March 04, 2021
ARTICLES

Procedural Bad Faith—Recent Trends and Developments

An insurer can potentially act in procedural bad faith even if a claim ultimately is properly denied or wholly paid.

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Development and Scope of Procedural Bad Faith

Bad-faith claims are frequently asserted against insurers because they typically entitle policyholders to consequential damages beyond policy limits, as well as, under certain circumstances, punitive damages.[1] Traditional bad-faith claims are based on the insurer's "refus[al], without proper cause, to compensate the insured for a loss covered by the policy," or, in other words, on the insurer's denial of coverage in situations where the existence of coverage cannot reasonably be disputed.[2] Such claims involving an unreasonable denial of coverage have become known as claims for "substantive bad faith."[3]

Of course, there may be situations in which coverage is properly denied, but the manner in which the insurer goes about that denial is—at least in the eyes of the policyholder—unreasonable. States have, to various degrees, recognized claims alleging such unreasonable conduct by the insurer as ones for "procedural bad faith."[4] Such claims are typically based on allegations that insurers "engag[ed] in oppressive and intimidating claim practices" in the investigation, handling, or denial of claims.[5] That means, of course, that an insurer can potentially act in procedural bad faith even if a claim ultimately is properly denied or wholly paid.[6]

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One prerequisite for the recognition of procedural bad-faith claims was the acknowledgement that insurers can act in bad faith even when they do not breach an express provision of a policy. The Idaho Supreme Court, for example, took that step when it addressed, in *White v. Unigard Mutual Insurance Co.* in 1986, the question of whether "the State of Idaho recognize[s] a tort action, distinct from an action on the contract, for an insurer's bad faith in settling the first party claims of its insured" (this question had been certified to the state supreme court by the U.S. District Court for the District of Idaho).[7] Without addressing the facts in the underlying case, the court held that such a claim could be stated under Idaho law because "insurance companies have a duty to act in good faith with their insureds, and . . . *this duty exists independent of the insurance contract*."[8] Going further, the court also recognized that a bad-faith claim could succeed even when a claim for breach of contract would fail.[9]

While *White* involved a certified question, and thus did not actually resolve the bad-faith claim at issue in the underlying federal suit, other cases have built on the foundation laid by *White* and similar cases. In Arizona, the doctrine of procedural bad faith was more fully developed in *Deese v. State Farm Mutual Automobile Insurance Co.*[10] There, the insurer made some payments toward chiropractic care necessitated after the policyholder was involved in an auto accident, but did not pay the entire amount of the medical bills, based on a review of the claim conducted by a chiropractor retained by the insurer.[11] The policyholder brought suit,

asserting both a claim for breach of contract, based on the insurer's failure to pay the entire claim, and a bad-faith claim, based on the insurer's allegedly unreasonable conduct in reviewing (and typically reducing) chiropractic claims.[12] The jury found for the insurer on the contract claim (thus recognizing that the policyholder had been paid all that was due under the policy), but for the policyholder on the bad-faith claim, awarding both compensatory and punitive damages.[13] The Arizona Court of Appeals reversed, and the Arizona Supreme Court granted review to determine whether insurers that had paid all that was due under a policy could nevertheless be liable under a theory of bad faith. The supreme court found that "a plaintiff may simultaneously bring an action both for breach of contract and for bad faith, and need not prevail on the contract claim in order to prevail on the bad faith claim" so long as the policyholder showed that the insurer acted unreasonably in reaching its coverage determination (which, according to the jury, Deese had shown).[14] In reaching that conclusion, the court specifically overruled an earlier court of appeals decision holding that a valid breach of contract claim was a prerequisite for pursuing a bad-faith claim.[15]

White and *Deese* thus both found that policyholders can assert bad-faith claims against insurers that did not breach any explicit policy provisions—and, in fact, insurers that complied with the explicit policy provisions and paid to or on behalf of their policyholders all the policyholders were due—so long as the insurers provided coverage in an unreasonable manner. These cases also suggest that, but did not address whether, an insurer could be held liable on a procedural bad-faith claim when the policyholder's claim is not covered and the insurer therefore accurately denies coverage.

The Washington Supreme Court addressed precisely this issue in *Coventry Associates v. American States Insurance Co.*[16] In *Coventry*, unusually heavy rains had undermined a retaining wall, resulting in a mudslide that caused damage to the policyholder's construction site.[17] The policyholder sought coverage for the resulting property damage.[18] The insurer conducted an exceedingly brief investigation and denied coverage.[19] The policyholder sued for breach of contract and bad faith.[20] The trial court granted summary judgment for the insurer on the contract claim, agreeing that coverage had been properly denied under the terms of the policy, and dismissed the bad-faith claim because that claim "could not exist in the absence of coverage."[21] The Washington Court of Appeals affirmed, and the policyholder appealed to the Washington Supreme Court.[22]

For purposes of that appeal, which addressed only the bad-faith claim, both the policyholder and the insurer agreed that the denial of coverage had ultimately been correct (though not on the basis initially asserted by the insurer) and that the insurer owed nothing to the policyholder under the policy at issue.[23] The policyholder's claim was that the insurer's investigation and decision-making process had been conducted in bad faith because they had been superficial, had focused only on damage to the retaining wall and not on damage to the construction site in its entirety, had not included an investigation of business loss, and had focused on only two of the policyholder's six policy forms with the insurer.[24]

In addressing the insurer's "no harm, no foul" argument that there could be no actionable bad faith because there was no coverage for the policyholder's loss, the Washington Supreme Court, relying on *Deese* and *White*, held that

> an insured may maintain an action against its insurer for bad faith investigation of the insured's claim . . . regardless of whether the insurer was ultimately correct in determining that coverage did not exist. And insurer's duty of good faith is separate from its duty to indemnify if coverage exists.[25]

Moreover, even though there was no coverage, the court held that, if the policyholder could prove those damages on remand, it was entitled to recover consequential damages in the form of "the amounts it has incurred as a result of the bad faith investigation, as well as general tort damages."[26]

Coventry thus stands for the proposition that a policyholder may state a claim for procedural bad faith even where there is no underlying coverage or obligation to pay any claim. This principle has, in fact, been codified in a statute approved by Washington's voters in 2007. [27] That statute provides that, if a policyholder establishes procedural bad faith with respect to a first-party insurer, the court "shall . . . award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees" and "may . . . increase the total award of damages to an amount not to exceed three times [those] actual damages."[28] Moreover, the Washington Supreme Court has held that *Coventry* also applies in the context of third-party bad-faith claims where liability insurers

appropriately deny the existence of the duty to both defend and indemnify, but engage in bad-faith conduct in the process by, e.g., delaying communications with policyholders or investigations of claims.[29]

While *Coventry* is thus well enshrined in Washington's jurisprudence, only very few other states have suggested that they would adopt the principle that a procedural bad-faith claim can lie even where there is no coverage. One of those states is Utah. The Utah Court of Appeals has held "that a breach of contract is not necessary for a claim of bad faith to arise" and has recognized that a delay in processing claims could constitute bad faith even where there is ultimately no coverage.[30] Similarly, the Arizona Court of Appeals has approved of the holding of *Coventry* (albeit in dicta),[31] as has the Supreme Court of Hawaii.[32] On the other hand, several courts have specifically rejected the *Coventry* principle.[33]

Although only a few states have gone as far as Washington State with respect to holding or suggesting that a procedural bad-faith claim may sound even where coverage does not exist, a majority of states have recognized that insurers can be held liable for their bad-faith conduct.[34] Of those states, the vast majority have followed the reasoning in *White* and held that a claim for insurer bad faith sounds in tort, not in breach of contract.[35] Only a minority of jurisdictions, including New York, continue to evaluate bad-faith insurer conduct on a purely contractual basis.[36] These determinations are generally based on a fear of "undesirable consequences" such as "open[ing] a new avenue for the litigation of claims that, by definition, are outside of the policy's coverage" and the resulting burden on the courts, or on a fear of increased costs of coverage.[37] But even some states adhering to this contract-based view of insurer bad faith have recognized that the "problem of dilatory tactics by insurance companies seeking to delay and avoid payment of proper claims" (i.e., conduct constituting procedural bad faith) requires remedies beyond the policy limits that are typically available in claims for breach of a policy.[38]

Thus, while a majority of states have adopted a claim for procedural bad faith, only a small minority of states, and most prominently Washington, have explicitly recognized, or suggested that they would or may recognize, that such claims can be brought even where coverage was properly denied. A few states have, for now, explicitly rejected such claims. Most states are somewhere in the middle—they recognize procedural bad-faith claims but are still developing those claims' contours and limitations. And even in the minority of jurisdictions that evaluate bad-faith claims strictly on a contract basis, some tort-like damages beyond policy limits are often available for foreseeable damages.

Insurer's Conduct Prior to the Submission of a Claim

Another open question with respect to procedural bad-faith claims is whether an insurer's conduct prior to a claim being submitted can constitute bad faith. Several cases from California suggest that bad faith can be based on the insurer's conduct only after a claim is submitted. But a recent Hawaii case holds otherwise.

No bad faith prior to claim submission. A trio of California cases indicate that bad-faith claims can arise only based on conduct by the insurer *after* the policyholder submits a claim. For example, in 1992 in *Globe Indemnity Co. v. Superior Court*, the California Court of Appeal decided that "[t]here can be no 'unreasonable delay' until the insurer receives adequate information to process the claim[.]"[39]

In *Globe Indemnity*, the policyholder was involved in an accident while a passenger on the back of a stolen motorcycle. Globe Indemnity investigated and requested an examination under oath. The policyholder and her attorney refused on numerous occasions to appear for such an examination. Ultimately, the policyholder appeared and testified that she did not know the motorcycle had been stolen. As a result, Globe Indemnity changed course and agreed there was coverage. The policyholder then sued Globe Indemnity for bad faith, and the trial court granted summary judgment in her favor.

The California Court of Appeal reversed. "The contractual duty to pay policy proceeds did not arise until plaintiffs provided the information necessary to allow Globe [Indemnity] to determine whether the accident on the stolen motorcycle was covered under the terms of the policy."[40] Globe Indemnity's delay in processing the claim was caused solely by the policyholder's failure to provide information about her knowledge or lack of knowledge that the motorcycle had been stolen.[41]

In a subsequent case, the California Court of Appeal considered (but did not decide) whether, under the circumstances at issue, the policyholder had even given notice of a claim to its insurer.[42] As relevant to that case, Michelle Miller left her friend, the plaintiff Jamey Parks, who was drunk and abusive, along a busy highway. Parks was struck and injured as he walked along the highway. He sued Miller.

Miller lived with her father and grandmother in a rented condominium but sometimes stayed with her mother, who lived with a man named Eddie Barnette. Barnette had a homeowner's policy issued by Safeco. Safeco refused to defend Miller in the suit brought against her by Parks. In that suit, an arbitrator awarded Parks $2,187,886 in damages, and judgment was entered against Miller. Miller settled with Parks by assigning to him any claims she might have against Safeco.

Parks sued Safeco to recover the judgment, alleging bad faith in not defending Miller and settling within policy limits. Safeco filed a separate action for declaratory relief against Miller and Parks, alleging that it had no duty to defend or indemnify Miller under the Barnette policy.

Subsequently, Miller discovered that Safeco had also issued her grandmother a renter's policy covering the condominium. Safeco then determined that Miller was an insured under her grandmother's policy and issued a check for the policy limits of $100,000 to Parks. Parks amended his complaint in the bad-faith action, alleging that Safeco had breached its duty of good faith by refusing to defend or indemnify Miller under the grandmother's policy. The jury found in favor of Parks and awarded damages of $3,245,333.76.

Safeco appealed, arguing that its motion for summary judgment had been improperly denied because (a) Miller had tendered her defense only under the Barnette policy and (b) there was no evidence that Safeco had had actual knowledge of the grandmother's policy when it declined to defend Miller.[43] The appellate court found that the trial court had correctly rejected this argument and allowed the case to go to the jury "because the adequacy of Safeco's investigation of Miller's claim and the prejudice [Safeco] may have suffered from delayed notice were disputed issues of material fact."[44]

The appellate court further noted that the duty of good faith and fair dealing included a duty on the part of the insurer to investigate claims submitted by its insured. But it also noted that "[t]hese duties, however, arise after the insured complies with the claims procedure described in the insurance policy," reaffirming its prior holding in *Globe Indemnity*.[45]

In the third case from the California Court of Appeal, the policyholder alleged that an insurer's failure to investigate after receiving a purported tender of defense constituted an act of bad faith.[46] The policyholder, California Shoppers, tendered the underlying lawsuit without a cover letter and in an envelope indicating it was sent by another entity, Adco, which was insured by Royal Globe under a different policy. As a result, Adco was denied a defense under its policy. The trial court ultimately entered a verdict for punitive damages against Royal Globe, based on its bad faith in failing to fully investigate California Shoppers' claim.[47]

The California Court of Appeal reversed the award of punitive damages. "[W]ithout actual presentation of a claim by the insured in compliance with claims procedures contained in the policy, there is no duty imposed on the insurer to investigate the claim."[48] There was no actual notice given to Royal Globe by California Shoppers of its request for a defense. Therefore, no duty to investigate ever arose, and Royal Globe's failure to investigate was not a breach of the duty of good faith and fair dealing.[49]

The court further reasoned that Royal Globe did not know of the claim because it had no substantive communication with the policyholder regarding it and the policyholder had failed to make a proper tender identifying itself. Nor did Royal Globe mislead the policyholder regarding potential coverage of what it knew the policyholder would request in coverage.

These three cases suggest that, under California law, bad-faith claims can be based only on insurer conduct that occurred after the insurer had been provided with proper notice of a claim. But what would the result be if the insurer knew of a claim and failed to tell its insureds there was no coverage months before a formal written request for such coverage was made, even though the insurer knew all along the request would be denied? This was the issue recently presented to the Hawaii Supreme Court.

A Change of Course by the Hawaii Supreme Court. Facing an issue of first impression in Hawaii, in *Adams v. Hawaii Medical Service Ass'n*, 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.[50]

The facts in *Adams* were compelling and heart-breaking. Brent Adams was diagnosed with a rare cancer, stage III multiple myeloma, in August 2005. His doctors recommended a tandem stem cell transplant, under which he would receive a transplant of his own stem cells (an autologous or "auto" transplant), followed by a stem cell transplant from a matched sibling donor (an allogenic or "allo" transplant). Brent informed his health insurance provider, Hawaii Medical Service Association (HMSA), of his doctors' recommendation that he pursue the auto and allo transplants.

Thereafter, HMSA directed Brent to seek treatment at City of Hope in Duarte, California. The HMSA case manager assigned to oversee Brent's care maintained a log of communications. The log recorded that Brent's wife, Patricia Adams, told HMSA that she and Brent were leaving for City of Hope on December 11, 2005, for testing and consultation. Patricia's declaration before the lower court stated that she told HMSA that Brent would seek the auto and allo transplants at City of Hope and asked if anything else was needed to further inform HMSA about the treatment plan. HMSA did not provide any further instructions.

On December 15, 2005, Brent's doctor at City of Hope, Dr. Stein, submitted a precertification request for an auto transplant. The request noted that Brent's siblings would be tested to determine if they could serve as donors, in which case Brent would pursue an allo transplant following the auto transplant. HMSA approved the auto transplant and further informed Dr. Stein that it would pay only for the testing of potential donors for the sibling that provided a match. In doing so, HMSA never suggested that it would not cover the allo transplant—which was the whole purpose of testing Brent's siblings.

The auto transplant took place in January 2006. Dr. Stein then contacted HMSA regarding Brent's participation in a clinical trial for stem cell transplants in preparation for the allo transplant. HMSA informed Dr. Stein that he should contact the precertification division and recommended that he submit data supporting the efficacy of the clinical trial.

Throughout January and February 2006, Brent and Patricia communicated with HMSA numerous times regarding Brent's desire to do the allo transplant. On January 17, 2006, HMSA informed Patricia that Dr. Stein had not yet submitted a precertification request for the allo transplant. On February 22, 2006, Brent informed HMSA that one of his siblings appeared to be a match and that he hoped to pursue the allo transplant. Never suggesting the allo transplant would not be covered, HMSA again noted that a precertification request had to be submitted. HMSA advised Brent that "in terms of the care plan, the goals remain appropriate and on target."[51] Patricia informed HMSA a couple of weeks later that they were "desperately trying to avoid any delays."[52]

On March 2, 2006, Dr. Stein submitted a precertification request for the allo transplant. Four days later, HMSA denied the procedure because it was "investigational."[53] The Adamses were taken by surprise, viewing the denial as an abrupt change by HMSA, especially when Brent had advised HMSA he had a matched sibling donor and there had been no hint that HMSA would deny coverage. Wary of further delays, Brent underwent a second auto transplant in April 2006 because HMSA had not approved the allo transplant. After Brent had an opportunity to recover from the two auto transplants, Dr. Stein submitted another precertification request for the allo transplant in February 2007. This request was also denied by HMSA.

Brent then appealed HMSA's 2007 denial of the allo transplant to the insurance commissioner. In April 2007, the panel reversed HMSA's denial of coverage, finding that although the allo transplant was not specifically included under the plan, it was not specifically excluded either. Further, HMSA had failed to consider professional standards of care and expert opinions in concluding that the efficacy of allo transplants was not supported by sufficient evidence. The insurance panel ordered that HMSA provide coverage for the allo transplant. Brent finally received an allo transplant in 2007 after the panel's reversal, but he died about one year later.

Disagreeing with the insurance panel's interpretation of the plan, HMSA appealed the decision to the circuit court prior to Brent's death. In addition, Brent and Patricia also filed suit for breach of contract, bad faith, and additional claims. That suit was stayed while HMSA pursued its appeal from the insurance panel's decision. In that appeal, the circuit court affirmed the panel's decision that the

allo transplant was covered under the plan. The Intermediate Court of Appeals (ICA) reversed, however, holding that the plan expressly excluded the allo transplant.[54]

HMSA then moved to lift the stay in the suit filed by the Adamses and sought summary judgment on all claims, which included breach of contract, bad faith, emotional distress, and punitive damages. The circuit court granted HMSA's motion. The ICA affirmed on the breach of contract claim but vacated the circuit court's grant of summary judgment on the bad-faith claim.[55] The ICA held that it could not conclude, as a matter of law, that HMSA had acted reasonably in its handling of Brent's claim for the allo transplant.

On remand, HMSA limited the focus of its argument to the time between the submission of a formal claim and HMSA's denial thereof, which had been issued a mere two days after the precertification request had been submitted. Therefore, HMSA argued, its handling of the claim had been objectively reasonable. The circuit court agreed and again granted summary judgment on the bad-faith claim to HMSA. But the ICA again vacated the decision, noting that Patricia's bad-faith claim was based on HMSA's overall unreasonable delay in notifying Brent that an allo transplant was not a covered benefit under the plan.[56] The ICA again held that it could not conclude, as a matter of law, that HMSA had reasonably handled Brent's claim for an allo transplant.[57]

Before the trial court once again, Patricia argued that, by remaining silent about its policy, HMSA had intentionally delayed the denial of coverage to deprive Brent of the opportunity to appeal HMSA's decision or to seek other options for receiving the allo transplant. HMSA had mishandled the claim by failing to timely inform Brent that the allo transplant was not covered and, therefore, had breached the duty of good faith and fair dealing implied in every insurance policy. Nevertheless, HMSA's motion for summary judgment was again granted by the circuit court.

Despite there never having been a trial on the bad-faith issue and with no further discovery, the ICA affirmed, determining that no genuine issues of material fact existed as to whether HMSA had mishandled the claim.[58] HMSA had denied the precertification request within the time period required under HMSA's plan—within two business days. Until a request was submitted, there was no claim for HMSA to process. Relying on *Safeco*, the ICA noted that "the duties of good faith and fair dealing implied in every insurance contract, arise after the insured complies with the claims procedure described in the insurance policy."[59] Therefore, HMSA's duty of good faith did not arise until Brent complied with the plan's claims procedure when his doctor submitted a formal precertification request for an allo transplant. Because Dr. Stein had submitted the request on March 2, 2006, and HMSA had timely responded four days later, on March 6, 2006, the ICA held that HMSA had not mishandled Brent's claim and affirmed summary judgment in favor of HMSA on the bad-faith mishandling claim.[60]

In granting certiorari, the Hawaii Supreme Court considered whether, viewing the evidence in the light most favorable to Patricia, the record contained evidence establishing that HMSA committed the tort of bad faith by unreasonably handling Brent's claim for an allo transplant.[61] The court concluded that a claim for bad faith could be grounded in the carrier's unreasonable handling of the policyholder's claim.[62] It was not sufficient to focus merely on whether the insurer strictly complied with the terms of the contract.[63] The ICA had mistakenly analyzed HMSA's conduct only in the limited timeframe between March 2 and 6, 2006, without considering the insurer's conduct throughout the duration of its relationship with Brent, starting with the first communication relating to his cancer.[64] The covenant of good faith and fair dealing required HMSA to act in good faith throughout its interactions with its policyholder, both before and after formal submission of the precertification request or claim.[65]

Facts in the record suggested that HMSA had unreasonably handled Brent's claim. HMSA had been aware, on December 15, 2005, that Brent was considering the allo transplant, but it had not bothered to inform him that the procedure would not be covered until after a formal request was submitted on March 2, 2006. Further, HMSA had been aware that Brent was testing his five siblings to seek a match, a necessary step for going forward with the allo transplant, but still had not told Brent the procedure was not covered.[66]

HMSA's duty of good faith and fair dealing arose from the insurance contract entered into with Brent, not from the submission of a formal claim. Evidence of HMSA's conduct during its relationship with Brent raised genuine issues of material fact as to whether HMSA had unreasonably handled Brent's claim for an allo transplant. Accordingly, the ICA's judgment on appeal was vacated, as was

the circuit court's order granting summary judgment to HMSA on the bad-faith claim. The case was remanded to the circuit court. At present, the case remains pending in the circuit court, with a trial date set for May 2021.

In the only other case located that indicates an insurer's duty of good faith and fair dealing commences on the date the policy is issued, the Colorado Court of Appeals noted in dicta that "[t]his 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 obligations to negotiate as a reflection of good faith."[67] In that case, the court nonetheless found that the policyholder had presented no evidence to suggest that the insurer had contested liability in bad faith or without any reasonable basis for doing so.[68]

Development and Trends

As we have noted, procedural bad faith is a developing area of the law. Nevertheless, the most prevalent procedural bad-faith claims that policyholders are making have not changed dramatically in the past 10 years. Rather, courts still grapple with these same issues as policyholders are more frequently and aggressively pursuing bad-faith claims, even where, as discussed above, the insurer has provided coverage or benefits under the policy.

Prerequisite to bad faith—breach of policy? The issue of whether a bad-faith claim can exist although policy benefits were properly denied or when benefits were actually paid is still frequently litigated and continues to raise new issues for courts to address, even where the law seems well established.

In one such case, the Texas Supreme Court recently reversed an opinion it had issued in 2001. The court held that, although there *generally* can be no extra-contractual cause of action where there has been no breach of the policy, there may be exceptions.[69] The case arose out of a first-party property claim for property damage caused by Hurricane Ike. The insurer, USAA, determined that damages were covered under the policy but that the covered damages were less than the policy deductible. The policyholder filed suit alleging breach of contract and violation of Texas's unfair settlement practices statute, claiming that USAA had failed to conduct a reasonable investigation.[70]

The case went to trial and a jury found (1) that USAA had not breached the policy, (2) that USAA had refused to pay the claim without conducting a reasonable investigation, and (3) that the policyholder's damages totaled $11,350. The trial court disregarded the jury's verdict regarding the breach of contract claim and entered judgment in the policyholder's favor.[71]

On appeal, the Texas Supreme Court held that bad-faith claims could, under certain circumstances, exist even if there was no breach of contract. Exceptions to the general rule that a breach of the policy was required for a bad-faith claim to be viable had to be narrowly construed, however.[72] The court listed five distinct rules to govern the relationship between contractual and extra-contractual insurance claims:

1. A policyholder cannot recover policy benefits as damages for bad faith if the policy does not provide the policyholder with a right to receive those benefits.[73]
2. policyholder can recover contractual and extra-contractual damages for breach of a policy condition if the bad-faith conduct caused the insurer to breach its policy obligations.[74]
3. Under what is termed the "benefits-lost rule," the policyholder can recover policy benefits as actual damages "if the insurer's statutory violation caused the insured to lose" its rights under the policy.[75]
4. An insurer can be liable if its bad-faith conduct causes a policyholder to suffer damages independent of the loss of policy benefits (i.e., mental anguish, emotional distress, or other "independent injuries").[76]

5. "[A]n insured cannot recover any damages based on an insurer's statutory violation if the insured had no right to receive benefits under the policy *and* sustained no injury independent of a right to benefits."[77]

While these rules appear to be repetitive and perhaps contradictory, the takeaway is that a policyholder must demonstrate some element of causation between the alleged bad-faith conduct and the claimed damages.

In *Ferguson v. USAA General Indemnity Co.*, the Middle District of Pennsylvania similarly grappled with the issue of whether a bad-faith claim can survive where a breach of contract claim fails.[78] Acknowledging that the court for the Middle District of Pennsylvania had previously held that a plaintiff can maintain a bad-faith claim even if the breach of contract claim does not succeed, the courts for the Eastern and Western Districts of Pennsylvania had held the opposite. In *Ferguson*, the court looked to the history of the Pennsylvania bad-faith statute (42 Pennsylvania Consolidated Statutes Annotated section 8371) and Third Circuit case law, and determined that a bad-faith claim may indeed survive denial of, or the absence of, a breach of contract claim.[79] The court reasoned that the statute is not confined to just a baseless denial of a claim but includes, for example, the "lack of investigation into the facts, or a failure to communicate with the insured[,]" as bad-faith conduct.[80] Such conduct is not necessarily tied to a determination of coverage under the policy, but an insurer may still be liable in bad faith for the same.

The court noted, however, that where a bad-faith claim is not predicated on a denial of policy benefits, an "insured cannot use a bad faith claim to compel an insurer to provide coverage beyond the applicable policy."[81] The court explained that, because bad faith constitutes a tort cause of action, policyholders would not be entitled to contractual damages as a remedy for bad faith and that policyholders "are confined to the categories of damages expressly stated by statute: punitive damages, court costs, attorney fees, and interest on any underlying compensatory damages."[82]

Consequently, even where courts have traditionally held that a breach of contract finding was a necessary predicate to a bad-faith claim, this may, under certain circumstances, no longer be the case, and policyholders and plaintiffs will therefore likely continue to aggressively pursue procedural bad-faith claims.

Bad-faith claims handling arising during litigation. Can conduct that occurs in the course of litigation between the insurer and a policyholder amount to procedural bad faith? In *Blanchard v. Mid-Century Insurance Co.*, the South Dakota Supreme Court refused to extend the scope of bad faith to actions involving procedural errors by defense counsel once litigation had commenced.[83] This decision clarified, however, what facts may be presented as evidence of bad faith, as well as the extent to which an insurer may be responsible for attorney conduct in the course of litigation.

In *Blanchard*, the plaintiff was paid workers' compensation benefits by Mid-Century Insurance in 2010, but further benefits were denied after 2011. Blanchard filed a petition with the workers' compensation board and was awarded additional benefits in 2014, based in part on the opinions of Blanchard's medical expert. Mid-Century was advised by counsel that there were deficiencies in the employer's opposing the plaintiff's expert's opinion that justified an appeal, and Mid-Century accordingly appealed.[84]

After the appeal had been filed, however, counsel for Mid-Century was advised that his proposed findings of fact and conclusions of law had failed to preserve any issues for appeal. Counsel did not share this information with Mid-Century. Blanchard moved to dismiss Mid-Century's appeal, and his motion was granted. Blanchard then filed a bad-faith claim, arguing that Mid-Century had pursued a "baseless and meritless appeal in an attempt to delay or avoid payment of that claim or settle that claim in an amount less than" the amount to which Blanchard was entitled.[85] Recognizing that the bad-faith claim arose after Mid-Century decided to appeal the workers' compensation board's decision, the court determined that the "litigation conduct rule" prevented it from considering evidence of an insurer's conduct in subsequent litigation as evidence of bad faith.[86] The court explained that bad faith is determined at the time a claim is denied, and thus litigation conduct occurring after the denial is irrelevant to assess an insurer's bad faith.[87]

Although this issue is not new, it has become increasingly prevalent as policyholders and their attorneys have begun to file bad-faith claims while insurers are still evaluating claims. The *Blanchard* case involved attorney conduct in the course of a disputed claim, but

policyholders frequently anticipate bad-faith claims and file suit even before a determination on coverage is made. This occurs particularly in first-party property claims and uninsured/underinsured motorist claims—claims that many courts acknowledge are, despite providing first-party coverage, adversarial and often give rise to disputes between the insurer and policyholder.

Bad faith in the context of challenging a settlement. With the increase in procedural bad-faith claims, policyholder attorneys are more aggressively pursuing such claims. As a result, insurers need to be aware of scenarios that may expose them to potential bad-faith claims. In *State Farm Fire & Casualty Co. v. Justus*, the Washington appellate court found that the insurer was not obligated to provide coverage for a covenant (or consent) judgment on issues of liability and damages between the policyholder and a third-party claimant where the possibility of the judgment was predicated on potentially uncovered claims.[88]

In *Justus*, State Farm's insured, William Morgan, was confronted by intruders attempting a robbery on his property. When the intruders attempted to flee in their truck, Morgan shot at the truck, causing the truck to crash and the driver to die. Morgan then pointed his gun at the passenger, Robert Justus, and ordered him to lie on the ground until police arrived.[89]

Justus eventually filed suit against Morgan more than two years after the incident, which was beyond the statute of limitations for intentional torts. In order to reach Morgan's insurance, however, Justus also asserted a claim for "negligent wrongful detention."[90]

State Farm defended Morgan under a reservation of rights, denying coverage for any "intentional acts." Morgan then entered into a stipulated judgment with a covenant not to execute against Morgan and assigned his rights to any potential bad-faith claim under the State Farm policy to Justus. The Washington court determined that the covenant judgment and settlement relating to the wrongful detention claim was reasonable and upheld the judgment and settlement between Morgan and Justus.[91]

State Farm then filed a separate declaratory judgment action to establish that it had no duty to indemnify, and Justus filed counterclaims for bad faith. During a bench trial, the trial court determined that State Farm had no duty to indemnify Morgan because his "actions could only constitute intentional acts of false arrest and false imprisonment," each of which were intentional acts barred by the statute of limitations.[92] Justus appealed, arguing that the settlement court's determination that the covenant judgment was reasonable collaterally estopped the trial court from determining underlying liability, i.e., whether Morgan's actions were negligent or intentional. On appeal, the Washington Court of Appeals sided with State Farm, holding that an insurer "will not be bound to findings and conclusions concerning liability if the insurer attempted to challenge the liability findings, and the trial court failed to adjudicate the merits of the substantive claims."[93]

Although this procedural issue came out in favor of the insurer, the result did not entirely dispose of the bad-faith claim, which was allowed to proceed. The Washington Court of Appeals addressed the sustainability of the bad-faith claim in the context of Justus's motion to compel discovery of State Farm's claim file, which the trial court had denied, along with dismissing the bad-faith claim on summary judgment.[94] State Farm had refused to disclose the claim file because the policyholder, in assigning his bad-faith claim to Justus, had not waived his attorney-client privilege.[95] The court of appeals, relying on Washington precedent such as that discussed above, which held that a bad-faith claim may survive even if there is no wrongful denial of insurance coverage, determined that a policyholder's right to the insurer's claim file in the course of pursuing a bad-faith claim extended to a third party who has been assigned the policyholder's claims under the policy.[96] For that reason, the court remanded the bad-faith issue to the trial court for further discovery and to address the bad-faith claims on summary judgment after discovery.

Legislative responses to procedural bad faith. While insurers will undoubtedly continue to face an increasing number of bad-faith claims, some state legislators are responding to assist insurers. The Missouri legislature, for example, recently amended its interpleader statute to provide more protections to insurance companies against bad-faith claims that may arise where an insurer attempts to defend and settle multiple claims against its insured arising out of the same incident or occurrence, which claims in the aggregate exceed policy limits. Under section 507.060 of Missouri's statutes, insurers may interplead policy limits into court for distribution among multiple claimants, and insurers are, following such an interpleader, statutorily protected from subsequent bad-faith actions relating to the payment of such limits, as long as they continue to defend the policyholder against the claims in the underlying actions.[97]

Missouri has another statute designed to protect insurers from bad-faith claims arising out of situations where a plaintiff makes an early, time-limited policy limit demand to settle claims for personal injury, bodily injury, or wrongful death, denial of which can provide a basis for a bad-faith claim for failure to settle within policy limits. The Missouri statute, section 537.058, requires a time-limited demand for policy limits to be in writing, sent via certified mail, and accompanied by healthcare provider information, medical releases, and employer information. The insurer then has at least 90 days to accept. The demand will not be considered a "reasonable opportunity to settle" if the policyholder fails to comply with the statutory requirements.[98]

Moreover, section 537.065 of the Missouri Statutes—which permits a plaintiff and tortfeasor to limit satisfaction of a claim to certain specified assets of the tortfeasor and the tortfeasor's insurance policy limits—was recently amended to provide that a policyholder may enter into a settlement agreement limiting recovery to policy limits only if the insurer has had the opportunity to defend without reservation but refused to do so. The amendment to the statute also permits the insurer to intervene as a matter of right within 30 days of the execution of such agreement.[99]

These statutory shields both operate as safeguards against certain bad-faith claims and grant insurers more time to make settlement decisions, particularly in a state that is considered one of the most policyholder-friendly jurisdictions with respect to bad-faith claims.

Conclusion

As procedural bad-faith claims continue to become more prevalent across the country with policyholders and claimants pursuing such claims to challenge actions of carriers in the handling of claims, both courts and state legislators will likely continue to grapple with these and similar issues.

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This is an academic discussion. The views and opinions expressed in this article do not necessarily reflect the opinions of all of its authors on everything expressed herein, nor of their firms and clients.

[1] *E.g.*, *White v. Unigard Mut. Ins. Co.*, 730 P.2d 1014, 1017–18 (Idaho 1986) (holding that bad-faith action "provides a remedy for harm done to insureds . . . where contract damages fail to adequately compensate [them]" and noting that policyholders who successfully pursue bad-faith claims may be entitled to punitive damages).

[2] *Waters v. United Servs. Auto. Ass'n*, 41 Cal. App. 4th 1063, 1070 (1996).

[3] *Interstate Fire & Cas. Co. v. Apartment Mgmt. Consultants, LLC*, 328 F. Supp. 3d 1242, 1263–64 (D. Wyo. 2018).

[4] *Interstate Fire & Casualty Co.*, 328 F. Supp. 3d 1242.

[5] *Interstate Fire & Casualty Co.*, 328 F. Supp. 3d 1242 (internal quotation marks and citations omitted).

[6] *Interstate Fire & Casualty Co*, 328 F. Supp. 3d at 1265; *see also, e.g.*, *White*, 730 P.2d at 1018 (holding that insurer can act in bad faith by unreasonably delaying claims payment); *Ania v. Allstate Ins. Co.*, 161 F. Supp. 2d 424, 430 (E.D. Pa. 2001) (holding that, "under Pennsylvania law, a bad faith insurance practice can include an unreasonable delay in payment" because "for all practical purposes, delay functions as the equivalent of denial"; recognizing that a two-and-a-half-month delay may constitute bad faith).

[7] *White*, 730 P.2d at 1015.

[8] *White*, 730 P.2d at 1016 (emphasis in original).

[9] *White*, 730 P.2d at 1018 (holding that insured asserting bad-faith claim could, under certain circumstances, "recover at tort, but not at contract"); *see also White*, 730 P.2d at 1017 (holding that "[a]n action in tort provides a remedy for harm done to insureds though no breach of an express contractual covenant has occurred" and emphasizing that "the tort of bad faith is not a tortious breach of contract" but a "*separate intentional wrong*" (emphasis in original)).

[10] *Deese v. State Farm Mut. Auto. Ins. Co.*, 838 P.2d 1265 (Ariz. 1992).

[11] *Deese*, 838 P.2d at 1266–67.

[12] *Deese*, 838 P.2d at 1267.

[13] *Deese*, 838 P.2d at 1267.

[14] *Deese*, 838 P.2d at 1270.

[15] *Deese*, 838 P.2d at 1270.

[16] *Coventry Assocs. v. Am. States Ins. Co.*, 961 P.2d 933 (Wash. 1998).

[17] *Coventry Associates*, 961 P.2d at 934.

[18] *Coventry Associates*, 961 P.2d at 934.

[19] *Coventry Associates*, 961 P.2d at 934.

[20] *Coventry Associates*, 961 P.2d at 934–35.

[21] *Coventry Associates*, 961 P.2d at 935.

[22] *Coventry Associates*, 961 P.2d at 935.

[23] *Coventry Associates*, 961 P.2d at 934–35.

[24] *Coventry Associates*, 961 P.2d at 934–35.

[25] *Coventry Associates*, 961 P.2d at 937; *see also Coventry Associates*, 961 P.2d at 939 (explaining that holding is premised on fact that "the insurance contract brings the insured a certain peace of mind that the insurer will deal with it fairly and justly when a claim is made," for which peace of mind part of the premium is paid). The court also emphasized that, "[u]nder [the insurer's] proposed rule [that there can be no bad faith if there is no coverage], insurers would have a duty of good faith toward their insureds only when coverage was required"; this outcome was unacceptable to the court, which consequently concluded that the duty of good faith exists regardless of whether there ultimately is coverage. *Coventry Associates*, 961 P.2d at 937.

[26] *Coventry Associates*, 961 P.2d at 940. In holding that the policyholder would be entitled to recover consequential damages, the court rejected the policyholder's argument that it should be entitled to coverage by estoppel and to the return of a part of its premium. *Coventry Associates*, 961 P.2d at 939–40. On remand, the policyholder was not able to provide any evidence of damages that resulted from the insurer's bad-faith investigation of its claim, and the case was ultimately dismissed. *Coventry Assocs. v. Am. States Ins. Co.*, 106 Wash. App. 1064 (2001).

[27] Wash. Rev. Code Ann. § 48.30.015(1).

[28] Wash. Rev. Code Ann. § 48.30.015(2), (3).

[29] *St. Paul Fire & Marine Ins. Co. v. Onvia, Inc.*, 196 P.3d 664, 668 (Wash. 2008) (holding that *Coventry Associates* applies to third-party bad-faith claim where "the benefit of the insurance contract (i.e., defense, settlement, and payment) is not available to the insured").

[30] *Colony Ins. Co. v. Human Ensemble, LLC*, 299 P.3d 1149, 1153 (Utah Ct. App. 2013) (citing *Christiansen v. Farmers Ins. Exch.*, 116 P.3d 259, 263 (Utah 2005)).

[31] *Lloyd v. State Farm Mut. Auto. Ins. Co.*, 943 P.2d 729, 737 (Ariz. Ct. App. 1996) ("The covenant of good faith and fair dealing can be breached even if the policy does not provide coverage.").

[32] *Enoka v. AIG Haw. Ins. Co.*, 128 P.3d 850, 865 (Haw. 2006) (noting that insurer must act in good faith in handling claim, even when policy ultimately excludes coverage).

[33] *See, e.g.*, *Waller v. Truck Ins. Exch., Inc.*, 11 Cal. 4th 1, 36, 900 P.2d 619 (1995), *as modified on denial of reh'g* (Oct. 26, 1995); *Capstone Bldg. Corp. v. Am. Motorists Ins. Co.*, 67 A.3d 961, 990 n.39 (Conn. 2013) (declining to adopt *Coventry Associates*' theory of bad faith); *Brethorst v. Allstate Prop. & Cas. Ins. Co.*, 798 N.W.2d 467, 480 (Wis. 2011) (suggesting that there can be no bad faith without coverage).

In *Judah v. State Farm Fire & Casualty Co.*, the California Court of Appeal stated that policyholders could, based on the statutory language at issue, pursue bad-faith claims based on violations of California Insurance Law section 790.3(h)(13) even "if it is determined that [the] policy does not provide coverage for the underlying loss." 266 Cal. Rptr. 455, 463 (Ct. App. 1990), *review dismissed as moot*, 810 P.2d 998 (Cal. 1991). The general rule in California remains, however, that, where there "is no *potential* for coverage . . . there can be no [bad-faith] action for breach of the implied covenant of good faith and fair dealing." *Waller*, 11 Cal. 4th at 36.

[34] Among those states are Alabama, Alaska, Arizona, Arkansas, California, Colorado, Idaho, Indiana, Iowa, Kentucky, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Wisconsin, and Wyoming. *Acquista v. N.Y. Life Ins. Co.*, 285 A.D.2d 73, 79–81 (N.Y. App. Div. 2001) (collecting cases).

[35] *Acquista*, 295 A.D.2d at 79–80.

[36] *Acquista*, 295 A.D.2d at 80–81; *Capstone Building Corp.*, 67 A.3d at 987 (holding that bad-faith claims must be based on breach of policy obligations).

[37] *Capstone Building Corp.*, 67 A.3d at 991.

[38] States that "have . . . expanded the scope of contract remedies to encompass more than just the policy limits" to include "foreseeable money damages beyond the policy limit" include Maine, New Hampshire, New Jersey, Utah, and West Virginia. *See Acquista*, 285 A.D.2d at 80–81 (collecting cases); *see also, e.g.*, *Young Men's Christian Ass'n of Plattsburgh v. Philadelphia Indem. Ins. Co.*, No. 8:18-CV-0565 (LEK/DJS), 2018 U.S. Dist. LEXIS 202818, at *15 (N.D.N.Y. Nov. 30, 2018) (holding that, "[t]hough it is not an independent cause of action, bad faith may justify the recovery of consequential damages in addition to the loss insured by the policy at issue so long as the consequential damages were within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting"); *Beck v. Farmers Ins. Exch.*, 701 P.2d 795, 801 (Utah 1985) (holding that dilatory insurer conduct can constitute bad faith entitling policyholder to foreseeable money damages in excess of policy limits).

The approach taken to this issue by Utah is somewhat unique. Utah has recognized a tort cause of action for bad faith for third-party claims but rejected the tort-based approach in the first-party context. *Beck*, 701 P.2d at 798–800. Nonetheless, under Utah law, a policyholder under a first-party policy can sue for breach of the contractual obligation of good faith and fair dealing, which "contemplates, at the very least, that the insurer will diligently investigate the facts to enable it to determine whether a claim is valid, will fairly evaluate the claim, and will thereafter act promptly and reasonably in rejecting or settling the claim." *Beck*, 701 P.2d at 801. If an insurer breaches these obligations, it can be liable for "general damages [that] flow[] naturally from the breach, and consequential damages [that are] reasonably foreseeable by the parties at the time the contract was made." *Beck*, 701 P.2d at 801–2 (also holding that such damages could be "well in excess of the policy limits, such as for [the loss of] a home or a business"). As exemplified by *Colony Insurance Co.*, 299 P.3d at 1153, discussed *supra*, the holdings in *Beck* leave open the possibility that policyholders could pursue procedural bad-faith claims against insurers under Utah law even where there ultimately is no coverage.

[39] *Globe Indem. Co. v. Superior Court*, 8 Cal. Rptr. 2d 251, 255 (Cal. Ct. App. 1992).

[40] *Globe Indemnity Co.*, 8 Cal. Rptr. 2d 251 at 255.

[41] *Globe Indemnity Co.*, 8 Cal. Rptr. 2d 251 at 255.

[42] *Safeco Ins. Co. of Am. v. Parks*, 88 Cal. Rptr. 3d 730, 740 (Cal. Ct. App. 2009).

[43] *Safeco Insurance Co.*, 88 Cal. Rptr. 3d 730 at 739.

[44] *Safeco Insurance Co.*, 88 Cal. Rptr. 3d 730 at 740.

[45] *Safeco Insurance Co.*, 88 Cal. Rptr. 3d 730 at 740.

[46] *Cal. Shoppers, Inc. v. Royal Globe Ins. Co.*, 221 Cal. Rptr. 171 (Cal. Ct. App. 1985).

[47] *California Shoppers, Inc.*, 221 Cal. Rptr. at 174.

[48] *California Shoppers, Inc.*, 221 Cal. Rptr. at 202.

[49] *California Shoppers, Inc.*, 221 Cal. Rptr. at 203.

[50] *Adams v. Haw. Med. Serv. Ass'n*, No. SCWC-15-0000396, 2019 Haw. LEXIS 263, 450 P.3d 780 (Haw. Sept. 30, 2019).

[51] *Adams*, 2019 Haw. LEXIS 263, at *23.

[52] *Adams*, 2019 Haw. LEXIS 263, at *6.

[53] *Adams*, 2019 Haw. LEXIS 263, at *6.

[54] *Haw. Med. Serv. Ass'n v. Adams*, 209 P.3d 1260, 1271 (Haw. Ct. App. 2009).

[55] *Adams v. Haw. Med. Serv. Ass'n*, 310 P.3d 1052, 2013 Haw. App. LEXIS 569 (Haw. Ct. App. 2013).

[56] *Adams*, 2013 Haw. App. LEXIS 569, at *4, *7. Following Brent's death, Patricia alone pursued the claims as both an affected plaintiff and the executor of Brent's estate.

[57] *Adams*, 2013 Haw. App. LEXIS 569, at *5.

[58] *Adams v. Haw. Med. Serv. Ass'n*, No. CAAP-15-0000396, 419 P.3d 1040, 2018 Haw. App. LEXIS 245, at *11 (Haw. Ct. App. June 8, 2018).

[59] *Adams*, 2018 Haw. App. LEXIS 245, at *7.

[60] *Adams*, 2018 Haw. App. LEXIS 245, at *8.

[61] *Adams v. Haw. Med. Serv. Ass'n*, 450 P.3d 780, 2019 Haw. LEXIS 263 (Haw. Sept. 30, 2019).

[62] *Adams*, 2019 Haw. LEXIS 263, at *17.

[63] *Adams*, 2019 Haw. LEXIS 263, at *19.

[64] *Adams*, 2019 Haw. LEXIS 263, at *19.

[65] *Adams*, 2019 Haw. LEXIS 263, at *20.

[66] *Adams*, 2019 Haw. LEXIS 263, at *21.

[67] *Sanderson v. Am. Family Mut. Ins. Co.*, 251 P.3d 1213, 1217 (Colo. Ct. App. 2010).

[68] *Sanderson*, 251 P.3d 1213 at 1220.

[69] *USAA Tex. Lloyds Co. v. Menchaca*, 545 S.W.3d 479, 484 (Tex. 2018).

[70] *Menchaca*, 545 S.W.3d at 485.

[71] *Menchaca*, 545 S.W.3d at 486.

[72] *Menchaca*, 545 S.W.3d at 488.

[73] *Menchaca*, 545 S.W.3d at 489.

[74] *Menchaca*, 545 S.W.3d at 489.

[75] *Menchaca*, 545 S.W.3d at 489.

[76] *Menchaca*, 545 S.W.3d at 489.

[77] *Menchaca*, 545 S.W.3d at 489 (emphasis added).

[78] *Ferguson v. USAA Gen. Indem. Co.*, No. 1:19-cv-401, 2019 U.S. Dist. LEXIS 209579 (M.D. Pa. Dec. 5, 2019).

[79] *Ferguson*, 2019 U.S. Dist. LEXIS 209579, at *2–3, *9.

[80] *Ferguson*, 2019 U.S. Dist. LEXIS 209579, at *5 (citation omitted).

[81] *Ferguson*, 2019 U.S. Dist. LEXIS 209579, at *7.

[82] *Ferguson*, 2019 U.S. Dist. LEXIS 209579, at *8 (citing *Ash v. Cont'l Ins. Co.*, 932 A.2d 877 (Pa. 2007)).

[83] *Blanchard v. Mid-Century Ins. Co.*, 933 N.W.2d 631 (S.D. 2019).

[84] *Blanchard*, 933 N.W.2d at 638.

[85] *Blanchard*, 933 N.W.2d at 635.

[86] *Blanchard*, 933 N.W.2d at 640.

[87] *Blanchard*, 933 N.W.2d at 640.

[88] *State Farm Fire & Cas. Co. v. Justus*, 398 P.3d 1258, 1260 (Wash. Ct. App. 2017).

[89] *Justus*, 398 P.3d at 1262.

[90] *Justus*, 398 P.3d at 1262.

[91] *Justus*, 398 P.3d at 1262.

[92] *Justus*, 398 P.3d at 1260.

[93] *Justus*, 398 P.3d at 1265.

[94] *Justus*, 398 P.3d at 1268.

[95] *Justus*, 398 P.3d at 1269.

[96] *Justus*, 398 P.3d at 1269.

[97] Mo. Ann. Stat. § 507.060.

[98] Mo. Ann. Stat. § 537.058.

[99] Mo. Ann. Stat. § 537.065.

Endnotes

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