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Bad Faith in the Absence of Coverage - Recent Trends and Developments
Coventry v. American States and its Progeny

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Background

One of the leading cases regarding the issue of bad faith in the absence of coverage and, therefore, the starting-off point for this article is *Coventry Associates v. American States Insurance Company*, 136 Wash. 2d 269, 961 P.2d 933 (1998). In *Coventry*, American States essentially conceded that it had acted in bad faith while investigating Coventry's claim, but contended that its bad faith conduct was not actionable as a matter of law because it had been established that there was no coverage for the insured's loss. In essence, American States argued that because its denial of the claim ultimately proved to be correct, Coventry was not harmed as a result of its bad faith claims investigation. However, Coventry argued that an insured suffers harm from a bad faith claims investigation regardless of whether the denial of coverage eventually turns out to be appropriate.

Both the trial court and the Washington State Court of Appeals agreed with American States and determined that Coventry was unable to establish harm, even though the denial of their claim may have been procedurally deficient. According to the Court of Appeals, "mere procedural errors in handling a specific claim do not support an action for bad faith because the errors do not harm the insured." However, the Washington Supreme Court disagreed and reversed both lower courts and held that an insured may maintain an action against its insurer for a bad faith investigation of its claim and for violating the Claims Practices Act ("CPA"), regardless, of whether the insurer was ultimately correct in determining that coverage did not exist, i.e., an insurer's duty of good faith is separate from its duty to indemnify if coverage exists. Although the court determined that a proper cause of action for bad faith existed, it also held that the insured has a burden to prove damages:

> While we hold the cause of action is available to first-party insureds, we decline to hold in the first-party context a rebuttable presumption of harm exists once an insurer acts in bad faith. This is not to say that a first-party insured suffers no harm when its insurer conducts a bad faith investigation of the claim. When an insurer fails to adequately investigate an insured's claim, the insured must either perform its own investigation to determine if coverage should have been provided or take no action at all. In either situation, the insured does not receive the full benefit due under its insurance contract.

The policyholder in *Coventry* also sought to impose coverage by estoppel, i.e., a remedy that may be extended to an insured where coverage was wrongfully or rightfully denied by the insurer,

based on the insurer's bad faith claims handling conduct. The court explained that while coverage by estoppel may be appropriate in certain third-party bad faith actions, it is not the appropriate remedy in most first-party bad faith actions. Thus, in the third-party context, an insurer's failure to honor the contractual obligation to protect the threatened interests of the insured "contributes" to the harm suffered by the insured. Whereas, in the first-party bad faith context, the loss occurs before the insurer is even aware that a claim exists and, therefore, the insurer does not contribute to the loss.

After considering the parties' arguments, the court held that Coventry was not entitled to coverage by estoppel or a return of a portion of its premium, but that its damages are limited to the amounts it incurred as a result of the bad faith investigation, as well as general tort damages:

> The record before us establishes that Coventry was required to go through some financial expense as a result of the bad faith investigation conducted by American States. These expenses include the cost of hiring their own experts and investigators to determine if American States should have covered the claim. To that extent, Coventry is entitled to make a claim for those amounts and damages normally associated with bad faith and CPA violations. Coventry must, like every other plaintiff, establish those damages at trial.
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> American States violated its duty of good faith and fair dealing in investigating Coventry's claim. Although coverage was eventually shown to be excluded under the policy, American States still breached its contract with Coventry by acting in bad faith and, thus, harming Coventry. As such, Coventry is entitled to bring actions for bad faith and violation of the CPA. Coventry is not entitled, however, to coverage by estoppel or return of a portion of the premium paid. Rather, Coventry's damages should be limited to its expenses as a result of American States' bad faith acts and ensuing tort and CPA damages.

In the aftermath of *Coventry*, a small but, what seems to be, a growing number of states have established a cause of action for bad faith in the absence of coverage. Under that backdrop, the following is an overview of several recent and noteworthy multi-jurisdictional decisions that pick up where *Coventry* left off.

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Bad Faith in the Absence of COVID-19 Business Interruption Coverage

Albuquerque Ambulatory Eye Surgery Center v. Transportation Insurance Company, 1:21-cv-00280-KWR-JFR, US District Court for the District of New Mexico (October 12, 2021)

On March 11, 2020, the first confirmed case of COVID-19 was reported in New Mexico. That same day, New Mexico Governor, Michelle Lujan Grisham issued an executive order in response to the state's increasing infection rates and declared a public health emergency. In the following months, New Mexico's Department of Health Secretary, Kathyleen Kunkel, issued additional public health orders, including orders limiting the size of gatherings to no more than 100 people, advising citizens to stay home, and warning citizens to undertake only outings "absolutely necessary for their health, safety, or welfare." Additionally, on March 16, 2020, the American Academy of Ophthalmology issued an advisory that "all ophthalmologists cease providing any treatment other than urgent or emergent care immediately."

Albuquerque Ambulatory Eye Surgery Center LLC ("AAESC") is an eye surgery center in Albuquerque, New Mexico, was considered to be an essential business, and it alleges that its business was impacted by the coronavirus pandemic and the resulting government health orders, and seeks coverage from their insurer, Transportation Insurance Company ("TIC"), over the loss of the use of its premises, lost business income, extra expenses, and other business-related losses stemming from business disruptions caused by the coronavirus. TIC denied coverage under the policy and AAESC alleges that TIC failed to adequately investigate its claim. According to AAESC, the policy has no applicable exclusions" that would preclude coverage nor does it have a "virus exclusion" and, therefore, losses due to COVID-19 are covered losses under the policy to which TIC is responsible.

Under New Mexico law, an insurer who fails to pay a first-party claim is generally viewed to have acted in bad faith where its reasons for denying or delaying payment of the claim are frivolous or unfounded (See: *Sloan v. State Farm Mut. Auto. Ins*. Co., 85 P.3d 230, 236 (N.M. 2004)). The terms frivolous or unfounded in this context does not mean erroneous or incorrect, rather, it was construed to mean "an arbitrary or baseless refusal to pay, lacking any support in the wording of the insurance policy or the circumstances surrounding the claim." Therefore, an insurer may generally deny coverage without exposure to a claim of bad faith failure to pay as long as it has reasonable grounds for the denial (*Haygood v. United Servs. Auto. Ass'n*, 453 P.3d 1235, 1241 (N.M. 2019)). Generally, reasonable grounds will follow from a reasonable investigation, but where an insurer fails to make an adequate investigation, it may be liable for a bad faith denial of a claim.

However, in response to a motion by TIC to dismiss AAESC's claims for bad faith, the court denied the motion and noted:

> On one hand, claims of bad faith to pay "cannot arise unless there is a contractual duty to pay under the policy…." (quoting Charter Servs., Inc. v. Principal Mut. Life Ins. Co., 868 P.2d 1307, 1313 (N.M. 1994)). "[H]owever, a bad faith claim need not depend on the existence of coverage." Id. (emphasis added). Therefore, if bad faith is asserted as to conduct beyond a denial of coverage and the refusal to pay, the bad faith claim is actionable as to that conduct regardless of whether the contract claim survives. Id. ("Haygood might establish bad faith in a variety of ways-whether by proving Defendants failed to deal fairly in handling the claim, failed to conduct a fair investigation, or failed to fairly evaluate coverage, among other possibilities.").
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> Here, Plaintiff plausibly alleges that Defendant failed to fairly investigate the claim. Plaintiff alleges that Defendant "did not follow up with its insured, request an interview, or visit the covered location. [Defendant] also failed to review ample publicly available and easily accessible information regarding [the] claim…." Plaintiff further asserts that "before AAESC even submitted its documentation in response to [Defendant's] May 8 inquiries, on May 22, 2020, without reviewing any facts around the claim or seeking additional information, [Defendant] denied coverage….." Finally, Plaintiff alleges that after requesting a consideration of the claim, "[i]nstead of considering the additional information, however, [Defendant] forced AAESC to chase a series of claims handlers for a response. Each time AAESC thought its claim was being reconsidered, it learned that CNA had once again changed claims handlers who were reviewing the claim…." Taking these facts as true, the Court finds that these allegations are sufficient to withstand a

motion to dismiss. Plaintiff has pled a claim for bad faith independent of the failure to pay. Plaintiffs claim for bad faith is not entirely foreclosed even in the absence of coverage under the Policy. See Haygood, 453 P.3d at 1243.

Reconciling Bad Faith Claim with Contractual Time Limit to File Suit

West Beach Condominium v. Commonwealth Insurance Company of America Court of Appeals of Washington, Division 1 - 11 Wash.App.2d 791, 455 P.3d 1193 (January 13, 2020)

The West Beach Condominium Association retained a building consultant, the Amento Group, to conduct an assessment and investigation on each of its three condo buildings. On September 8, 2015, the consultants uncovered water damage behind the exterior cladding and the buildings' envelopes. One year later, on September 26, 2016 West Beach filed a claim with their insurer, Commonwealth Insurance Company, while at the same time filed a lawsuit against Commonwealth in order to preserve any claims that may become time barred. The parties agreed to enter into a tolling agreement and West Beach dismissed its complaint without prejudice in order to allow Commonwealth time to conduct an investigation. Commonwealth retained an engineering consultant and subsequently elected to deny coverage contending that West Beach had been experiencing water intrusion issues for at least 10 years, and alleging that:

- All of the policies required suit to be commenced at least 12 months after the "occurrence" giving rise to the claim, and West Beach did not sue within that time period;

- The 2009 policy covered only direct physical loss or damage "commencing" during the policy period, and the 2010 and 2011 policies covered only direct physical loss or damage "occurring" during the policy periods. Commonwealth concluded that the losses West Beach had sustained neither commenced nor occurred during the applicable policy periods;

- The policies only covered "fortuitous risks," and none had been identified by West Beach;

- The policies did not cover faulty construction or inadequate repairs, and the Amento Group report identified numerous deficiencies that fell into this excluded category;

- The policies did not cover rust, corrosion, wear and tear, or gradual deterioration, and some of the losses fell into this excluded category; and

- The policies excluded coverage for mold, bacteria, fungi, and wet or dryrot, and some of the losses fell into this excluded category.

In May 2017, West Beach refiled its complaint, alleging breach of contract, bad faith investigation, and violations under the Consumer Protection Act (CPA) relating to the investigation of West Beach's claim and Commonwealth's denial of coverage. In order to prevail under the CPA, a plaintiff must prove (1) an unfair or deceptive act or practice, (2) occurring in trade or commerce, (3) with a public interest impact, (4) injury to the plaintiff's business or property, and (5) causation. A denial of coverage is not an unfair or deceptive act or practice if based on reasonable conduct by the insurer, even if the denial of coverage is ultimately proved incorrect. West Beach later filed an amended complaint adding a claim for violations

under the Insurance Fair Conduct Act (IFCA). The IFCA provides that "[a]ny first-party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action…to recover the actual damages sustained."

In December 2017, the trial court held the 2009 policy did not cover any of West Beach's losses because the claimed damage commenced years before 2009. It also held that Commonwealth's 2010 and 2011 all-risk policies covered damage from faulty construction, faulty maintenance, and wind-blown rain, contrary to the position Commonwealth had taken in its denial letter. It also concluded that the policies covered damage resulting from a combination of excluded and non-excluded perils, and that Commonwealth was liable for all covered damage if any of the damage occurred during the policy periods.

Because the court found genuine issues of fact regarding the causes and timing of the claimed damages, Commonwealth moved to dismiss West Beach's breach of contract claim based on the "suit limitation" provision in the policies. The provision at issue required any lawsuit to be filed no later than twelve months after discovery of the loss. Commonwealth argued that West Beach had notice of its loss no later than September 8, 2015, the date Amento Group presented the results of its investigation, and West Beach did not file suit within one year of that date. In August 2018, the trial court granted Commonwealth's motion and dismissed West Beach's breach of contract claim.

Both parties subsequently filed motions for a legal ruling as to whether the suit limitation provision *also* barred West Beach's IFCA and CPA claims and, if not, what damages West beach could recover. Commonwealth argued that the suit limitation clause not only barred a breach of contract claim but it also voided its underlying coverage obligation under the 2010 and 2011 policies. It maintained that under *Coventry Associates v. American States Insurance Co.*, 136 Wn.2d 269, 961 P.2d 933 (1998), West Beach could not use the CPA or IFCA to obtain policy coverage that otherwise did not exist. West Beach contended that the suit limitation clause did not affect Commonwealth's obligations under the policy and that *Coventry* only addressed which damages a policyholder could recover in the absence of coverage. It asserted both IFCA and the CPA allow a policyholder to recover policy benefits when those benefits should have been paid by the insurer.

The trial court agreed with Commonwealth and dismissed the bad faith, CPA, and IFCA claims with prejudice and entered judgment for Commonwealth, ruling that

> [i]n light of [its] August 17, 2018 order granting [Commonwealth's motion to enforce the suit limitation provisions], [West Beach] cannot establish that Commonwealth's coverage denial was unreasonable. [West Beach] failed to allege any consequential damages proximately caused by Commonwealth's alleged bad faith or breach of the [CPA], and it cannot seek contract damages on its extracontractual claims.

West Beach filed an appeal arguing that, while the policies' suit limitation clause bars it from suing Commonwealth for breach of contract, it does not discharge the insurer's underlying coverage obligation. In other words, if Commonwealth violated the IFCA and the CPA by unreasonably denying West Beach's claim for coverage or payment of benefits, then West Beach can recover the contractual benefits that Commonwealth should have otherwise paid. The Court of Appeals agreed with West Beach and noted that Commonwealth's suit limitation clause says nothing about its underlying coverage obligations. It is merely a contractual modification to the statute of limitations otherwise applicable to West Beach's breach of contract

claim.

> This clause does not negate coverage or extinguish Commonwealth's obligations under the all-risk policies. The trial court's dismissal of West Beach's IFCA claim was based on its determination that the suit limitation clause made Commonwealth's denial of coverage reasonable as a matter of law. Because West Beach has an independent statutory claim for failure to provide coverage and because the coverage obligation was not extinguished by the suit limitation clause, the trial court erred in concluding that Commonwealth's denial of coverage was reasonable as a matter of law. The suit-limitation clause does not affect Plaintiff's extra-contractual claims for bad faith, violation of the CPA, and violation of IFCA.

The appellate court further noted that, in *Coventry,* the Washington Supreme Court held, that in the first-party context, coverage by estoppel is not the appropriate remedy because "the loss in the first-party situation has been incurred before the insurance company is aware a claim exists." But coverage by estoppel was at issue in *Coventry* only because the parties agreed that there was, in fact, no coverage for the claimed losses. Thus, Coventry's only allegation was bad faith in the investigation of its claim, not bad faith in the denial of coverage. It was in this context that the Supreme Court limited Coventry's damages to the amounts it incurred as a result of American States' bad faith investigation.

The court noted that in this case, West Beach contends that the Commonwealth's policies actually cover its claimed losses. In that regard, under the IFCA a claimant is entitled to actual damages sustained together with the costs of the action, and an insurer is liable for those damages proximately caused by its IFCA violations. Similarly, the CPA allows a plaintiff injured in his or her business or property" by a CPA violation to recover actual damages, and the deprivation of contracted-for insurance benefits is an injury to business or property. Thus, recoverable damages under both IFCA and the CPA can include policy benefits that were unreasonably denied, subject to the policy's limits and other applicable terms and conditions.

The Appellate Court concluded that Commonwealth's obligation to pay covered losses is triggered by the notice of loss, not the initiation of a lawsuit; that because West Beach has an independent statutory claim for failure to provide coverage and because the coverage obligation was not extinguished by the suit limitation clause, the trial court erred in concluding that Commonwealth's denial of coverage was reasonable as a matter of law; that *Coventry* does not apply unless and until a jury determines that no coverage exists under the two relevant policies, and that the trial court erred by not allowing the jury to decide whether the damage at West Beach's property was caused by covered perils and, if so, whether Commonwealth unreasonably denied coverage violated the IFCA and the CPA by failing to pay for that covered damage.

Texas Supports the Doctrine of Bad Faith in the Absence of Coverage

USAA Texas Lloyds Company v. Menchaca - Supreme Court of Texas - No. 14-0721 (April 13, 2018)

After Hurricane Ike struck Galveston Island in September 2008, Gail Menchaca contacted her homeowner's insurance company, USAA Texas Lloyds, and reported that the storm had damaged her home. USAA's adjuster investigated the loss but declined to pay Menchaca any benefits because the total estimated repair costs did not exceed the policy's deductible. Five months later, at Menchaca's request, USAA sent another adjuster to re-inspect the property and this adjuster

generally confirmed the first adjuster's findings and, therefore, USAA again refused to pay any policy benefits. Menchaca sued USAA for breach of contract and for unfair settlement practices in violation of the Texas Insurance Code. As damages for her claims, Menchaca sought insurance benefits under the policy, plus court costs and attorney's fees. As damages for USAA's alleged statutory violations, she sought "actual damages," which include the loss of the benefits that should have been paid pursuant to the policy, court costs, and attorney's fees.

The parties tried the case to verdict and charged the jury with the following questions:

- Question one, which addressed Menchaca's breach-of-contract claim, asked whether USAA failed "to comply with the terms of the insurance policy with respect to the claim for damages filed by Gail Menchaca resulting from Hurricane Ike." The jury answered "No."

- Question two, which addressed Menchaca's statutory claims, asked whether USAA engaged in various unfair or deceptive practices, including whether USAA refused "to pay a claim without conducting a reasonable investigation with respect to" that claim. As to that specific practice, the jury answered "Yes."

- Question two separately asked whether USAA engaged in an unfair or deceptive act or practice by: "Failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim when the liability under the insurance policy issued to Gail Menchaca had become reasonably clear;" "Failing to promptly provide to Gail Menchaca a reasonable explanation of the factual and legal basis in the policy for the denial of a claim(s);" "Failing to affirm or deny coverage within a reasonable time;" or "Misrepresenting to Gail Menchaca a material fact or policy provision relating to the coverage at issue." As to each of these specific practices, the jury answered "No."

- Question three asked the jury to determine the amount of Menchaca's damages that resulted from either USAA's failure to comply with the policy or its statutory violations, calculated as "the difference, if any, between the amount USAA should have paid Gail Menchaca for her Hurricane Ike damages and the amount that was actually paid." The jury answered "$11,350."

- Question three separately asked: "What sum of money ... would fairly and reasonably compensate Gail Menchaca for her damages, if any, that resulted from the failure to comply you found in response to Question number 1 and/or that were caused by an unfair or deceptive act that you found in response to Question number 2?" The question thus required the jury to determine damages resulting from either a contract breach or a statutory violation or both. The charge instructed the jury to answer Question 3 only if it "answered ‘Yes’ to Question No. 1 or any part of Question No. 2 or both questions." The charge then instructed the jury that the "sum of money to be awarded is the difference, if any, between the amount USAA should have paid Gail Menchaca for her Hurricane Ike damages and the amount that was actually paid." The jury found that Menchaca's reasonable and necessary attorney's fees "for representation in the trial court" totaled $130,000, and did not find that Menchaca failed to mitigate her damages or that USAA "knowingly" violated the Insurance Code.

Both parties moved for judgment in their favor based on the jury's verdict. USAA argued that because the jury failed to find in answer to Question one that USAA failed to comply with the policy, Menchaca could not recover for "bad faith or extra-contractual liability as a matter of law." Menchaca argued that the court should enter judgment in her favor based on the jury's answers to Questions two and three, neither of which required a "Yes" answer to Question one. The trial court disregarded Question one and entered final judgment in Menchaca's favor based on the jury's answers to Questions two and three. The court of appeals affirmed and the Supreme Court granted USAA's petition for review.

The Supreme Court noted that this case presented an opportunity to provide clarity regarding the relationship between claims for an insurance policy breach and Insurance Code violations, i.e., whether an insured can recover policy benefits as "actual damages" caused by an insurer's statutory violation absent a finding that the insured had a contractual right to the benefits under the insurance policy. In that regard, the Texas Insurance Code, § 541.060(a), grants insureds a private action against insurers that engage in certain discriminatory, unfair, deceptive, or bad-faith practices, and it permits insureds to recover "actual damages ... caused by" those practices, including court costs, attorney's fees, plus treble damages if the insurer "knowingly" commits the prohibited act. Id. §§ 541.151, .152; "Actual damages" under the Insurance Code are those damages recoverable at common law which include "benefit-of-the-bargain" damages representing "the difference between the value as represented and the value received." The court noted, however, that the Code does not create insurance coverage or a right to payment of benefits that does not otherwise exist under the policy. Similarly, a claim for bad faith conduct that breaches the common-law duty can potentially result in three types of damages: (1) benefit of the bargain damages for an accompanying breach of contract claim, (2) compensatory damages for the tort of bad faith, and (3) punitive damages for intentional, malicious, fraudulent, or grossly negligent conduct.

USAA contends that an insured cannot recover policy benefits for an insurer's statutory violation if the insured does not have a right to those benefits under the policy. However, the Supreme Court disagreed:

> USAA's argument overlooks the fact that—as we have clarified today—an insured need not prevail on a separate breach-of-contract claim to recover policy benefits for a statutory violation. Instead, as we have explained, the insured can prevail under the entitled-to-benefits rule or the benefits-lost rule if she establishes (1) the insurer violated the statute and (2) the violation resulted in her loss of benefits she was entitled to under the policy.

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Additional Cases and Articles of Interest

- *Dale L. and Georgia A. Ferguson v. USAA General Indemnity Company*, No. 1:19-cv-401, 2019 U.S. Dist. LEXIS 209579 (M.D. Pa. Dec. 5, 2019) – “Pennsylvania's bad-faith insurance statute was designed to generally regulate dishonest conduct by insurers. It is meant to encourage insurers to thoroughly investigate claims made by policyholders, respond to them promptly, negotiate reasonable claim settlements, and generally treat insureds honestly while caring for their interests. If the insurer truly has no contractual obligation to the insured, because their claim does not fall within the scope of the policy, the bad faith statute does not obligate the insurer to give coverage out of kindness of heart.

It simply obligates the insurer to take all reasonable efforts to assess the validity and value of the claim before taking such actions, and, if coverage is effective, to carry out its duties honestly (Berg v. Nationwide Mut. Ins. Co., 44 A.3d 1164, 1170 (Pa. Super. Ct. 2012)) ("[A]n insurer has a duty to act with the utmost good faith towards its insured."). But an insurer's knee-jerk denial letter cannot be saved from triggering the penalties enumerated in Section 8371 merely because the insurer's lawyer is able to construct a post-hoc justification for denying coverage. See Gallatin Fuels, Inc., 244 F. App'x at 435; Newhouse, 2017 WL 4122405 at *3 (explaining that Section 8371 applies to "'insurers that unreasonably delay the evaluation of the insureds' claims, even if the insurer's ultimate assessment of the claim proves to be correct '" (quoting Ironshore Specialty Ins. Co., 319 F.R.D. at 212). Holding otherwise could potentially result in insurers taking the gamble that a denial based on a cursory review will be rescued by a clever trial lawyer.

- *Matthew Haygood v. United Services Automobile Association*, From the New Mexico Court of Appeals - Opinion Number: 2019-NMCA-074 No. A-1-CA-36158 (September 5, 2019) – Court affirms the district court's grant of summary judgment determining Haygood was not entitled to coverage and dismissing Haygood's claims for breach of contract, breach of the implied covenant of good faith and fair dealing, violations of UIPA and UPA, and bad faith based on failure to pay a covered claim. Court reverses the district court's grant of summary judgment dismissing Haygood's claim of bad faith premised on Defendants' investigation and evaluation, and remand for further proceedings consistent with this opinion.

- *Patricia E.G. Adams v. Hawaii Medical Service Association*, 145 Hawai'i 250, 2019 Haw. LEXIS 263, 450 P.3d 780 (September 30, 2019) - Tort of bad faith allows an insured to recover even if the insurer performs the express covenant to pay claims; as such, the Hawaii Supreme court found that an insurer's conduct before an actual claim is submitted can be considered in determining whether the insurer acted in bad faith.

- *Leonard Sanderson v. American Family Mutual Insurance Company*, 251 P.3d 1213 (Colorado Court of Appeals – No. 09CA1263 (2010) – The duty of good faith and fair dealing continues unabated during the life of an insurer-insured relationship, including through a lawsuit or arbitration between the insured and the insurer, although the adversarial nature of such proceedings may suspend the insurer's obligation to negotiate as a reflection of good faith.

- *Kimberly K. Zilisch v. State Farm Mutual Automobile Insurance Company*, 196, Ariz. 234 (2000), "The insurer has "some duties of a fiduciary nature," including "[e]qual consideration, fairness and honesty." Thus, "an insurer may be held liable in a first-party case when it seeks to gain unfair financial advantage of its insured through conduct that invades the insured's right to honest and fair treatment," and because of that, "the insurer's eventual performance of the express covenant-by paying the claim-does not release it from liability for 'bad faith."

- *Deborah C. Deese v. State Farm Mutual Automobile Insurance Company*, 172 Ariz. 504 (1992) - An insurance contract provides more than just security from financial loss to the insured. We said, "the insured also is entitled to receive the additional security of knowing that she will be dealt with fairly and in good faith." Thus, if an insurer acts unreasonably in the manner in which it processes a claim, it will be held liable for bad faith "without regard to its ultimate merits."

- *White v. Unigard Mutual Insurance Co.,* 112 Idaho 94, 730 P.2d 1014 Idaho Supreme Court – No. 16228 (1986) – "The tort of bad faith breach of insurance contract…has its foundations in the common law covenant of good faith and fair dealing and is founded upon the unique relationship of the insurer and the insured, the adhesionary nature of the insurance contract including the potential for overreaching on the part of the insurer, and the unique, "non-commercial" aspect of the insurance contract. Accordingly, we hold that there exists a common law tort action, distinct from an action on the contract, for an insurer's bad faith in settling the first party claims of its insured."

- Karin S. Aldama, Perkins Coie, Tred R. Eyerly, Damon Key Leong Kupchak Hastert, and Meghan E. Ruesch, Lewis, Wagner, LLP authored an excellent article, "Procedural Bad Faith—Recent Trends and Development," that was published by the ABA in 2021. It can be found at: https://www.lewiswagner.com/9C8985/assets/files/News/Procedural%20Bad%20FaithRecent%20Trends%20and%20Developments%20MER.pdf

- Todd S. Schenk of Tressler, LLP authored an excellent compendium, "State-by-State Analysis: Bad Faith in the Absence of Coverage." Although it was last updated in 2016, it is still a great resource. It can be found at: https://www.tresslerllp.com/docs/default-source/Publication-documents/50_state_bad_faith_in_the_absence_of_coverage.pdf?sfvrsn=0

About the Author

Rick Hammond serves as the Principal of Insurance Claims and Litigation Consultants, LLC, a firm that provides expert witness services and testimony on claims and lawsuits involving insurance coverage, bad faith, underwriting, agent-broker liability, regulatory issues and good faith claims handling practices. He also provides consultation and oversight of pre-suit and litigated coverage matters that potentially implicate allegations of statutory, common law or institutional insurer bad faith. He has served as an expert on numerous cases pending throughout the United States, Puerto Rico and the U.S. Virgin Islands, and he is an adjunct professor on insurance law at Loyola University Chicago Law School.

Previously and for more than 30 years, Mr. Hammond served as a coverage and bad faith trial attorney for a number of national insurance carriers. His law practice included in-house training and consultation with insurers on a variety of insurance coverage types, including identifying and assessing potential bad faith exposures. As a result, he has personally reviewed and analyzed hundreds of insurance policies, claims and underwriting files, and examined statutory and case laws in numerous states and federal jurisdictions throughout the United States and U.S. territories. He also routinely authors articles, publications and lectures on the subject of insurance law and bad faith issues. Prior to becoming an attorney, Mr. Hammond was the managerial head of the Illinois Department of Insurance's Chicago office, manager of their Consumer Division and a hearing officer on a variety of regulatory issues. He also held a managerial position in property claims at Allstate Insurance Company, previously worked as a full-lines (life, health, property and casualty) insurance producer for the Equitable Life Assurance Society of the U.S., and served as the executive director and legal counsel for a national insurance trade association, the Insurance Committee for Arson Control.

He is Past-President of the Illinois Association of Defense Trial Counsel, a member of the Federation of Defense and Corporate Counsel, DRI, a Fellow of both the American College of

Coverage Counsel and the Litigation Counsel of America, former board and faculty member of the Insurance School of Chicago, former Chartered Property and Casualty Underwriters (CPCU) instructor, a certified mediator, on the panel of arbitrators for the American Arbitration Association and holds a Chartered Life Underwriters (CLU) certificate. At the onset of the global pandemic, Mr. Hammond was appointed by the Chief Justice of the Illinois Supreme Court to serve on the state's COVID-19 Task Force on Court Operations and was one of two attorneys in the United States selected by the Lexis Nexis Insurance Law Center to receive its "Insurance Lawyer of the Year Award."