Texas Supreme Court Update: From the Perspective of the Insurer, the Insured, and the Plaintiff

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The Texas Supreme Court issued several opinions this year that will have varying effects upon insurers, insureds, and third-party claimants. Following is a short discussion of the relevant opinions.

I. *Minnesota Life Ins. Co. v. Vasquez*, 192 S.W.3d 774 (Tex. 2006) (Majority opinion by Justice Brister).

This is a bad faith case involving a mortgage insurance policy and the level of proof required to establish a breach of the duty of good faith and fair dealing under former article 21.21 of the Texas Insurance Code. The mortgage insurance policy at issue in *Vasquez* only paid off the mortgage if the insured died by accident and "independently of all other causes."

The insured, Joe Vasquez, fell ill with a seizure disorder and went into the hospital. While recuperating in the hospital, he fell, hit his head, and died. Joe's wife, Elia Vasquez, sought recovery under the policy to pay off her mortgage, and she furnished the autopsy and death certificate.

These documents, however, listed both the seizure disorder and the fall as causes of death. So, the carrier hired a consultant to evaluate the cause of death. The consultant said he needed to review the medical records to determine whether the death resulted solely from the fall.

The insurer hired a records vendor to obtain the medical records. The vendor requested the records several times without success. Eventually the hospital told the vendor it needed a medical authorization to release the records.

The insurer then engaged an attorney to obtain the records, and the attorney sent its demand letter approximately one month later. The insurer received the records 171 days after it received notice of the surviving spouse's claim.

As it turned out, the medical records did not provide any help in determining whether the death resulted solely from the fall or from a combination of the fall and the seizure disorder. Thus, the insurer paid the claim on the 174th day after notice.

Elia Vasquez sued the insurer for bad faith. A jury found the insurer knowingly violated the Insurance Code and awarded Vasquez $60,000 for mental anguish, $250,000 in additional damages (reduced to $120,000 in the judgment), and $37,000 in attorneys' fees.

The supreme court reversed the judgment, finding the record contained no evidence of bad faith conduct by the carrier. The court said:

> Unquestionably, the insurance company here might have done better. But when insurers are negligent, the Texas Insurance Code does not grant policyholders extracontractual damages. Instead, such cases are reserved for cases in which an insurer knew its actions were false, deceptive, or unfair. There is no such evidence here. Claims for extra-contractual damages should not be a routine addition to every breach-of-policy case.

Id. at 775.

The trial court had submitted to the jury two alleged unfair settlement practices: (a) failing to attempt in good faith a prompt, fair, and equitable settlement of a claim with respect to which the insurer's liability has become reasonably clear; and (b) failing within a reasonable time to affirm or deny coverage of a claim to a policyholder. *Id.* at 777. On the failure-to-settle theory, the court found that the carrier never knew any more about the cause of death than what was stated in the autopsy and death certificate, and those documents failed to establish that accident (the fall) was the sole cause of

death. Because coverage was not reasonably clear from these documents, the insurer could not be liable for failing to pay a claim on which liability had become reasonably clear.

On the second claim (delay in affirming or denying a claim), the carrier acknowledged it paid the claim beyond 60 days. The supreme court held, however, that the record contained no evidence of a knowing violation of the Insurance Code that would authorize special damages (*i.e.*, mental anguish and additional damages).

Although there was "plenty of evidence of unaccountable delays," what was missing from the record was "any evidence that [the insurer] was aware that its protracted efforts to obtain the medical records was false, deceptive, or unfair to Ms. Vasquez." *Id.* at 779. The court found no evidence that the insurer intentionally prolonged the investigation, or that its efforts were a sham to avoid payment, or that the insurer gave false reasons for the delay, or that the insurer knew Ms. Vasquez was suffering mental anguish. *Id.* at 780.

Therefore, although the insured might be able to recover actual damages, the record did not support an award of bad faith damages against the insurer:

> Payments beyond [actual damages] cannot be based on negligence or hindsight; there must be evidence that the insurer was actually aware that it was handling the claim in a way that was false, deceptive, or unfair. As there is no such evidence here, the lower courts erred in awarding extra-contractual damages.

Id. The court thus reversed the awards of mental anguish and additional damages.

II. *Guideone Elite Ins. Co. v. Fielder Road Baptist Church*, 197 S.W.3d 305 (Tex. 2006) (Majority opinion by Justice Medina; Concurring opinion by Justice Hecht, joined by Justices Wainwright, Brister, and Willett)

In this case, the Texas Supreme Court declared that courts may not consider extrinsic evidence in determining an insurer's duty to defend.

In *Guideone*, the carrier had issued a CGL policy to the church with a policy period of March 31, 1993 to March 31, 1994. A parishioner sued the church for alleged sexual abuse and exploitation by an associate youth minister (Evans), alleging that Evans was "at all times from 1992 to 1994 ... employed … and under the church's direct supervision and control."

The carrier filed a declaratory judgment action and, during discovery, obtained employment records establishing that Evans ceased employment with the church on December 15, 1992, before the policy incepted. The carrier relied on this extrinsic evidence in its motion for summary judgment on duty to defend, arguing it established no coverage. The trial court considered the evidence and granted summary judgment, but the court of appeals reversed.

The supreme court upheld the court of appeals' ruling that extrinsic evidence may not be considered in determining the duty to defend. Its rule is broad with no exceptions for mixed fact and coverage questions. The *Guideone* court strictly construed the eight-corners rule and held that the only relevant documents for purposes of duty to defend are (a) the policy, and (b) the petition or complaint.

The court recognized that, under the typical liability policy, the carrier must defend regardless of whether the allegations are "groundless, false, or fraudulent." *Id.* at

310. Allowing extrinsic evidence to refute the allegations in the petition would, therefore, be inconsistent with both the eight-corners rule and the carrier's obligations in the insuring agreement. *Id.*

The court said, "A plaintiff's factual allegations that potentially support a covered claim is all that is needed to invoke the insurer's duty to defend." *Id.* Accordingly, the extrinsic evidence of employment records could not be considered, and the allegations in the plaintiff's petition triggered a duty to defend. *Id.* at 311.

The court also held that, in a sexual molestation case, "bodily injury" is commonly understood to be a consequence of sexual assault or abuse. *Id.* Thus, allegations of emotional and psychological injuries were sufficient to constitute "bodily injury" under the CGL policy. *Id.*

In the concurring opinion, Justice Hecht agreed that the carrier owed a duty to defend based on the policy and the pleadings, but not solely based on the employment issue. Because the petition alleged a number of other potentially covered claims (*e.g.*, breach of fiduciary duty, misrepresentation) that were not dependent on the period of Evans' association with the church, the carrier owed a duty to defend. Thus, Justice Hecht said, the discussion of extrinsic evidence and the eight-corners rule was unnecessary and should be saved for another case.

III. *Fiess v. State Farm Lloyds*, 202 S.W.3d 744 (Tex. 2006) (7-2 opinion; Majority opinion by Brister; Dissenting opinion by Medina).

In this case, the Texas Supreme Court answered a question certified to it by the Fifth Circuit Court of Appeals: "Does the ensuing loss provision contained in Section I-Exclusions, part 1(f) of the Homeowners Form B (HO-B) insurance policy as prescribed by the Texas Department of Insurance effective July 8, 1992 (Revised January 1, 1996), when read in conjunction with the remainder of the policy, provide coverage for mold contamination caused by water damage that is otherwise covered by the policy?"

In a 7-2 majority opinion, the supreme court answered "No." The court found the homeowners' policy at issue was not ambiguous and interpreted the policy according to long-standing Texas rules of policy construction. The dispute centered on the following provision, exclusion 1(f):

> We do not cover loss caused by:
>
> (1) wear and tear, deterioration or loss caused by any quality in property that causes it to damage or destroy itself.
>
> (2) rust, rot, mold or other fungi.
>
> (3) dampness of atmosphere, extremes of temperature.
>
> (4) contamination.
>
> (5) rats, mice, termites, moths or other insects.
>
> We do cover ensuing loss caused by collapse of the building or any part of the building, water damage, or breakage of glass which is part of the building if the loss would otherwise be covered under this policy.

The supreme court held the policy could not be clearer in stating, "We do not cover loss caused by . . . mold." *Id.* at 748. The issue was whether the last clause, known as the ensuing loss clause, affected the unambiguous exclusion for mold.

The majority held it was not required to disregard the first part of the provision (excluding coverage for mold) because of how the provision ends (ensuing loss). *Id.* The court relied on the San Antonio Court of

Appeals' opinion in *Lambros v. Standard Fire Ins. Co.*, 530 S.W.2d 138 (Tex. Civ. App.—San Antonio 1975, writ ref'd),[1] which had interpreted the ensuing loss clause under slightly different facts.

The *Lambros* court held that "ensuing loss" meant a loss which follows as a consequence of some preceding event or circumstance. *Id.* at 141. Therefore, the plain language of the ensuing loss clause compelled the conclusion that the water damage must be a consequence (*i.e.*, follow from or be the result of) the types of damage enumerated in the exclusion. In other words, under the facts of *Lambro*, "ensuing loss caused by water damage" refers to water damage which is the *result*, rather than the *cause*, of "settling, cracking, . . . of foundations. . . ." *Id.*

In *Fiess*, the supreme court held it would follow the precedent in *Lambros*. Thus, the ensuing loss clause in *Fiess* also applied only to losses caused by an intervening cause (like water damage) that in turn follow from an exclusion listed in paragraph 1(f) (like mold). *Fiess*, 202 S.W.3d at 749. That is, for example, coverage only exists for water damage that ensues from mold, not the other way around.

In addition, even setting aside this interpretation, the *Fiess* court found the ensuing loss clause did not require coverage for mold because it is caused by water, not by "water damage" (as the exception states). *Id.* at 750 and n.28 (citing *Aetna Cas. & Sur. Co. v. Yates*, 344 F.2d 939, 941 (5th Cir.1965)). The court said, "Mold does not grow without water; if every leak and drip is 'water damage,' then it is hard to imagine any mold, rust, or rot excluded by this policy, and the mold exclusion would be practically meaningless." *Id.* at 750.[2]

Lastly, the court held the last phrase of the exclusion (if the loss would otherwise be covered under this policy) also did not negate the mold exclusion. Here, the first sentence of 1(f) excludes mold, and the second sentence extends coverage to ensuing losses caused by water damage. Section 1(f) limits the second clause (the ensuing loss clause) whenever it conflicts with anything else in the policy. By placing this proviso where it is, the only reasonable construction is that the second sentence (covering ensuing losses) must yield to the first (excluding mold), not the other way around. *Id.* at 751.

The dissent would hold that the exclusion is ambiguous and should be construed in favor of the insured. *Id.* at 753 (Medina, J., dissenting). In other words, the dissent would hold that the ensuing loss clause is an exception to the exclusion, which means the policy covers mold caused by water damage and is not otherwise excluded elsewhere in the policy. Applying that rule, the dissent said, required the supreme court to answer "Yes" to the certified question.

IV. *Allstate Ins. Co. v. Forth*, 204 S.W.3d 795 (Tex. 2006) (per curiam).

The issue in this breach of contract suit was whether the insured had standing to sue her insurance company for settling her medical bills in an allegedly arbitrary and unreasonable manner. The supreme court held the insured lacked standing to sue her insurer when she had not alleged that she had suffered any damages or that the

[1] The fact that the supreme court denied the writ "refused" meant the *Lambros* opinion carried equal weight to a supreme court opinion. *See Fiess*, 202 S.W.3d 749, n.23; *see also* TEX. R. FORM App. E at 103 (11th ed. 2006).

[2] The *Fiess* court said it "need not decide today the precise scope of 'water damage' in the ensuing-loss clause," because it was an issue not framed by the certified question. *Id.* at 751. "The issue we do decide is that a policy exclusion for 'mold' cannot be disregarded by simply deeming all mold to be 'water damage.'" *Id.*

carrier's manner of settling the medical bills caused her injury.

Ms. Forth was apparently upset that her insurer "arbitrarily reduced her bills without using an independent and fair evaluation to determine what amount of her medical expenses were reasonable." *Id.* at 795. However, the record showed that Forth's medical providers accepted the amounts the insurer paid them without complaint. *Id.* at 796.

Also, Forth did not claim she had any unreimbursed, out-of-pocket medical expenses, or that any provider withheld medical treatment because of the reduced payment, or that any provider threatened to sue her for the deficiency. *Id.* And, Forth had no future liability because limitations had expired on the medical claims. *Id.*

Therefore, in the absence of any threatened or actual injury or damages, Forth lacked standing to sue her insurer based on the manner in which it settled her claim.

V. *Via Net US Delivery Sys. V. TIG Ins. Co.*, 211 S.W.3d 310 (Tex. 2006) (per curiam).

This case involves additional insured coverage and applicable statutes of limitations.

Safety Lights required its subcontractors to list it as additional insured on all CGL policies. One of the subs, Via Net, agreed to do so and provided Safety Lights with a certificate of insurance effective February 1997. Via Net added Safety Lights as additional insured but said "this certificate does not amend, extend, or alter the coverage afforded by the policies." In actuality, Via Net's CGL policy did not provide for additional insured coverage and the carrier did not issue an additional insured endorsement.

In June 1997, a Via Net employee was injured at Safety Light's workplace. The employee sued Safety Lights, and Safety Lights requested a defense under Via Net's CGL policy. The carrier denied the request for defense on December 9, 1997.

Safety Lights settled the employee's claim for $235,000 and then sued Via Net and the carrier for breach of contract and misrepresentation. Safety Lights lost this suit on a ruling of no coverage – that is, Via Net's policy did not have additional insured coverage, and Safety Lights' reliance on the certificate of insurance was unreasonable. *Id.* at 312.

Having lost on coverage, Safety Lights sued Via Net for breach of contract for failing to add it to the CGL policy as additional insured. Via Net asserted a limitations defense on the theory that Safety Lights did not sue within four years of the alleged breach (*i.e.*, the failure to add as an additional insured in June 1997). Instead, Safety Lights had sued within four years of the date on which the carrier denied a defense (December 1997).

The trial court granted summary judgment on limitations, even though Safety Lights had raised the "discovery rule" in defense of limitations in its summary judgment response. The discovery rule defers accrual of a claim for purposes of limitations if the nature of the injury incurred is inherently undiscoverable and the evidence of injury is objectively verifiable. *Id.* at 313.

The court of appeals reversed, finding the discovery rule applied to extend the accrual of limitations for Safety Lights' breach of contract claim until it received notice of the carrier's denial of its request for a defense under the CGL policy.

The supreme court reversed the court of appeals' opinion, finding that the breach of contract at issue (*i.e.*, failure of the named insured to add an additional insured to its

CGL policy) was not inherently undiscoverable and could be discovered by due diligence. *Id.* at 313-15. Safety Lights argued that it acted diligently by obtaining a certificate of insurance.

The supreme court disagreed (somewhat reluctantly), noting that the certificate of insurance plainly warned that it conferred no rights and was limited by the underlying policy. Thus, the court said, "those who take such certificates at face value do so at their own risk." *Id.* at 314. In essence, the court now requires an additional insured to obtain a copy of the subject policy in addition to the certificate of insurance.

The supreme court also found it relevant that Safety Lights learned of the breach within a few months after it occurred. That is, the certificate issued in February 1997, the employee sued in July 1997, and Safety Lights received the denial letter in December 1997. Thus, the court found a breach like the one asserted by Safety Lights to generally be discoverable within four years. *Id.*

The *Via Net* court was careful to note that it was not holding the discovery rule can never apply to breach of contract claims. But, the court did say that it would only apply in a rare case because diligent contracting parties should be able to discover a breach within the relatively long four-year limitations period. *Id.* at 315.

VI. *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, ___ S.W.3d ___, 2006 WL 1195330 (Tex. 2006) (Majority opinion by Justice Green).

This case involves the availability of coverage for an additional insured under an excess liability policy and whether the contract between the parties (specifically, the indemnity provision) affects coverage.

The subcontractor (Triple S) agreed to list the plant owner (ATOFINA) as an additional insured on both its CGL and excess policies. The CGL policy provided additional insured coverage but specifically excluded any liability arising from ATOFINA's sole negligence. The excess policy was a "following form" policy and expressly stated the excess coverage would "be no broader than the underlying insurance" except for the policy limit.

In addition, the contract between Triple S and ATOFINA required Triple S to indemnify ATOFINA against personal injuries or property losses sustained during the performance of the contract, unless the losses were attributable to ATOFINA's concurrent or sole negligence.

While working at the ATOFINA plant, a Triple S employee drowned after he fell through the corroded roof of a storage tank filled with fuel oil. The employee sued Triple S and ATOFINA. The CGL carrier immediately tendered its $1 million policy limit to ATOFINA. ATOFINA then made a claim against the excess policy, which the excess carrier denied.

In the breach of contract suit, the trial court granted summary judgment to the excess carrier, finding no coverage. The court of appeals reversed, finding ATOFINA was covered under the excess policy because the contract between Triple S and ATOFINA required Triple S to obtain the exact same insurance coverage for ATOFINA as it had for itself.

The supreme court reversed. It held that, while the indemnity agreement in the parties' contract is relevant to determining what the parties *intended* with respect to the scope of the indemnity obligation, an insurance policy secured to insure that obligation stands on its own. *Id.* at *3. If the insurance policy fails to satisfy the indemnity obligation, the obligor (Triple S) remains exposed. *Id.*

Here, however, the court found no conflict between what the indemnity

agreement required and the insurance the policy provided. The indemnity agreement expressly excluded indemnity for losses arising from ATOFINA's concurrent or sole negligence. Likewise, the CGL policy excluded coverage for losses arising from the additional insured's sole negligence, and the excess policy provided coverage "no broader" than the underlying insurance. *Id.* Therefore, the excess policy did not provide coverage if the loss arose from ATOFINA's sole negligence. *Id.*

Ultimately, however, the supreme court could not determine from the record before it whether the employee's death resulted from ATOFINA's sole negligence (the case had settled prior to trial). Therefore, the court remanded the case to the trial court for a determination of the respective liabilities of the parties. Given the resolution of this issue, the court did not address the applicability of former article 21.55 or the reasonableness of the settlement between the employee's family and ATOFINA.

VII. *Brainard v. Trinity Universal Ins. Co.*, ___ S.W.3d ___, 2006 WL 3751572 (Tex. 2006) (Majority opinion by Chief Justice Jefferson).

This is an underinsured motorist ("UM") case in which the supreme court determined the recoverability of prejudgment interest and attorneys' fees in a UM suit, as well as the proper calculation of prejudgment interest after applying offsets.

Brainard involved a fatality auto accident. The Brainard family settled with the owner of the other vehicle (Premier) for $1 million.

Premier's insurer, Trinity, paid the $5,000 PIP benefits to the Brainards but requested more information before it would pay the UM claim. The Brainards sued for UM coverage, and a jury found Premier caused the accident and awarded the Brainards $1,010,000 in damages and $100,000 in attorneys' fees. The trial court applied credits for the $1,000,000 settlement and the $5,000 PIP payment and signed a judgment for the remainder.

Trinity appealed, challenging the award of attorneys' fees, and the Brainards appealed, challenging the denial of prejudgment interest. The Texas Supreme Court first addressed the recoverability of prejudgment interest.

The court noted that, if the Brainards had recovered past damages against Premier, Premier would be liable for prejudgment interest. *Id.* at *2. Whether the Brainards could recover this prejudgment interest from Trinity is governed by the UM insurance contract.

Because the supreme court has traditionally treated prejudgment interest as an element of damages (designed to fully compensate the injured party, rather than punish the defendant), the court held that Trinity's policy covered prejudgment interest. The UM insuring agreement required Trinity to pay "damages which [Brainard] is legally entitled to recover" from Premier. *Id.* The court found that the purpose of the UM statute was to compensate drivers for financial loss, thus supporting its interpretation that the term "damages" as used in the UM policy included prejudgment interest.

The court also distinguished *Henson v. Southern Farm Bureau Ins. Co.*, 17 S.W.3d 652 (Tex. 2000), by explaining that the issue in *Henson* was not whether the insured could recover prejudgment interest that the undersinsured tortfeasor would owe, but whether the insured could recover interest from the carrier on the contractual UM claim. *Brainard*, 2006 WL 3751572 at *5. Ultimately, because Premier (the underinsured tortfeasor) would be liable for prejudgment interest, and because the policy covered those damages that the Brainards were legally entitled to recover from

Premier, the supreme court held that Trinity owed prejudgment interest.

As to the calculation of prejudgment interest, the court held that the "declining principal" formula applies. *Id.* at *6. Therefore, the beginning principal amount was $1,010,000 (amount of damages found by the jury). Trinity then received a credit for the $5,000 PIP payment, and prejudgment interest accrued only on $1,005,000 from the date of the PIP payment. Then, Trinity received a credit for the $1,000,000 payment, which was first applied to prejudgment interest and then to principal. Whatever principal remained after this credit continued to accrue prejudgment interest, up to the Brainards' UM policy limit.

On the recoverability of attorneys' fees, the supreme court recognized the unique nature of the UM contract, which requires the insured to obtain a judgment establishing the tortfeasor's liability and the amount of damages before the carrier is obligated to pay benefits. *Id.* at *8 (citing *Henson*, 17 S.W.3d at 654). Under the attorneys' fee statute, a defendant is only liable for attorneys' fees if it has failed to pay the just amount owed within 30 days after the claim is presented. *Id.* at *8 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 38.002(3)). In a UM case, the court said, presentment cannot and does not occur until the trial court signs a judgment holding the tortfeasor liable. Thus, if the carrier pays the UM judgment within 30 days, it is not liable for attorneys' fees. *Id.* at *9.

The court's holdings in *Brainard* also affected two other pending cases. In *State Farm Mut. Auto. Ins. Co. v. Nickerson*, ___ S.W.3d ___, 2006 WL 3754824 (Tex. 2006), the court applied its holding regarding attorneys' fees and reversed a fee award in favor of Nickerson because the carrier had paid the UM judgment within 30 days.

In *State Farm Mut. Auto. Inc. Co. v. Norris*, ___ S.W.3d ___, 2006 WL 3751580 (Tex. 2006), the supreme court applied its holdings on the calculation of prejudgment interest and attorneys' fees to reverse the judgment. The court also affirmed that, under section 304.104 of the Texas Finance Code, prejudgment interest does not begin to accrue until the earlier of: (1) 180 days after the date the defendant receives written notice of a claim; or (2) the date suit is filed. Thus, prejudgment interest did not accrue in *Norris* until 180 days after it received notice of the accident.

In an issue of first impression, the *Norris* court held that, when the insured settled its claim with the tortfeasor for less than the tortfeasor's liability limits, it released any claim for prejudgment interest on the difference between the settlement amount ($40,000) and the liability policy limit ($50,000). Thus, the insured could only recover prejudgment interest on the settlement proceeds and the amount by which the judgment exceeded the liability insurance. *Id.* at *2.

VIII. *State Farm Life Ins. Co. v. Martinez*, ___ S.W.3d ___, 2007 WL 431043 (Tex. 2007) (Majority opinion by Brister).

This case involves interpretation of the former article 21.55 penalty provision, now contained in section 542.060 of the Texas Insurance Code, as applied to an interpleader by the insurer.

Martinez involved a life insurance policy covering the life of Ed Martinez. As part of a divorce settlement, Ed agreed to list his ex-wife (Linda) as the beneficiary on the life insurance policy. In August 2002, shortly before he died, Ed signed a "change of beneficiary" form naming his current wife (Toni) as the beneficiary.

Ed died on August 25, 2002. Within three weeks, State Farm had received three conflicting claims to the life insurance

proceeds: Ed's daughter (Lisa) on September 2, Linda on September 5, and Toni on September 10. Toni, the surviving spouse, sued State Farm for the benefits on November 20, 2002. Two days later, State Farm filed an interpleader and deposited the policy proceeds in the court's registry. The parties ultimately settled their rights to the life insurance proceeds.

However, Toni also asserted that State Farm violated former article 21.55 by failing to pay her within 60 days of notice of her claim. State Farm had received Toni's claim by September 11, 2002, so the 60-day period ended November 10, 2002. *Id.* at *2. State Farm interpleaded the funds 12 days later. *Id.*

First, the supreme court determined Toni was a "beneficiary" and, thus, a "claimant" for purposes of article 21.55. Under Ed's policy, a change of beneficiary took effect when Ed signed a written request. Thus, even though State Farm rejected the beneficiary change until it received proof that the change complied with the divorce decree, the change took effect when Ed signed it. As a result, Toni was a beneficiary under the policy and had standing to assert an article 21.55 violation.

Next, the supreme court rejected State Farm's argument that the prompt payment of claims statute does not apply when it receives competing claims to insurance proceeds. *Id.* at *3. After analyzing the common-law rule (*i.e.*, that the insurer extinguished its liability by interpleading its funds and joining the rival claimants), the court held that the common-law rule did not survive the changes in 1991 to the prompt payment statute (when the Legislature raised the penalty rate to 18% and changed the payment deadline to 60 days). *Id.* First, the statute itself includes no exception for interpleader. *Id.*

Second, the 1991 changes required that the statute be liberally construed to promote its underlying purpose. Therefore, excepting interpleaders would be inconsistent with a liberal interpretation. *Id.* at *4. Third, requiring compliance with the statute even where the insurer interpleads the funds would not frustrate the purpose behind interpleader. *Id.* Even under the common law, the insurer could be penalized if it delayed more than 30 days in interpleading the funds. *Id.*

As to the precise violation and appropriate penalties, the *Martinez* court ultimately held that the interpleader halted the accrual of the statutory penalties. *Id.* Because interpleader is designed to promote a quick resolution to competing claims to a fund, assessing penalty interest and attorneys' fees after an interpleader would punish insurers for doing what the law encourages. *Id.* Thus, the court determined it would treat interpleader the same as payment for purposes of halting further penalty interest and attorneys' fees.

The court was careful to note that this benefit only applies when the insurer has a good-faith basis for the interpleader. In describing a good-faith basis, the court seemed to require, at a minimum, rival claims to the insurance proceeds. *Id.* at *5.

The *Martinez* court held that, once State Farm interpleaded the entire policy proceeds, it owed nothing more on the policy. The award of penalty interest and attorneys' fees was limited to the 12 days between the 60-day deadline and the interpleader. The court reversed any larger award for any time period after the interpleader. *Id.* The court also reversed the award of prejudgment interest on the penalty and fees for any time period after the interpleader. *Id.*