F.3d 456 (5th Cir. 1997); *Teate v. Mutual Life Ins. Co. of*

New York, 965 F. Supp. 891 (E.D. Tex. 1997); *Oram v. State Farm Lloyds*, 977 S.W.2d 163 (Tex. App.—Austin 1998, no pet.).

The 18 percent per annum penalty is simple interest and is not compounded. See *Primrose Operating Co. v. Nat'l Amer. Ins. Co.*, No. Civ.A. 5:02-CV-101-C, 2003 WL 21662829, at *3 (N.D. Tex. July 15, 2003) *reversed in part* by 382 F.3d 546 (5th Cir. 2004). Further, because the penalty is punitive in nature, prejudgment interest is not assessed on it. *Id.*

In the case of a partial payment, the amount of penalties is only due on the part of the claim not paid and not on the entire amount of the claim. In *Republic Underwriters Ins. Co. v. Mex-Tex, Inc.*, 150 S.W.3d 423 (Tex. 2004), the Texas Supreme Court reversed an appellate court decision holding that penalties and interest under now Chapter 542 should be calculated on the entire amount of the claim, and not just the disputed amount of the claim. There, the carrier tendered payment on the undisputed amount which a court later determined to be insufficient following a bench trial. The court then calculated the eighteen (18%) percent penalty and interest on the full amount of the claim of \$179,000, and not simply on the \$33,540 which remained in dispute at the time of trial.

The Supreme Court of Texas analyzed the statute's definition of "claim." The Court held that by including the phrase "that must be paid" the definition limits the meaning of "claim" to: "the amount ultimately owed," – i.e., less any partial payments made prior to that determination. The Court intended to "encourage insurers to pay the undisputed portion of a claim early, consistent with the statute's purpose to obtain prompt payment of claims made pursuant to policies of insurance." But, the Court agreed with the lower court and *Mex-Tex*, through finding that the tender of partial payment must be "unconditional." The Court nevertheless imposed the burden on the insured to prove the tender was conditioned on a full release. Likewise, the carrier has the burden to prove accord and satisfaction based on the initial payment. Here, the court found no proof that the partial payment was conditioned on a full release and concluded that *Mex-Tex* was only entitled to the statutory penalty on the disputed amount of \$33,540.

5. Traditional first party claims

The Prompt Payment Statute was initially applied to traditional first-party claims, such as property policies. While the statute appears to lay out straight forward deadlines and requirements in handling the claims, whether an insured or insurer has met the requirements of the statute or missed the deadlines is not always straight-forward. For example, in *McMillin v. State Farm Lloyds*, 180 S.W.3d 183 (Tex. App.—Austin 2005, pet. denied), the Austin Court of Appeals interpreted the definition of "notice of claim" to require written notice by the insured. In that case, the insured reported the claim by telephone. The court rejected arguments that State Farm's telephone logs would satisfy the "in writing" submission requirement. The court concluded that the insured never triggered Chapter 542, and consequently, no statutory penalties were owed.

We note several issues that may arise in a traditional first-party claim. For example, if a policyholder has a claim for property damage to their home, under *McMillin*, it must provide

written notice to the insurer of the claim in order to trigger the statute. On the other hand, Section 542.055 does not require that acknowledgement of receipt of the claim be in writing. Rather, the statute specifically provides requirements for an acknowledgement or request for information that is not in writing. Typically, a log entry note confirming the adjuster called the insured constitutes adequate acknowledgement, but oftentimes the adjuster may not send a letter requesting necessary information to investigate the claim. The better course is to acknowledge the claim in writing including all necessary information requests.

Issues may also arise in determining when the clock starts for different claims made by the same insured arising from the same incident. For instance, a policyholder may provide notice of a claim to an insurer for property damage due to a hurricane, however, it may present proof of loss for different parts of its claim at different times. For example, the policyholder may present losses for the building, the contents for the buildings or different buildings arising from the same hurricane. If an insured provides the insurer with the requisite information for each of these various claims at different times, it may mean that each claim is subject to a separate statutory deadline for acknowledgement, period of investigation and computation of any potential penalty.

6. Defense costs in third-party action

As noted above, the statute applies to “first-party” claims. The Texas Supreme Court recently held that defense costs for third-party actions were subject to the statutory penalties set forth in Chapter 542. *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 242 S.W.3d 1, 16 (Tex. 2007). In *Lamar Homes*, the court noted it previously distinguished between first-party and third-party claims on the basis of the claimant’s relationship with the loss. *Id.* at 17. Thus, a first-party claim is where an insured seeks to recover for its own loss, while a third-party claim involves injuries to a third party. *Id.* (citing *Universal Life Ins. Co. v. Giles*, 950 S.W.2d 48, 54, n.2 (Tex. 1997)). The court held that defense costs were a first-party claim because if an insured does not have the defense provided by a liability policy, then it would be responsible for such costs. *Id.* *But see* *Evanston Ins. Co. v. Atofina Petrochemicals, Inc.*, 256 S.W.3d 660, 674-75 (Tex. 2008) (finding that a loss in satisfaction of a settlement is not a first-party claim).

For the statute to apply, there must be a valid duty to defend. *Lamar Homes, Inc.*, 242 S.W. at 20; *see also* *Progressive Cnty. Mut. Ins. Co. v. Boyd*, 177 S.W.3d 919 (Tex. 2005). When an insurer erroneously denies the duty to defend, it must then determine when the penalty began to accrue. It was previously believed that under *Lamar Homes*, the Texas Supreme Court expressly required the insured to tender and present the actual legal invoices, as they are received, to the insurer in order to trigger penalty interest based upon its statement that:

When the insurer wrongfully rejects its defense obligation, the insured has suffered an actual loss that is quantified after the insured retains counsel and begins receiving statements for legal services. These statements or invoices are the last piece of information needed to put a value on the insured’s loss.

242 S.W.3d at 19. Accordingly, the statutory penalty would only begin to accrue after the actual invoices were presented to the insurer. Under this approach, an insurer’s statutory penalty could

be very limited if the insured did not present any of the defense bills to the insured until after a determination that the insurer owed a duty to defend. For example, an insurer could deny the duty to defend a claim in 2005 (assuming the insured met all of other statutory requirements) and have a judgment entered that this decision was erroneous five years later, in 2010. If the insured did not present the defense bills as they were incurred, starting in 2005, the statutory penalty would not accrue until the bills were presented to the insured after the resolution of coverage dispute in 2010. Thus, the insurer would not be liable for five years of penalties.

On the other hand, a federal district court held that, under the reasoning set forth in *Lamar Homes*, the claim under the statute matures upon denial of the defense and the statutory penalty begins to accrue at the time the invoice is paid by the insured, regardless of when the invoice was tendered. *Trammell Crow Residential Co. v. Virginia Sur. Co.*, 643 F. Supp. 2d 844, 859 (N.D. Tex. 2008). The District Court rejected the insurer's argument that it was not liable for damages under the Prompt Payment Statute because Trammell Crow had not submitted any legal bills for the underlying litigation. The insurer cited to *Lamar Homes* for the proposition that there could be no damages under the Prompt Payment Statute unless the insured retained counsel, began to receive invoices for the legal services and submitted them to the insurer. *Id.* (citing *Lamar Homes*, 242 S.W.3d at 19). The court disagreed that an insurer cannot be liable under the statute unless the insured submitted its defense invoices to the insurer. Rather, the District Court found under *Lamar Homes*, an insurer is liable under the statute once it denies the duty to defend, but that the penalties under the statute do not accrue until the insured provides evidence of the amount of the defense costs and the date paid. *Id.* "In other words, there can be a determination of liability without a calculation of damages." Accordingly, under the reasoning of *Trammell Crow*, an insurer is liable under the statute when it denies coverage, but damages are calculated based upon the amount of defense costs and the date they are paid by the policyholder. Under our above example, the insurer would be liable for all statutory interest on the defense costs from 2005-2010, as these costs were incurred by the insured.

7. Insured's delay and its effect on Prompt Payment

In *Allison v. Fire Ins. Exchange*, 98 S.W.3d 227 (Tex. App.—Austin 2002, no pet.), an insurer was held to have violated the prompt payment statute. However, the insurer was not the sole cause of the delay, and the court noted that there was evidence that some payments were delayed due to the conduct of the insured. Instead of assessing the 18% penalty against the entire amount of money owed to the insured, the court held that the 18% penalty should *only* be assessed on late payments which were delayed because of the insurer's conduct. *Id.* at 264. Accordingly, if an insured can prove that its payments were delayed because of an insured's conduct, it should not be required to pay penalty interest on that amount.

Similarly, in the case of a partial payment, penalty interest is only assessed on the portion of the claim that is not paid, and is not assessed on the entire amount of the claim. In *Republic Underwriters Ins. Co. v. Mex-Tex, Inc.*, 150 S.W.3d 423 (Tex. 2004), the insurer tendered payment on the undisputed amount which a court later determined to be insufficient following a bench trial. The court then calculated the 18% percent penalty and interest on the full amount of the claim of \$179,000, and not simply on the \$33,540 which remained in dispute at the time of trial. The Texas Supreme Court reversed the appellate court's decision, and held that penalties

and interest under now Chapter 542 should be calculated on just the disputed amount of the claim.

C. No Double Dipping

Claims for extra-contractual damages do not allow for a double recovery. A double recovery exists when a plaintiff obtains more than one recovery for the same injury. *Bekins Moving & Storage Co. v. Williams*, 947 S.W.2d 568, 585 (Tex. App.—Texarkana 1997, no pet.). However, an insured can recover under the Insurance Code and under the DTPA, and it is not necessarily considered a double recovery. *Id.* Accordingly, it is possible for an insurer to be liable for prejudgment interest, treble damages under Chapter 541, and 18 percent penalty under Chapter 542.

IV. COMMON LAW BAD FAITH

The duty of good faith and fair dealing arises from the special relationship between the insurer and the insured. Courts have routinely held that the application of the duty of good faith and fair dealing is not limited solely to the denial and/or delay in the payment of individual claims. In many jurisdictions, a cause of action for breach of the duty of good faith and fair dealing also exists when the insurer wrongfully cancels an insurance policy without a reasonable basis. This cause of action is typically pled by the insured alleging that the insurer had no reasonable basis for the cancellation of the policy, and the insurer knew or should have known of that fact.

A policyholder may bring a claim against an insurer for breach of the common law duty of good faith and fair dealing as well as a claim for Unfair Settlement Practices under Subchapter 541 of the Texas Insurance Code. *See Arnold v. Nat. Cnty. Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987). There is considerable overlap in these two remedies. Under both causes of action, the policyholder must prove that the insurer had no reasonable basis for denial or delay in payment of the claim. TEX. INS. CODE § 541.060(a)(3); *Arnold*, 725 S.W.2d at 167. Further, the insured must prove that the insurer “knew or should have known” that there was no reasonable basis for denying or delaying payment. *See Giles*, 950 S.W.2d at 50-51 (citing *Transp. Ins. Co. v. Moriel*, 879 S.W.2d 10, 18 (Tex. 1994)).

As with statutory bad faith, *any* reasonable basis is sufficient to allow the insurer to avoid bad faith liability. *See Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48, 66 (Tex. 1997). Examples of what is considered to be a reasonable basis for denial include a legitimate dispute over the scope of damage to property or the cost of repair. *See id.* A bona fide dispute over whether a claim is covered will also suffice. *Id.* (citing *Transp. Ins. Co. v. Moriel*, 879 S.W.2d 10, 17 (Tex. 1994)). In addition, if it turns out that there is in fact no coverage for a claim, the insurer cannot be held liable no matter how poorly it handled the matter. In other words, the insurer can avoid common law bad faith liability even if it denies coverage for the wrong reason. *Republic Ins. Co. v. Stoker*, 903 S.W.2d 338, 341 (Tex. 1995).

Texas does not recognize a tort of bad faith premised on third-party insurance, except in the limited situation in which an insurer fails to settle third-party claims against its insured (i.e., a

so-called *Stowers* claim). See *Maryland Ins. Co. v. Head Indus. Coatings & Servs., Inc.*, 938 S.W.2d 27, 28-29 (Tex. 1996). However, as a practical matter, there is no common law duty of good faith and fair dealing in third party claims.

Because a breach of the common law duty of good faith and fair dealing requires a finding that an insurer had no reasonable basis for denying coverage, and knew or should have known of this fact, it is exceedingly difficult for insureds to prevail on common law bad faith claims.

Finally, even if an insured prevails on its claim that the insurer breached its common law duty of good faith and fair dealing, the insured is not automatically entitled to recover punitive damages. *Giles*, 950 S.W.2d at 54. Instead, the policyholder may only recover punitive damages if it can prove that the insurer acted maliciously, intentionally, fraudulently, or grossly negligently. *Id.* In fact, Texas courts have held that, in the context of bad faith claims, “punitive damages will ordinarily be available only in exceptional cases.” *Id.*; see also *Standard Fire Ins. Co. v. Stephenson*, 963 S.W.2d 81, 91 (Tex. App.—Beaumont 1997, no pet.). Again, this standard is exceedingly difficult to meet, and absent proof that the insured’s conduct was dishonest or malevolent, courts are hesitant to allow the recovery of punitive damages.

V. CONCLUSION

Bad faith litigation has grown rapidly in the past twenty years and has become a regular hassle that insurers face on a daily basis. These days, insureds rarely, if ever, bring claims against insurers *without* including claims for statutory or common law bad faith. Because of this, it is exceptionally important for insurers to understand the differences between contractual and extra-contractual causes of action, as well as the stringent rules insurers must follow to avoid liability on these claims. However, the key to evading bad faith findings is simple: act reasonably, and insureds will rarely prevail on bad faith claims.