

HOW INSURANCE COMPANIES DEFRAUD THEIR POLICYHOLDERS, AND WHAT COURTS AND LEGISLATORS SHOULD DO ABOUT IT

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The insurance industry devotes substantial resources to a lobbying campaign against insurance fraud. These efforts have borne fruit, and rightly so. Insurance fraud, though, is a two-way street. It is now time to address the fraud and wrongful practices that the insurance industry perpetrates on policyholders.

Over the past twenty years, state courts and regulators have found on several occasions that major insurance companies had procedures in place that systemically denied or underpaid policyholders' legitimate claims. In other cases, courts have found that misrepresentations or other dishonest behavior on the part of insurance company personnel have wrongfully denied claims. Below, we overview illustrative cases, as well as various forms of recourse provided by state law to policyholders who have been wrongfully denied or outright cheated out of coverage.

I. It Is Judicially Established That Insurance Companies Defraud Their Policyholders.

In *Campbell v. State Farm*,¹ a driver made a dangerous maneuver that caused two cars to collide. The driver was insured by State Farm, which investigated the accident and produced a report that stated there was evidence of fault on behalf of its policyholder. Despite this evidence, and despite that it seemed likely there could be an excess judgment in the resulting litigation against its policyholder, State Farm rejected offers to settle and “never departed from its ‘no settlement stance.’” Instead, State Farm’s superintendent and divisional superintendent rejected their own claim investigator’s report and ordered the claim investigator to alter the facts and analysis of liability that indicated exposure for its policyholder and the potential of a high settlement value. The superintendent also demanded that the claim investigator return a letter proving the superintendent had agreed with the claim investigator’s initial analysis, whereafter the claims investigator’s involvement was discontinued in the case.

Although State Farm’s appointed attorney reassured the policyholder that his assets were safe, and that he had no liability for the accident, the jury found the policyholder 100 percent at fault for the accident. The jury entered a judgment of \$185,849 in damages, greatly exceeding any proposed settlement amount and resulting in \$135,849 in excess liability. Subsequently, the three parties to the accident entered into an agreement compelling the policyholder to pursue a bad faith action against State Farm. In doing so, the policyholder uncovered how his claim was part State Farm’s larger “national scheme to meet corporate fiscal goals by capping payouts on claims company wide” – known as State Farm’s Performance, Planning and Review (“PP & R”) policy.

¹ *Campbell v. State Farm Mut. Auto. Ins. Co.*, 2001 UT 89, 65 P.3d 1134, *rev'd*, 538 U.S. 408, 123 S. Ct. 1513, 155 L. Ed. 2d 585 (2003).

The Supreme Court of Utah, in laying out the PP & R scheme, summarized just three examples of the “most egregious and malicious behavior” from twenty-eight pages of extensive findings. First, to meet financial goals, State Farm “repeatedly and deliberately deceived and cheated its customers,” consistently targeting “poor racial or ethnic minorities, women, and elderly individuals” – groups State Farm believed would be less likely to object or take legal action. For instance, agents would change the contents of claim files to distort the assessment of the value of claims against State Farm's policyholders. In the underlying lawsuit, the claim adjuster was instructed to falsely report that the victim was “speeding to visit his pregnant girlfriend.”

Second, State Farm “engaged in deliberate concealment and destruction of all documents related to this profit scheme” to avoid potential disclosure through discovery requests. To shield itself from bad faith actions, it created company policy not to retain any corporate records related to lawsuits against the company.

Finally, State Farm “systematically harassed and intimidated opposing claimants, witnesses, and attorneys” to deter litigation. It did this by mandating attorneys to ask claimants personal, intrusive questions – sometimes bribing third parties in exchange for scandalous information – and using its large company resources to employ “mad dog defense tactics” and “‘wear out’ opposing attorneys by prolonging litigation, making meritless objections, claiming false privileges, destroying documents, and abusing the law and motion process.” The Utah Supreme Court found that this scheme supported the imposition of a higher-than-normal punitive damages award.²

This is not a case of a rogue employee. This is a deliberate and conscious fraud perpetrated by a major insurance company – ‘the good neighbor’ – on its most vulnerable policyholders.

Campbell v. State Farm is just one example of insurance companies consciously and deliberately committing fraud. Unum, one of the nation’s leading disability insurers, was investigated in 2005 and found to have committed widespread fraud.³ The investigation concluded that the company was engaged in pervasive violations of state insurance regulations and in fraudulent denial practices. Those included using phony medical reports, policy misrepresentations, low-balling tactics and biased investigations as pretexts for cutting off legitimate claims of disabled, and often destitute, policyholders.

In another example of blatantly fraudulent behavior, in March 2007 California’s Department of Managed Health Care fined Blue Cross of California and its parent

² The case made its way to the Supreme Court of the United States, which found that a punitive award of \$145 million, where full compensatory damages were \$1 million, was excessive and violated due process. *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 123 S. Ct. 1513, 1515, 155 L. Ed. 2d 585 (2003). On remand, the Utah Supreme Court found that State Farm’s egregious conduct warranted punitive damages of over \$9 million. *Campbell v. State Farm Mut. Auto. Ins. Co.*, 2004 UT 34, ¶ 51, 98 P.3d 409, 420.

³ See “The Ten Worst Insurance Companies”, Am. Ass’n for Just., at p. 6, <https://www.decof.com/documents/the-ten-worst-insurance-companies.pdf>; see also “Insurance Watchdog Petitions California Commissioner to Bar ‘Outlaw’ Insurer,” *Ins. J.*, Sept. 6, 2006, <https://www.insurancejournal.com/news/west/2006/09/06/72065.htm>

company, WellPoint, \$1 million after an investigation revealed that the insurer routinely illegally rescinded individual plan members' policies after they became seriously ill and filed expensive claims. While at that time individual market health plans were medically underwritten, and policies could be rescinded if applicants had concealed pre-existing conditions, the suit alleged that the insurance company routinely abused that process, selling people false promises of coverage and concealing a scheme to renege on the policies for those with conditions including cancer and congestive heart failure.⁴

Farmers Insurance Groups' most high-profile run-in with state regulators occurred in California after the 1994 Northridge earthquake, which killed 72 people, injured nearly 12,000, and caused over \$12 billion in damages.⁵ Many of the affected homeowners were covered by Farmers. Despite paying out over \$1.9 billion for 37,000 claims, the company was hit with a wave of bad faith lawsuits for failing to pay policyholders the full value of their homes. In one case, a Farmers' subsidiary was sued for bad faith and fraud by a condominium homeowners association after the insurance company refused to pay to rebuild the severely damaged building. The homeowners, who were mostly minorities, were aided by the testimony of a former claims adjuster, Kermith Sonnier, who admitted that a supervisor told him to settle the claim for a target amount, despite never having seen the damage firsthand.

Legal scholars have also written about the extensive fraud committed by insurance companies. In *The Disaster After the Disaster: Insurance Companies' Post-Catastrophe Claims Handling Practices*, Kelsey D. Dulin explains the fraud that followed in the wake of Hurricane Katrina, and the ways that independent adjusters may have contributed or participated in that fraud alongside insurance companies.⁶ The article explains that insurance companies have been held liable for committing fraudulent claims handling practices in Oklahoma, as well as on the Gulf Coast, "for hiring biased engineering firms to produce predetermined reports against the interest of policyholders and hiring ill-trained independent adjusters and falsely representing that the adjusters are employees of the insurance company."

Fraud by insurance companies can be the result of company-wide policy or be perpetrated at an individual level. In *Alpizar-Fallas v. Favero*,⁷ a driver insured by Progressive, was involved in a two-car accident. A Progressive claims handler called on her and asked her to sign some papers that he said would help move the process forward. He did not tell her that one of the papers that she signed was a release of the other driver, who was also a Progressive policyholder. The Third Circuit found Progressive's conduct so reprehensible that it vacated the lower Court's dismissal, and allowed the policyholder to maintain their claim under the New Jersey Consumer Fraud Act. Specifically, the complaint alleged that the claims adjuster "falsely represented the nature of the documents that she signed," that others at the insurance company "have

⁴ See *The Ten Worst Insurance Companies*, at p. 14; see also Lisa Girion, "Anthem Blue Cross Over Rescissions," *L.A. Times* (April 17, 2008), <https://www.latimes.com/business/la-fi-insure17apr17-story.html>.

⁵ See *The Ten Worst Insurance Companies*, at pp. 16-17.

⁶ Kelsey D. Dulin, *The Disaster After the Disaster: Insurance Companies' Post-Catastrophe Claims Handling Practices*, 61 *Okla. L. Rev.* 189, 206 (2008).

⁷ *Alpizar-Fallas v. Favero*, 908 F.3d 910 (3d Cir. 2018).

engaged in this same pattern of unlawful conduct with respect to other similarly situated individuals,” and that “as a result of this deceptive and unconscionable practice, present and former insurance policyholders [...] have continued to be stripped of their rights to pursue claims” However, the opinion did not address whether the claims handler acted on his own initiative or pursuant to company policy.

In a recent case handled by the authors’ firm, a religious school was sued in a sex abuse case dating back forty years. The school was able to identify the name of its insurance company in 1982, but had no evidence of the policy. The insurance company repeatedly stated that it had performed a search and had not identified any policy documents. The school sued the insurance company, and the day before certified discovery responses were due, the insurance company produced the key document that proved the existence of the policy, and agreed to defend. Once again, we do not know if the insurance company’s misrepresentation was the work of a rogue employee or company policy.

Fraud by insurance companies occurs on both a small and a large scale. It occurs as the result of company-wide policy or the action of an individual claims handler. By its very nature, fraud involves concealment and is difficult to detect. The overwhelming majority of victims of fraud do not even know that they have been defrauded when an insurance company denies their claim or cancels their policy, and have no recourse.

II. Insurance Company Claims Handlers Wrongly Deny Coverage

Insurance claims handlers are the industry’s front line in its battle with its policyholders. As a general rule, but admittedly not in every instance, they are under-educated in insurance law, underpaid, and overworked. They do not receive bonuses for resolving disputed claims against their employer. While some claims handlers are conscientious about protecting policyholders, others have a bias in favor of denying coverage.

In a recent case handled by the authors’ firm, an apartment suffered mold damage. The insurance company denied coverage because, allegedly, the mold was caused by water vapor, which was an excluded peril. However, the adjuster’s report identified water vapor and precipitation as causes of the mold; precipitation was a covered cause of loss. When the policyholder told the insurance company that the precipitation entitled him to coverage, the insurance company agreed and paid the claim. While we cannot now determine if this was an innocent oversight by the claims handler or a deliberate misrepresentation, it shows the importance of policyholders asserting their grounds for coverage.

In another recent claim that we handled, the claims handler in the aftermath of a flood denied a claim based on a surface water exclusion. However, the state’s appellate court had recently ruled in an almost identical case that the exclusion did not apply. The claims handler simply did not know the law, and wrongly denied coverage

as a result. Fortunately, the policyholder was introduced by a mutual friend to policyholder coverage counsel, who wrote a letter to the claims handler explaining the law. The insurance company recanted and admitted coverage.

Most policyholders do not have access to policyholder counsel who will as a favor take on a small claim that the insurance company wrongfully had denied. Most individual policyholders do not even know that they can challenge an insurance company's claim denial, much less have the ability and assets to pursue it. This is the crux of insurance company bad faith. While large companies with large claims have access to experienced coverage counsel, most individuals and small policyholders, have no way to defend themselves against an insurance company's wrongful conduct. *Campbell* and *Alpizar-Fallas* are exceptional in that they managed to find counsel and access the courts. The overwhelming majority of wronged policyholders are not so fortunate.

Courts have held that the insurance company is the fiduciary of its policyholder in claims handling.⁸ Insurance companies have a duty to try to find coverage as a matter of law. The Supreme Court of Pennsylvania has combated claims handlers' reluctance to adhere to this duty by noting that "[i]f the insurer is derelict in [its fiduciary] duty, as where it negligently investigates the claim or unreasonably refuses an offer of settlement, it may be liable regardless of the limits of the policy for the entire amount of the judgment secured against the insured."⁹

The Supreme Court of New Mexico has explained that an insurance company's fiduciary duty arises "because of the fiduciary obligations inhering in insurance relationships and because of concerns arising from the bargaining position typically occupied by the insured and the insurer."¹⁰ The Court found that North River Insurance Company breached its fiduciary duty where there was substantial evidence that if North River had disclosed its knowledge of continuing inadequate third-party claims handling to its policyholder it "would have prevented the losses suffered by [its policyholder] in having to pay excessive premiums under a retrospective worker's compensation insurance plan." Because under the retrospective premium plan North River could largely determine the amount of premiums, "a certain trust was reposed in them" – a trust which was violated. By not disclosing the unfair claims handling practice, North

⁸ *Illinois Emcasco Ins. Co. v. Nationwide Mut. Ins. Co.*, 2015 IL App (1st) 140928-U, ¶ 45, *as modified* (Nov. 9, 2015) ("[T]he insurer has a fiduciary duty and a duty of good faith to its insureds. In sum, an insurer must not put its own interests ahead of the protection it has promised to its insured."); *Gray v. Nationwide Mut. Ins. Co.*, 422 Pa. 500, 504, 223 A.2d 8, 9 (1966) ("By asserting in the policy the right to handle all claims against the insured, including the right to make a binding settlement, the insurer assumes a fiduciary position towards the insured and becomes obligated to act in good faith and with due care in representing the interests of the insured."); *St. Paul Fire & Marine Ins. Co. v. Onvia, Inc.*, 165 Wash. 2d 122, 129, 196 P.3d 664, 667 (2008) ("The good faith duty between an insurer and an insured arises from a source akin to a fiduciary duty. This fiduciary relationship, as the basis of an insurer's duty of good faith, implies more than the honesty and lawfulness of purpose which comprises a standard definition of good faith. It implies a broad obligation of fair dealing ... and a responsibility to give equal consideration to the insured's interests.") (citations and quotation marks omitted).

⁹ *Gray v. Nationwide Mut. Ins. Co.*, 422 Pa. 500, 504, 223 A.2d 8, 9–10 (1966).

¹⁰ *Allsup's Convenience Stores, Inc. v. N. River Ins. Co.*, 1999-NMSC-006, ¶ 37, 127 N.M. 1, 15, 976 P.2d 1, 15.

River benefitted by receiving premium payments “far greater than would otherwise have been due.”

Because insurance coverage is not an even playing field, courts have held that the rules of insurance policy construction must favor the policyholder. Policy ambiguities must be construed in favor of coverage. Policy exclusions must be construed narrowly. Words must be given their ordinarily understood meaning. Claims handlers must apply these rules to find coverage whenever possible, and not aggressively seek ways to deny coverage.

III. Unfair Trade Practices Acts Should Have a Private Right of Action.

The Unfair Trade Practices Act (“UPTA”)¹¹ prohibits “unfair or deceptive acts or practices in or affecting commerce” and applies to all persons engaged in commerce. An act or practice is “unfair” when it (1) causes or is likely to cause substantial injury to consumers, (2) cannot be reasonably avoided by consumers, and (3) is not outweighed by countervailing benefits to consumers or to competition. An act or practice is “deceptive” where (1) a representation, omission, or practice misleads or is likely to mislead the consumer; (2) a consumer’s interpretation of the representation, omission, or practice is considered reasonable under the circumstances; and (3) the misleading representation, omission, or practice is material.

At least one state, Maryland, has decided to substantively amend its own version of the act, the MCPA,¹² to increase the scope of the statute to cover not only unfair and deceptive practices, but also *abusive* practices. In the same amendment, the MCPA also increased the floor for civil penalties for a single violation from \$1,000 to \$10,000¹³ – the maximum penalty under the UPTA.¹⁴ Repeat violations under the MCPA can warrant a \$25,000 fine.¹⁵ In addition to civil penalties recoverable by the State, any person who violates the MCPA is guilty of a misdemeanor and can be subject to both a \$1,000 fine and imprisonment.¹⁶

Some states have even created a private right of action under the Act. The District of Columbia enacted the CCPA¹⁷, which provides for a private right of action where a consumer who is harmed by an unlawful trade practice may sue for treble damages, punitive damages, and attorney’s fees, as well as an injunction against the unlawful

¹¹ Federal Trade Commission Act, 15 U.S.C 45 § 5.

¹² Maryland Consumer Protection Act, MD. CODE ANN., COM. LAW §§ 13-101 et seq.

¹³ MD. CODE ANN., COM. LAW § 13-410(a).

¹⁴ “Any person, partnership, or corporation who violates an order of the Commission after it has become final, and while such order is in effect, shall forfeit and pay to the United States a civil penalty of not more than \$10,000 for each violation, which shall accrue to the United States and may be recovered in a civil action brought by the Attorney General of the United States.” 15 U.S.C. § 45(l).

¹⁵ MD. CODE ANN., COM. LAW § 13-410(b).

¹⁶ MD. CODE ANN., COM. LAW § 13-411.

¹⁷ Consumer Protection Procedures Act, D.C. CODE §§ 28-3901 to 28-3913.

trade practice.¹⁸ Pennsylvania’s version of the statute, the UTPCPL¹⁹, also provides a private right of action, permitting a victim to sue for treble damages, costs, and reasonable attorney fees,²⁰ and has an extensive section defining what “unfair or deceptive acts or practices” are.²¹

Aside from general versions of the UTPA, states also specifically target the dangers faced by consumers dealing with insurance companies. Every state has adopted some form of the Uniform Unfair Trade Practices Act to govern the claims handling relationship.²² For example, Connecticut enacted the Connecticut Unfair Insurance Practices Act²³, which prohibits unfair or deceptive acts or practices in the business of insurance, and grants the commissioner the “power to examine the affairs of every person engaged in the business of insurance” to determine if there is a violation. Such violations can relate to “unfair claim settlement practices,” whereby the statute effectively codifies an insurance company’s duty to settle in the best interest of its policyholder.²⁴

Connecticut’s general version of the UTPA, the CUTPA,²⁵ provides a private right of action,²⁶ and the statute’s legislative intent “is to make insurance policies subject to both the Connecticut Unfair Insurance Practices Act and the Connecticut Unfair Trade Practices Act.” If a court awards a temporary restraining order or an injunction issued under the Connecticut statutes, any person who violates its terms can pay a civil penalty of up to \$25,000 per violation. New Mexico also provides a private right of action for those who have suffered damages as a result of insurance companies or agents whereby that person may recover actual damages, costs, and potentially attorneys’ fees, in addition to remedies otherwise available under common law or other statutes.²⁷

These statutes are direct evidence of the unfortunate reality of wrongful business practices employed by insurance companies. The statutes set forth standards for appropriate and proper claims handling by insurance companies. However, in most

¹⁸ DC CODE § 28-3905(k)(1); *see also* District of Columbia Consumer Protection Laws, Office of the Attorney General for the District of Columbia, <https://oag.dc.gov/consumer-protection/other-consumer-help-agencies-and-websites/submit-consumer-complaint/district-columbia-consumer-protection-laws>.

¹⁹ Pennsylvania Unfair Trade Practices and Consumer Protection Law, 73 P.S. §§ 201-1 to 201-9.2.

²⁰ 73 P.S. § 201-9.2.

²¹ 73 P.S. § 201-2.

²² *See Unfair Trade Practices Act*, NAIC (Summer 2021), <https://content.naic.org/sites/default/files/model-law-state-page-786.pdf>.

²³ Conn. Gen. Stat. Ann. § 38a-815.

²⁴ Conn. Gen. Stat. Ann. § 38a-816(6). Such practices can include “attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled” or “failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy cover.” § 38a-816(6)(H), (M). Other states also prohibit “unfair claim settlement practices.” *See* N.J. Stat. Ann. § 17B:30-13.1.

²⁵ Connecticut Unfair Trade Practices Act, Conn. Gen. Stat. Ann. § 42-110b; *see also The Connecticut Unfair Trade Practices Act (CUTPA)*, Dep’t of Cons. Protection, <https://portal.ct.gov/DCP/Trade-Practices-Division/About-the-Connecticut-Unfair-Trade-Practices-Act-CUTPA>.

²⁶ Stating that any person who suffers a measurable loss of money or property as a result of an unfair or deceptive act prohibited by CUTPA may bring an action to recover that loss.

²⁷ N.M. Stat. Ann. § 59A-16-20.

states, such statutes do not contain a private right of action. It is essential that such statutes allow individual policyholders to sue insurance companies for violating the standards that the statutes set forth.

IV. Courts Should Award Attorneys' Fees When an Insurance Company Wrongly Denies Coverage

A policyholder with a small claim that an insurance company has wrongly denied can be stuck. It may prove economically unfeasible to pursue coverage for the claim. Coverage litigation can be lengthy and expensive. Insurance companies are expert at dragging out litigation and increasing its expense. A small policyholder may simply not have the finances to pursue litigation. These are difficult cases for an attorney to take on a contingency, because it is difficult for an attorney to commit an indeterminate amount of resources to a recovery of one third of a small claim. Many such claims are never pursued.

This situation cries out for remedy, and one is easily available: courts should have the discretion to award attorneys' fees to a policyholder who is victorious on a disputed insurance claim. Very few states currently provide this remedy in the absence of bad faith by an insurance company. Hawaii broadly allows such an award. So does New Jersey, but only on liability policies. New York allows such an award, but only in cases when an insurance company brings suit against its policyholder.

The possibility of an award of attorneys' fees allows an attorney to take on a small claim that may otherwise be economically unfeasible. It disincentivizes insurance companies from dragging out coverage litigations and increasing their expense. It encourages early settlement of claims without litigation. Policyholders who are wrongly denied coverage deserve their day in court to obtain the coverage for which they paid premiums, and the possibility of an award of attorneys' fees enhances such a recovery.

V. Courts Should Award Extra-Contractual Damages for Fraudulent and Malicious Conduct by Insurance Companies

In *Pickett v. Lloyds*,²⁸ mistakes by an insurance company and its agent were so significant that the policyholder, a trucker, was so late in getting payment for his vehicle that he lost his seniority status, causing him to miss out on more desirable and lucrative work assignments. The New Jersey Supreme Court held that the defendants' actions were in bad faith, even though no malice was involved. The court then examined damages, and whether they should be contractual or tort-based. The court held that in the case before it, the damages should be contract-based and limited to consequential damages. The court also opined that in a more egregious case, tort damages may be appropriate.

Consequential damages are an insufficient measure of damages in many cases when an insurance company wrongly denies coverage. Typically, there are no consequential damages. The policyholder is only deprived of the use of his or her

²⁸ *Pickett v. Lloyd's*, 131 N.J. 457, 621 A.2d 445 (1993).

money. *Bi-Economy*²⁹ is the classic case in which the insurance company's wrongful nonpayment resulted in the collapse of the business, so that substantial consequential damages existed. This is the exception, and not the rule. Typically, an insurance company's wrongful denial of a claim has no consequences.

Moreover, the court in *Pickett* set the bar for an award of tort damages extremely high, and no New Jersey court has ever awarded them. Clearly, 'egregiousness' is in the eye of the beholder. Because contract-based damages typically are meaningless and tort-based damages typically unavailable, insurance companies are insulated from the consequences of wrongful claim denial.

Clearly, courts should not award punitive damages every time an insurance company makes a mistake. In many cases, a private right of action under the UFTA and an award of attorneys' fees are sufficient to make the policyholder whole and punish the insurance company. However, as discussed above, not all mistakes by insurance companies are innocent. Courts when confronted with malicious and fraudulent conduct by insurance companies should not hesitate to award extra-contractual relief, including punitive damages.

VI. **Conclusion**

It is documented that insurance companies sometimes commit fraud. Such fraud may be company-wide, or it may be the result of an individual action. Insurance companies are also prone to mistaken analyses by claims handlers that wrongly deny coverage to policyholders.

Policyholders have few rights when their claims are fraudulently or wrongly denied. Many individuals do not know that they can dispute their insurance company's coverage decisions, and even if they do know it, they don't know how to do it.

Many if not most of the wrongly denied claims are small and fly under the radar of the courts and media. But to an individual, denial of a \$20,000 claim may be more consequential than a million dollar claim is to a large corporation. Financially, an attorney cannot handle a claim for \$20,000, and the policyholder is lost.

Courts and legislatures need to protect policyholders. They need a private right of action under the UTPA and an award of attorneys' fees. They need better access to extra-contractual remedies. When the New Jersey courts instituted an award of attorneys' fees in a successful action on a liability insurance policy, they reasoned in part that this would have a salutary effect on insurance companies' determination to delay resolution of claims and hang on to their money for as long as possible. Courts and legislatures need to even the playing field and give policyholders the tools they need to protect their contractual rights when their fiduciary insurance companies wrongfully deny coverage.

²⁹ *Bi-Econ. Mkt., Inc. v. Harleysville Ins. Co. of New York*, 10 N.Y.3d 187, 886 N.E.2d 127 (2008).