The Murky Waters Between ‘Good Faith’ and ‘Bad Faith’

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In honor of Shark Week, that annual television-event where we eagerly flip on the Discovery Channel to get our fix of these magnificent (and terrifying!) creatures, I was inspired to write about the “predatory” practices we’ve encountered recently in our construction insurance practice. The more sophisticated the business and risk management department is, the more likely they have a sophisticated insurer writing their coverage. Although peaceful coexistence is possible, that doesn’t mean that insurers won’t use every advantage available to them – compared to even large corporate insureds, insurance companies are the apex predators of the insurance industry.

In order to safeguard policyholders’ interests, most states have developed a body of law (some statutory, some based on judicial decisions) requiring insurers to act in good faith when dealing with their insureds. This is typically embodied as a requirement that the insurer act “fairly and reasonably” in processing, investigating, and handling claims. If the insurer does not meet this standard, insureds may be entitled to damages above and beyond that which they could otherwise recover for breach of contract.

Proving that an insurer acted in “bad faith,” however, can be

like swimming against the riptide. Most states hold that bad faith requires more than just a difference of opinion between insured and insurer over the available coverage – the policyholder must show that the insurer acted "wantonly" or "maliciously," or, in less stringent jurisdictions, that the insurer was "unreasonable."/FN 1/

There are, of course, many different types of insurer behavior which exist in the murkier waters between "good faith" and "bad faith" of which policyholders should beware. The following list provides some examples of this questionable behavior.

– **Aggressive use of case law.** When new case law is published, carriers race to the smell of blood and attempt to implement the law in new, overly aggressive ways. We saw this after the New York Court of Appeals issued its decision in the Burlington/FN 2/ case in 2017. The true impact of the decision was fairly limited; the court found no coverage for an additional insured where it had been judged that the named insured was not at fault and the additional insured was solely at fault. That didn't stop insurers from attempting to use Burlington to deny defense coverage to additional insureds. Policyholders should be sure they review insurer communications thoroughly and evaluate whether the insurer's basis for disclaiming coverage is valid and appropriate.

– **Changes to insurer personnel.** For policyholders who have been with the same insurer for years, there may be a sense of security that claims will be investigated, defended, handled, or settled a certain way. While it is certainly beneficial for corporate insureds to develop partnerships with their insurers, risk managers should always be on the lookout for change which could spell disaster. Sometimes a personnel change – especially when it comes to "legacy" claims like asbestos matters – could signal a shift in the insurer's treatment of those claims. Risk managers should insist on dedicated claims personnel whenever possible and hold regular

stewardship meetings to maintain relationships and ensure that the insurer is aligned with their goals and strategy as much as possible.

– **Shifting retroactive dates.** Claims-made policies, such as professional, directors & officers, and pollution insurance, often contain retroactive dates which limit how far back in time the insurer's obligation to pay attaches. Sometimes, at renewal, the carrier may bump up that date to the start of the policy period – a change that may go by undetected, but can result in a major coverage gap. Retroactive dates should almost always be as far in the past as possible, coinciding with the start of the insured's business if feasible or, at least, as far back as potential losses may have occurred which would give rise to current liabilities.

– **Refusal to disclose policies, claim numbers, and other non-privileged information.** Upstream parties, such as owners and general contractors, have a right to see a copy of the policy on which they have been added as additional insureds. Insurers sometimes inappropriately refuse access to the policy, which hampers the additional insureds' ability to pursue their rights. Similarly, other non-privileged information stored by the insurer should be accessible to the insured, including loss runs and other claims data. Redacting sensitive information (i.e., premiums) is acceptable, but complete withholding of policies on which you are insured is not.

– **Delay by document request.** Another common tactic employed by insurance companies is delaying their coverage analysis until substantial documentation has been submitted to the insurer. Although this may be understandable in the first-party context (i.e., providing back-up documentation to support the cost of repairs for a builder's risk claim) it is rarely valid when the insured is seeking defense from a liability insurer. Voluminous document requests for contracts, communications, job-site reports, and the like sometimes serve as a hidden means for insurers to delay providing defense, which should be

determined based on the complaint’s allegations.

Staying safe in shark-infested waters takes an educated and dedicated team of professionals. Risk managers should stay afloat by keeping up-to-date on current market and legal developments.

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1 Compare Martin v. Am. Equity Ins. Co., 185 F. Supp. 2d 162 (D. Conn. 2002) (requiring “wanton and malicious injury, evil motive and violence”) with King v. Atlanta Cas. Ins. Co., 631 S.E.2d 786 (Ga. App. 2006) (taking a reasonableness-based approach to bad faith claims).

2 Burlington Ins. Co. v. NYC Transit Auth., 29 N.Y.3d 313 (2017).