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RECOGNIZING AND COMBATING BAD-FAITH CLAIM TACTICS

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Getting a corporate insurance claim fully and promptly paid many times requires leverage. Too often, insurance companies drag their feet through the claims process, look for issues that delay resolution of a claim, and in the meantime, hold off payment. Insurance company methods sometimes cost policyholders time and money, and result in policyholders settling for less than their insurance claim may be worth. Policyholders can avail themselves of bad-faith law to deter this conduct and, if necessary, recover the additional damages it can cause.

Overzealous use of claim scrutiny can rise to the level of bad faith. Because insurance companies have claims departments specifically designed to investigate claims, they are well equipped to exploit the facts and issues involved in a given claim. Insurance companies should not be able to leverage their experience and resources to the detriment of their policyholders, who seek coverage after having suffered a loss and at a time when they need the value of their insurance coverage. Insurance companies should base their analysis of a claim on the merits of that claim. If they do not and instead take unreasonable positions, delay payment, or limit coverage, that type of conduct may well constitute bad faith for which they can be held accountable.

Being able to recognize bad faith and being prepared to assert it, where appropriate, can provide valuable leverage to a policyholder and may be necessary to obtain a fair insurance recovery. Bad-faith conduct, if it can be established, opens the door to additional types of damages that policyholders can recover.

While the legal conception of bad faith differs from state to state, it typically involves similar types of conduct in many jurisdictions. This article analyzes some of the types of conduct that have been viewed to constitute bad faith.

What Is the Difference Between Denial and Bad Faith?

Insurance companies deny claims for coverage every day. Not all denials are the result of bad-faith conduct. It may be that a denial is warranted based on the policy language. It also may be that a reservation of rights is warranted. But that is not to say that a denial or reservation of rights letter need not be read with a critical eye.

In considering a denial or reservation of rights, a policyholder should understand what conduct by an insurance company crosses the line. Depending on the jurisdiction, "bad faith" may be legally considered an independent tort, or it may be considered to be a breach of the duty of good faith and fair dealing, which is contractual in nature but more than a simple breach.[2] These legal distinctions can make a difference in what policyholders can do about bad-faith conduct, but from a practical point of view, they may involve similar facts. Put another way, bad faith goes beyond a mere breach of the insurance policy terms and usually involves some form of conduct in addition to a "good faith" breach of contract.[3]

Court determinations of whether an insurance company's conduct involves bad faith typically focus on the claims handling process, rather than policy interpretation. Examples of bad-faith scenarios include inordinate delay, failure to investigate, baseless denials, or failure to explain a coverage denial.[4] Entirely baseless interpretations of policy language can be another form of bad-faith conduct.[5]

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To figure out what bad faith is, it can be helpful to contrast it with what it is not. Michigan's highest court took this approach:

Good-faith denials, offers of compromise, or other honest errors of judgment are not sufficient to establish bad faith. Further, claims of bad faith cannot be based upon negligence or bad judgment, so long as the actions were made honestly and without concealment. However, because bad faith is a state of mind, there can be bad faith without actual dishonesty or fraud. If the insurer is motivated by selfish purpose or by a desire to protect its own interests at the expense of its insured's interest, bad faith exists, even though the insurer's actions were not actually dishonest or fraudulent.[6]

The Maryland legislature similarly set forth a statutory explanation of what constitutes a lack of good-faith conduct. The Maryland Code states that an insurance company acts in good faith if it makes

> an informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time the insurer made a decision on a claim.
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> * * *
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> An insurer may not be found to have failed to act in good faith under this section solely on the basis of delay in determining coverage or the extent of payment to which the insured is entitled if the insurer acted within the time period specified by statute or regulation for investigation of a claim by an insurer.[7]

While these standards for bad faith are set forth differently and somewhat in the negative, both latch onto the concepts of honesty, transparency, and diligence. It is important to note that they both cast the standard as an objective one. An insurance company can be held accountable for bad-faith actions even if it is not engaged in "actual dishonesty or fraud" and if it may not have known but "should have known" of facts demonstrating insurance proceeds should be paid.

The objective standard makes it difficult for claims handlers to hide behind claim logs that they keep meticulously and to support their coverage position, which may be to deny coverage.[8] It also means that policyholders may have an incentive to keep their insurance companies well informed in writing—and should do so.

The policyholder can take significant control over a particular claim by creating a written record of the development and investigation of a claim. The goal of this record is to put the insurance company in the position that it cannot deny that it knew key facts at certain times. Documenting these facts in a record other than the insurance company's claim log—and asking what else needs to be done to resolve a claim—keeps a claim moving and places the onus on the insurance company to make a coverage decision. Insurance companies are aware that they need to be careful, not engage in bad faith, and have sound reasons if they decide not to pay the full amount of a claim. The decision to place a claim on a hold with a reservation of rights letter, much less deny the claim, should be carefully evaluated based on an objective consideration of the facts and policy language. A proactive policyholder can force even a reluctant insurance company to engage in a prompt and correct claim resolution.

If an insurance company denies coverage without providing a complete or well-reasoned explanation, the policyholder should make a record of that conduct and may want to request a further explanation. The policyholder also should compare the coverage denial, or reservation of rights, with the facts of the claim and the policy language. If, for example, there appear to be objectively dishonest or less-than-diligent claims handling efforts, then the denial should be evaluated to determine whether the policyholder has a strong claim not only for payment in full but also for amounts above and beyond the limits or beyond the coverage terms of an applicable policy.

Seeking Damages Greater Than Limits or Outside the Coverage

Insurance companies can sometimes view nonpayment and delay as a "no lose" situation. If they eventually are ordered to pay by a court, but pay no more than the applicable policy limits (or the amount of the policyholder's loss, whichever is less), then they may well risk nothing by denying coverage wrongly. In contrast, and at the same time, policyholders often have a significant monetary loss or exposure leading to their claim for insurance coverage. The prospect of disputing coverage with their insurance company while simultaneously recovering from a significant loss or fighting an underlying liability claim can be daunting. Bad-faith tort damages and extra-contractual damages for breach of the duty of good faith are tools that courts and legislatures have provided policyholders to break the logjam that can sometimes exist when an insurance company might otherwise not see the importance of properly and quickly resolving a claim.

Awards of attorney fees, consequential damages, and statutory damages erase the built-in advantage of delay and deter insurance companies from letting claims reach the jury. Without the threat of liability for acting in bad faith, insurance companies might rightly assume they have little to lose.

The concept of bad faith also relieves pressure on policyholders to accept settlements of the value of their insurance coverage that are below the fair value of their losses. The specter of there being no ceiling, based on bad-faith recovery, increases the risk for the insurance

company and helps level the playing field. Linking an insurance company's liability to its conduct is an important principle. In the world of aleatory contracts such as insurance, bad faith is one of the few concepts that can have such effect.

What Damages Can Be Sought?

The types of damages a policyholder can recover above the policy limits or beyond the value of the covered claim and outside the coverage of the policy can vary. Consequential damages, established long ago in *Hadley v. Baxendale*,[9] permit the plaintiff to recover not only the value of the damages caused by the failure to perform under the breached contract but also the value of the damages that foreseeably flowed from that breach. Put another way, consequential damages generally are damages not covered by the contract that a plaintiff would not have suffered but for the defendant's breach of the contract.

It is important that the consequential damages claimed are within the contemplation of the parties. Courts have stated that consequential damages consist of those damages outside the contract that were "within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting."[10] For example, in *Bi-Economy Market, Inc. v. Harleysville Insurance Co.*, New York's highest court found that the consequential damages included the damages resulting from delay in paying the claim, particularly where business interruption coverage was involved. It further held that the policyholder could recover such damages if the insurance company breached its duty of good faith and fair dealing.[11] The holding links the breach of contract itself with the consequential damages.

To illustrate the breadth of possible damages, take the following hypothetical example. If a policyholder claims coverage for repairs to damaged property that housed equipment and is unable to repair the property because the insurance company fails to promptly pay for the covered repair of the property, the policyholder may foreseeably not be able to use that equipment. In that case, the policyholder may very well have a claim for damages suffered to the equipment due to the delay in repair caused by the insurance company's failure to pay and for the damage to its business from not being able to use that equipment. Those damages could be substantial and outside the scope of coverage in the policy terms.

Attorney fees are another category of frequently sought consequential damages. These fees are often those spent to obtain coverage. They can sometimes be more important than other types of consequential damages because the policyholder would otherwise be forced to spend money on professionals when it already had suffered major loss, knowing it cannot otherwise recover the fees. Not only are these fees costly, they are directly caused by the insurance company's refusal to pay. Policyholders are, not surprisingly, frustrated to have to hire an attorney to fight for coverage that plainly should have been promptly granted. Their frustration is based on clear logic. In that situation, a policyholder must spend money on professional fees incurred solely to recover the value of its insurance coverage that should have been paid without dispute and without the necessity of lawyers or litigation. It follows that attorney fees should be recoverable. Moreover, insurance companies should not be permitted to limit such fee awards based on arguments that only a portion of the disputed coverage was denied or withheld on bad-faith grounds.[12]

Several states, including Maryland, have first-party insurance statutes that require an insurance company to pay attorney fees as damages if bad faith is found.[13] Florida, Georgia, and Illinois, among others, similarly have codified the policyholder's right to attorney fees when the insurance company acts in bad faith.[14] Third-party insurance coverage can present different obstacles to obtaining consequential damages for liability to others, but, as discussed below, courts have found conduct to rise to the level of bad faith where an insurance company refuses to defend or settle claims against policyholders.

Applying the Law to Identify Insurance Company Bad-Faith Conduct

In reviewing a coverage denial or reservation of rights letter critically, a policyholder should be able to readily identify the factual underpinnings of the positions the insurance company has taken. If the facts are not clear, it is difficult, if not impossible, for an insurance company to set forth why not assuming its coverage responsibilities is justified. Neither can an insurance company adopt unreasonable or baseless interpretations of policy language based on the facts. In particular, an insurance company cannot take a position that clearly contradicts the plain meaning of the policy language (or what the policy language has been held to mean by courts in the applicable jurisdiction).

Many states have statutes that create torts for bad faith or other claims that have statutory damages. For example, Alabama empowers a policyholder to recover extra-contractual damages when it demonstrates that the insurance company intentionally refused to pay, that any reasonably legitimate or arguable reason for that refusal is absent, and that the insurance company had actual knowledge of the absence of any legitimate or arguable reason.[15] Alabama also recognizes "abnormal" bad faith where an insurer intentionally fails to determine the existence of a lawful basis for its refusal to pay insurance benefits.[16] This approach creates a tort remedy, but it sets a high bar for the policyholder to meet. It is significantly different from the approach taken in New York, where the remedy is tied to the breach of contract.

Some states further require evidence that the insurance company had an improper or dishonest motive in denying or delaying payment. In Connecticut, "improper" conduct can include reversing a coverage position, requiring an excessive submission from a policyholder, or delaying an investigation.[17]

To establish a bad-faith claim in Ohio, a policyholder must establish that an insurance company's refusal to pay the claim "is not predicated upon circumstances that furnish reasonable justification therefor."[18] A policyholder does not need to establish that an insurance company's failure to pay the claim was intentional, as intent is not an element of bad faith.[19] A lack of "reasonable justification" exists when an insurer refuses to pay a claim in an arbitrary or capricious manner.[20] The insurance company is liable for consequential damages to compensate the policyholder for the effects of the bad-faith conduct.[21]

Other states have unfair claims practices statutes that do not create a private cause of action but the violation of which can be grounds for bad faith. In California, insurance practices that violate the state's Unfair Insurance Practices Act can support a claim against the insurance company under the Unfair Competition Law and may violate other statutes or common law.[22]

In New York, a state notoriously difficult for policyholders, recent decisions have demonstrated that consequential damages are a real risk for insurance companies that engage in delay and that force their policyholders to sue for coverage. In 2015 in *National Railroad Passenger Corp. v. Arch Specialty Insurance Co.*,[23] the Southern District of New York held that a policyholder could recover attorney fees as consequential damages if it showed "that the Insurers declined to make interim payments required under the policies for amounts that are 'not the subject of a reasonable dispute' and . . . conditioned additional payments of undisputed amounts on certain legal concessions." The holding highlights particular conduct but does not look beyond the circumstances of the breach of the insurance policy. The focus is on the breach and the damages that flowed from it—attorney fees and the harm suffered from not receiving timely payment.

That holding applies the approach set forth in *Bi-Economy*. Prior to *Bi-Economy*, New York courts awarded consequential damages only if a policyholder demonstrated that no reasonable insurance company would have denied coverage or its insurance company acted in gross disregard of its obligations.[24] This high standard permitted insurance companies to argue with some success that a breach of contract claim did not support a claim for any damages other than the policy limits, even if the policyholder suffered damages outside the scope of coverage or policy limits.

In Bi-Economy, the corporate policyholder's business collapsed due to the insurance company's delay in paying business interruption coverage.[25] The New York Court of Appeals held that the policyholder could recover consequential damages based on a breach of the implied duty of good faith and fair dealing, without the need to prove that no reasonable insurance company would have delayed payment or that the insurance company acted in gross disregard. It is important to note that the decision states that permissible damages include those damages foreseeable as a consequence of the breach. The damages of going out of business due to delayed payment are merely an example.

The decision demonstrated the New York Court of Appeals' focus on the purpose of insurance and the insurance companies' inherent advantages in the context of a claim. It stated that "[a]n insured may also bargain for the peace of mind, or comfort, of knowing that it will be protected in the event of a catastrophe."[26] It further stated that parties to an insurance contract understand at the time the policy is sold that the policyholder expects the insurance company to investigate a claim in good faith and pay covered claims, and purchases the policy as protection in the event of a loss.[27]

Prior to *Bi-Economy*, insurance companies often argued that insurance policies were different from other types of contracts and that damages were capped at the policy limits. Indeed, the landmark decision reached by the New York Court of Appeals in *Bi-Economy* and its companion case *Panasia Estates, Inc. v. Hudson Insurance Co.*[28] resulted from the insurance company moving for summary judgment dismissing the policyholder's claim for consequential damages. The decision was reached even though the insurance company cited policy provisions excluding coverage for "consequential loss." The Supreme Court for Monroe County, New York, had dismissed the claim based in part on those provisions. On appeal, the Court of Appeals found that the insurance company's failure to pay promptly the full value of the business interruption coverage led to the demise of the policyholder's business, a foreseeable consequence of the failure to pay business interruption coverage.[29] Thus, while consequential damages was not a new theory of damages, the decision was a significant victory for policyholders in establishing that insurance companies cannot claim they are not subject to consequential damages.

Building on *Bi-Economy*, the Supreme Court for Nassau County, New York, held that a physician seeking disability coverage also could recover consequential damages. In that case, the insurance company initially granted coverage based on the physician's total disability and then, one year later, reversed its position, denying coverage completely. In denying the insurance

company's motion for summary judgment on consequential damages, the court stated:

> In the instant matter, the Court finds that the defendant failed to establish, prima facie that it acted in good faith, in finding that the plaintiff was at first disabled, then reversing its finding and disclaiming coverage.[30]

Turning the burden back onto the insurance company to demonstrate that it did not engage in bad faith and did perform its duty of good faith and fair dealing shifts the focus of a coverage dispute. The inclusion of a claim that the insurance company breached that duty allows the policyholder, and the court, to analyze the insurance company's conduct. Making that conduct an issue in the case is appropriate, as the policyholder purchased insurance to have protection, not a dispute.

Various Extra-Contractual Remedies Are Available

Courts in jurisdictions across the country recognize that fair remedies for bad-faith conduct by insurance companies include consequential damages. A couple of recent examples stand out.

In one example, the Washington Court of Appeals recently upheld a multimillion-dollar jury verdict in which an insurance company's bad-faith failure to settle within policy limits resulted in compensatory damages of $4.15 million—i.e., the amount of the settlement in the underlying action—and consequential damages in excess of $7.75 million.[31] The court characterized the compensatory damage award as "a floor, not a ceiling" on the type of damages a jury can award for an insurance company's bad faith.[32] The Washington court listed a number of potential grounds for consequential damages, including attorney fees: "the potential effect on the insured's credit rating, damage to reputation, loss of business opportunities, and loss of control of the case . . . loss of interest, attorney fees and costs, financial penalties for delayed payments, and emotional distress, anxiety, and fear."[33]

In another example, applying West Virginia law, the Fourth Circuit Court of Appeals held that "consequential damages are part and parcel of the remedies obtainable in a bad-faith action against an insurer[.]"[34] In West Virginia, the damages available in a bad-faith action include the attorney fees incurred in the action, as well as "additional consequential damages for aggravation and inconvenience."[35] Such broad terms leave room for argument that a variety of damages could be attributable to the insurance company's conduct.

Not all states approach the issue the same way. For example, in North Carolina, the claim of bad faith is a tort claim that requires proof of bad-faith conduct that is separate from the breach of contract. North Carolina recognizes a statutory cause of action for "unfair and deceptive acts."[36] If an insurer does not attempt in good faith to effectuate prompt, fair, and equitable settlements of claims for which liability has become reasonably clear, then it could be liable for tort damages for which the policyholder can show causation.[37]

Similarly, states have fashioned different remedies for bad faith, other than consequential damages. Other types of remedies could include attorney fees, emotional distress damages, punitive damages, and statutory damages.[38] But not all jurisdictions permit an array of damages. For example, Tennessee's bad-faith statute provides a penalty that is the exclusive extra-compensatory remedy.[39]

Considerations in Protecting and Pursuing Potential Bad-Faith Claims

Policyholders should document their claim and their efforts to get their claim paid. There are obstacles to mounting a claim that an insurance company breached its duty of good faith and fair dealing or acted in bad faith (or both). For example, in a third-party scenario where a policyholder seeks coverage for an underlying liability, the policyholder should keep the insurance company informed of the case's progress. If the policyholder fails to inform the insurance company of developments regarding the underlying case, it may become difficult for the policyholder to prevail on an argument that the insurance company should have taken action. It is good practice to not only tender the defense of the underlying case to the insurance company but also thereafter keep the insurance company informed of developments, including settlement offers; facts that may give rise to coverage; and other pertinent developments that may affect liability or coverage.

In first-party claims, such as claims for damage to property, the same concept applies. Even if the insurance companies have an adjuster, the policyholder should keep them informed of developments, including those that relate to business interruption, cost of repairs, timing of repairs, and cost estimates.

All of this communication should be memorialized in writing. Remember, the insurance companies have claim logs that they use to document each step and communication in a claim. Those logs are written by and for the insurance company, not the policyholder. It is important to have an accurate, contemporaneous record that the policyholder kept its insurance company or companies fully informed, because it is not always wise to trust that their logs are accurate.

Primary layer insurance companies raise certain defenses to coverage. Case law demonstrates why a written record is important in both first- and third-party contexts. For example, in a first-party case involving a claim against a primary insurance company for bad faith based on its failure to pay for dental injuries, Utah's highest court found there was a question of fact as to the issue of bad faith, based in part on the statements

recorded in the insurance company's claim log. The claims adjuster continually had expressed doubt in log entries about the scope of the policyholder's injuries based on his characterizations of conversations with the policyholder.[40] Had the policyholder presented evidence in support of the bad-faith allegations, including contemporaneous records of the conversations characterized in the claim log, perhaps the outcome would have been more favorable to the policyholder.

In other first-party cases, insurance companies have raised similar defenses. While most courts recognize that a policyholder's delay or lack of cooperation does not automatically bar a bad-faith claim unless the conduct is egregious, courts will consider those facts in evaluating an insurance company's conduct.[41] For instance, in a case involving a policyholder who owned a bar and suffered a loss from vandalism, a court held that the policyholder's months' long delay in submitting proofs of loss to the insurance company weighed against a finding that the insurance company acted in bad faith.[42] Similarly, after a flood at a beauty salon, a New York court denied the policyholder's claim for bad faith and consequential damages in part because the insurance company offered proof that the policyholder delayed in submitting tax returns and other documents necessary to evaluate the claim.[43]

In third-party liability cases, bad faith often arises when the insurance company has refused to provide coverage for a settlement offer made in the underlying case and the verdict rendered is higher than the settlement offer and, in some cases, the coverage limits.[44]

Excess insurance companies raise certain other defenses to coverage. Insurance companies that sold excess insurance policies often look for defenses to coverage, as well as defenses to bad-faith claims, that primary insurance companies may not have. For example, the Tenth Circuit recently held that excess insurance companies may not have a duty to initiate settlement discussions in a third-party coverage scenario. It held that, under Oklahoma law, while a primary insurer must affirmatively initiate settlement negotiations when a policyholder is sued, where liability is clear and a judgment for liability in excess of policy limits is likely, this affirmative duty does not apply to excess insurance companies.[45] The court agreed with the excess insurance company's arguments that it has no duty to initiate or investigate settlement "absent any settlement demand from the plaintiffs or proposed settlement agreement from the primary insurer."[46] This decision highlights that a policyholder, and its broker, should strive to be clear about making sure that all potentially liable insurance companies are kept apprised of settlement offers.

Excess insurance companies are not subject to a different legal standard for allegations of bad faith or breach of the duty of good faith and fair dealing. The decisions addressing the differences between holding a primary insurance company versus an excess insurance company liable focus instead on the facts.

California courts also have held that an insurer cannot be liable for bad-faith failure to settle without a settlement demand or some other manifestation that the injured party is interested in settlement.[47] Other courts have followed this reasoning.[48]

Not all courts have agreed with this decision. Across the country, inconsistent results have been reached. For example, in 2015, the Louisiana Supreme Court was asked to consider "[w]hether an insurer can be liable to its insured for a bad faith failure to settle [] in the absence of a 'firm' settlement offer."[49] The court applied Louisiana's statute codifying insurance companies' duty of good faith and fair dealing and ultimately held that an excess insurer can be found liable for a bad-faith failure to settle an underlying claim, whether or not a settlement offer was ever received.[50]

Other states have reached the same conclusion. Courts in Georgia, New Jersey, New Mexico, Oregon, Tennessee, and Wisconsin[51][51] have held that the duty to settle is an affirmative duty, regardless of whether a settlement offer was properly communicated to the excess carriers.

Prudent policyholders should keep all of their insurance companies, primary and excess, informed of developments in their claim, particularly settlements. Doing so protects their claim and places the insurance company in a position to make a decision.

Conclusion

A policyholder can maximize its insurance recovery by learning to identify the markers of insurance company bad faith. A potential award of consequential damages above and beyond policy limits—including attorney fees—is a powerful bargaining chip that should not be overlooked. While the standards for proving bad-faith conduct vary from state to state, demanding explanations for adverse coverage positions, promptly informing the insurance company of case developments, building a written record of compliance and communications, and tracking attorney fees are crucial to maximizing insurance coverage and being prepared to combat conduct that falls short of speedy, good-faith claims resolution.

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[2] In states that have recognized the tort of bad faith in insurance transactions or enacted statutes providing for bad-faith claims, the required allegations of bad faith often differ from those needed to support a claim of bad-faith breach of contract or breach of the duty of good faith and fair dealing. Some states also allow the recovery of punitive

damages in bad-faith cases. Punitive damages are not addressed this article.

[3] In performing its contractual obligations, an insurance company owes its insured the duty of good faith and fair dealing that is part of every contract. See *Christian v. Am. Home Assurance Co.*, 577 P.2d 899, 904 (Okla. 1977) (quoting *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032, 1038 (Cal. 1973)). Breach of this duty may lead to the recovery of damages beyond policy limits or the scope of coverage.

[4] *See, e.g.*, *Millers Mut. Ins. Ass'n v. House*, 2866 Ill. App. 3d 378 (1997) (inordinate delay);*Egan v. Mut. of Omaha Ins. Co.*, 24 Cal. 3d 809 (1979) (failure to investigate); Conn. Gen. Stat. § 38a-816(7) (bad-faith cause of action can be based on failure to "promptly provide a reasonable explanation of the basis . . . for denial of a claim[.]").

[5] *See, e.g.*, *State Farm Fire & Cas. Co. v. Brechbill*, No. 1111117 (Sept. 27, 2013) (bad faith can be found in the absence of a debatable reason for both the failure to pay and the failure to investigate), *petition for reh'g denied* (Jan. 17, 2014).

[6] *Commercial Union Ins. Co. v. Liberty Mut. Ins. Co.*, 426 Mich. 127, 136–37 (1986).

[7] *Cecilia Schwaber Tr. Two v. Hartford Accident & Indem., Co.*, 636 F. Supp. 2d 481, 482 (D. Md. 2009) (paraphrasing Md. Code Ann., Cts. & Jud. Proc. § 3-1701(a)(4), (f)).

[8] *Jackson Nat'l Life Ins. Co. v. Receconi*, 827 P.2d 118, 135–36 (N.M. 1992).

[9] 9 Exch. 341, 156 Eng. Rep. 145 (1854) (Eng.).

[10] *Bi-Economy Mkt., Inc. v. Harleysville Ins. Co. of N.Y.*, 10 N.Y.3d 187, 192 (N.Y. 2008).

[11] *Bi-Economy Market*, 10 N.Y.3d at 192.

[12] An insurance company may raise such an argument where a lawsuit is brought to recover insurance proceeds based on breach of contract and on declaratory judgment grounds. It would be artificial to limit the attorney fee recovery to fees incurred for prosecuting the breach of contract claim when the insurance coverage issues for breach of contract are intertwined with those of the declaratory judgment claim.

[13] See Md. Code Ann., Cts. & Jud. Proc. § 3-1701.

[14] See Fla. Stat. § 624.155(4); Ga. Code. Ann. § 33-4-6(a); 215 Ill. Comp. Stat. 5/155(1).

[15] *Nat'l Sec. Fire & Cas. Co. v. Bowen*, 417 So. 2d 179, 183 (Ala. 1982).

[16] *Bowen*, 417 So. 2d at 183; *see also State Farm Fire & Cas. Co. v. Brechbill*, No. 1111117 (Sept. 27, 2013) (holding there is only one tort of bad faith and that policyholder must prove the absence of a debatable reason for both the failure to pay and the failure to investigate),*petition for reh'g denied* (Jan. 17, 2014).

[17] *See, e.g.*, *PSE Consulting, Inc. v. Frank Mercede & Sons, Inc.*, 838 A.2d 135 (Conn. 2004).

[18] *See, e.g.*, *Zoppo v. Homestead Ins. Co.*, 644 N.E.2d 397, 400 (Ohio 1994).

[19] *Zoppo*, 644 N.E.2d at 400.

[20] *Ohio Nat'l Life Assurance Corp v. Satterfield*, 2011 Ohio 2116, 2011 Ohio App. LEXIS 1811 (Ohio Ct. App. May 4, 2011).

[21] *Zoppo*, 644 N.E.2d at 402.

[22] *See, e.g.*, *Zhang v. Superior Court*, 57 Cal. 4th 364 (2013).

[23] 2015 U.S. Dist. LEXIS 104477 (S.D.N.Y. July 31, 2015). The authors, along with Rhonda D. Orin, served as counsel for the policyholder in this case.

[24] *Sukup v. State of New York*, 19 N.Y.2d 519, 522 (N.Y. 1967).

[25] *Bi-Economy Market*, 10 N.Y.3dat 192.

[26] *Bi-Economy Market*, 10 N.Y.3d 187.

[27] *Bi-Economy Market*, 10 N.Y.3d at 194.

[28] *Bi-Economy Market*, 10 N.Y.3d at 194; *Panasia Estates, Inc. v. Hudson Ins. Co.*, 10 N.Y.3d 200 (N.Y. 2008)

[29] *Bi-Economy Market*, 10 N.Y.3d at 194; *Panasia Estates*, 10 N.Y.3d 200.

[30] *Niesenbaum v. AXA/Equitable Life Ins. Co.*, Index No. 2013/600412 (N.Y. Sup. Ct. Nassau Cty. Mar. 10, 2015). The authors, along with Rhonda D. Orin, served as counsel for the policyholder in this case.

[31] *Miller v. Kenny*, 325 P.3d 278 (Wash. Ct. App. 2014).

[32] *Miller* at ¶ 1.

[33] *Miller* at ¶ 57.

[34] *Graham v. Nat'l Union Fire Ins. Co.*, 556 F. App'x 193, 198 (4th Cir. 2014)

[35] *Graham*, 556 F. App'x at 197.

[36] N.C. Gen. Stat. §75-1.1; *Howerton v. Arai Helmet, Ltd.*, 597 S.E.2d 674, 693 (N.C. 2004).

[37] *Topsail Reef Homeowner's Ass'n v. Zurich Specialties London, Ltd.*, 11 F. App'x 225, 2001 WL 565317 (4th Cir. 2001) (unpublished).

[38] *See, e.g.*, *Tackett v. State Farm Fire & Cas. Ins. Co.*, 653 A.2d 254, 264 (Del. 1995);*Hershenow v. Enter. Rent-A-Car Co.*, 840 N.E.2d 526, 533 (Mass. 2006).

[39] Tenn. Code § 56-7-105. *See Fred Simmons Trucking, Inc.*; *Westfield Ins. Co. v. RLP Partners*, LLC, No. 3:13-00106, 2013 WL 2383608 (M.D. Tenn. May 30, 2013).

[40] *Jones v. Farmers Ins. Exch.*, 2012 UT 52, at ¶¶ 3, 16 (Utah 2012).

[41] *See, e.g.*, 1-8 *New Appleman Insurance Bad Faith Litigation* § 8.05 (Matthew Bender ed. 2015) ("[C]ourts have ruled that an insured's non-compliance with conditions to coverage will not automatically defeat that policyholder's bad faith claim unless its conduct, in failing to satisfy its contractual obligations, is so grave that it might permit the insurer to cancel the policy.").

[42] *Nw. Nat'l Ins. Co. v. Pope, 791 F.2d 649, 652 (8th Cir. 1986) (applying Iowa law).*

[43] *Lola Roberts Beauty Salon, Inc. v. Leading Ins. Grp. Ins. Co. Ltd.*, Index No. 2135/2012, 2015 N.Y. Misc. LEXIS 2825, at *8 (N.Y. Sup. Ct. July 30, 2015).

[44] *See, e.g.*, *Miller v. Kenny*, 325 P.3d 278 (Wash. Ct. App. 2014) (an insurance company's failure to accept a settlement).

[45] *SRM, Inc. v. Great Am. Ins. Co.*, 798 F.3d 1322, 1328–29 (10th Cir. 2015).

[46] *Id.* at *6. <<*SRM*, 798 F.3d at ?>>

[47] *Reid v. Mercury Ins. Co.*, 220 Cal. App. 4th 262, 266 (2013), *as modified on denial of reh'g* (Nov. 6, 2013), *review denied* (Jan. 21, 2014).
[48] *See, e.g., Maldonado v. Allstate Ins. Co.*, 519 F. Supp. 2d 981, 992 (D. Minn. 2007).
[49] *Kelly v. State Farm Fire & Cas. Co.*, 169 So. 3d 328, 341 (La. 2015).
[50] *See Kelly*, 169 So. 3d at 330 (citingLa. Rev. Stat. § 22:1973 (A)).
[51] *See, e.g., Baker v. Huff*, 747 S.E.2d 1 (Ga. Ct. App. 2013); *Georgetown Realty v. Home Ins. Co.*, 831 P.2d 7 (Or. 1992); *State Farm v. Price*, 684 P.2d 524, 531 (N.M. 1984); *Rova Farms Resort, Inc. v. Inv'rs Ins. Co.*, 65 N.J. 474, 479 (N.J. 1974); *State Auto. Ins. Co. v. Rowland*, 427 S.W.2d 30, 34 (Tenn. 1968); *Hilker v. W. Auto. Ins. Co.*, 235 N.W. 413, *on rehearing*, 235 N.W. 413 (Wis. 1931).

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