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The Availability of Excess Damages for Wrongful Refusal To Honor First Party Insurance Claims—An Emerging Trend

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I. Introduction

Insurance has become an integral part of the existence of nearly every individual and business in America. To some degree we all look to insurance companies for economic security. In case of catastrophe we depend upon them to relieve our financial hardships, and, for the most part, the insurance industry has fulfilled this trust by paying legitimate claims fairly and promptly.

When fraudulent claims are made, it is not only the right of the insurance companies to challenge their validity, it is in the public interest for the companies to do so. The insurance industry must be strong if it is to remain dependable. It is to no one's advantage if the industry is weakened by repeated payments of false claims.

On the other hand, the vast resources of the insurance industry give it overwhelming power in those instances where an insurance company, for one reason or another, refuses to pay a legitimate claim. The cases cited herein indicate that wrongful refusal to pay claims occurs with enough frequency that adequate legal recourse should be available to insureds in order to prevent this practice. Unfortunately, however, when an insured resorts to the courts for relief, the law, rather than balancing the inequality between the parties, generally tips the scales even further in the direction of the industry.

In a majority of states, an insurance company can intentionally and unreasonably delay the payment of first party insurance claims with veritable impunity. Regardless of the degree of anguish, harassment or financial hardship imposed upon the insured, the insurer is aware that when a claimant is forced to litigate, his maximum recovery is limited to the policy limits plus interest. Moreover, by pressuring the insured to a point of desperation, the company might be able to force an inadequate settlement or avoid payment entirely. Numerous cases indicate that some insurers have taken willful advantage of this opportunity to avoid their contractual obligations.

1. First party insurance refers to policies which indemnify the insured for a personal loss he has sustained. Third party insurance refers to policies which protect the insured against liability for injury to the person or property of a third person. It is necessary to distinguish these types of insurance since the law generally imposes an entirely different measure of damages on claims by an insured against the insurer, depending upon whether a first party or third party policy is involved. See text accompanying notes 90-94 infra.


3. For example, in Eckenrode v. Life of America Ins. Co., 470 F.2d 1 (7th Cir. 1972) (applying Illinois law), plaintiff was the beneficiary of her husband's life insurance policy. When the insured was killed, the insurer refused to make the $5,000 payment due under the policy. Plaintiff alleged that the insurer, knowing the plaintiff and her large family were in dire financial circumstances, exerted economic coercion by inventing a non-existent defense and pressuring her into compromising her claim. Id. at 2-3.

4. See notes 5-16 infra and accompanying text. In Fletcher v. Western Nat'l Life Ins. Co., 10
In cases involving disability and health policies, certain insurance companies have left insureds and their families destitute and have engaged in malicious and outrageous conduct for the purpose of avoiding meritorious claims. These companies have subjected disabled insureds to unnecessary and burdensome medical examinations, have fraudulently attempted to induce insureds into waiving their rights under their policies, and have

Cal. App. 3d 376, 392, 89 Cal. Rptr. 78, 87 (1970), after conceding that its treatment of the insured claimant was deplorable and outrageous, the insurer readily admitted that it would not hesitate to engage in similar conduct in the future.

5. In Fletcher v. Western Nat'l Life Ins. Co., 10 Cal. App. 3d 376, 89 Cal. Rptr. 78 (1970), before discontinuing payments under the plaintiff's disability policy, the insurer conducted a financial investigation which determined that the plaintiff was barely making ends meet. Id. at 389, 89 Cal. Rptr. at 85. The plaintiff surmised that this investigation was made to determine his economic ability to legally resist the insurer's attempt to discontinue his benefits. Id. at 389 n.5, 89 Cal. Rptr. at 85 n.5.

In Silberg v. California Life Ins. Co., 11 Cal. 3d 452, 521 P.2d 1103, 113 Cal. Rptr. 711 (1974), the plaintiff's foot was severed in an accident. He was forced to go from hospital to hospital and to switch surgeons because he was unable to meet the medical bills which the insurer refused to pay. Id. at 458-59, 521 P.2d at 1107, 113 Cal. Rptr. at 715. Ultimately, the plaintiff lost his dry cleaning business. Id. He could not pay his rent. His utilities were turned off. His wheelchair was even repossessed and he could not obtain medication to ease his constant pain. He later suffered two nervous breakdowns. Id. at 459, 521 P.2d at 1108, 113 Cal. Rptr. at 716. The policy application read "Protect Yourself Against the Medical Bills That Can Ruin You." Id. at 461, 521 P.2d at 1109, 113 Cal. Rptr. at 717. The insurer's defense was that it was entitled to await the outcome of a workmen's compensation proceeding. Although the policy's application was ambiguous if the insured had other coverage, the insurer knew that the workmen's compensation claim was doubtful and the insurer could have placed a lien on this claim.

6. In Fletcher v. Western Nat'l Life Ins. Co., 10 Cal. App. 3d 376, 89 Cal. Rptr. 78 (1970), the plaintiff, a father of eight, worked 70 to 80 hours per week, earning approximately $289. After suffering a severe back injury he submitted a claim for payments under his disability policy. The policy provided for payments of $150 per month to last two years in the case of sickness and 30 years for a disabling injury. Despite innumerable medical reports indicating the plaintiff's disability was due to an injury, the insurer, wishing to restrict its exposure to the two year provision, insisted that the plaintiff was suffering from a sickness which he may have contracted from a horse. Then the insurer discontinued payments after a year, by seizing on one physician's statement that a congenital condition had contributed to the plaintiff's disability. Without any investigation of this assertion or information as to whether the plaintiff knew of the alleged congenital condition, the insurer accused the plaintiff of misrepresentation on his insurance application form for failing to divulge his defect. It then demanded return of the payments previously made. The next step was a proposal to allow plaintiff to retain the payments already made in exchange for a complete release. Id. at 386-90, 89 Cal. Rptr. at 83-86. At trial the insurer stipulated to its liability under the thirty year provision of the policy. Id. at 385, 89 Cal. Rptr. at 82.


8. Apparently a common technique is for the insurer to contrive a non-existent defense to a claim and then attempt to procure a release or compromise under the policy. See notes 3 & 6 supra; see also, Note, Punitive Damages For Breach of Contract in South Carolina, 10 S.C.L.Q. 444, 468 (1958) [hereinafter cited as S.C.L.Q.].

In Egan v. Mutual of Omaha, No. EA C 15054 (Super. Ct. Cal., Co. of Los Angeles, Nov. 24, 1974), the plaintiff was injured in a fall from a ladder. After it became evident that the
verbally abused insureds,\textsuperscript{9} going so far as to fabricate accusations of fraud.\textsuperscript{10} 
"[U]nless prevented by the courts, it is to the interest of a disability insurer to engage in protracted and unwarranted litigation creating undue stress which may well precipitate the insured's death."\textsuperscript{11}

In the area of fire insurance, the companies have subjected their insureds to costly and time-consuming examinations for the sole purpose of delaying payment.\textsuperscript{12} They have initiated allegedly unfounded prosecutions for arson and fraud.\textsuperscript{13} By wrongfully delaying desperately needed funds, insurers have forced businesses into bankruptcy.\textsuperscript{14}

Other examples of unethical conduct have occurred in cases involving life\textsuperscript{15} and accident\textsuperscript{16} insurance.

Several jurisdictions have attempted to protect the public from these tactics by permitting first party insurance claimants to recover amounts in excess of policy limits plus interest. A number of states have enacted statutes which provide for the recovery of attorney's fees and punitive damages when an insurance company willfully refuses to pay a clearly justified claim.\textsuperscript{17} Courts in other states, most notably California, have allowed judgment for amounts above the policy limits of first party insurance contracts.

Nevertheless, the majority of states still relegate the insured to the face value of the policy plus interest, regardless of the circumstances involved.\textsuperscript{18}
Since it is to the advantage of the insurer to delay payment, these states tempt insurance companies to engage in unethical conduct. From the insurer's point of view, it has nothing to lose. At best, the company may be able to avoid payment entirely. At worst, it will have to pay its original obligation plus interest. When commercial interest rates are far above legal interest rates, a company may even profit by the difference between the interest it may earn while litigation is pending and the amount it will pay as damages. On the other hand, the insured is faced with the strain of years of litigation, plus enormous contingent fees and legal expenses.

This Note will examine the principles of law that have made courts reluctant to grant recovery beyond policy limits and will discuss concepts that are developing within the legal framework to allow more adequate and equitable recovery.

II. THE TRADITIONAL VIEW

An insurance policy is a contract between the insurance company and the insured. For the sake of consistency and legal certainty, the general rules of contract law have traditionally been applied to deny recovery beyond the face amount of insurance policies.

Under the rule of Hadley v. Baxendale, consequential damages for breach of contract are limited to those which arise naturally from the breach or which were reasonably foreseeable at the time the contract was made. This concept of foreseeability is very narrowly construed. It is not sufficient that damages of a general nature are foreseeable. Unless the specific consequences of the breach could be foreseen they will be considered too remote. For instance, it can certainly be expected that an insured who becomes disabled might suffer economic losses and compounded physical hardship when his insurer refuses to pay under the policy. However, the specific consequences of the insurer's breach, such as loss of a home because of inability to meet mortgage obligations, are not necessarily foreseeable. Thus, under the strict construction of the Hadley rule, consequential damages for such losses are unavailable.

Even where specific consequences are patently foreseeable, the insured is generally denied consequential damages because, in a suit for money due under a contract, recovery is normally limited to the debt plus interest.

19. For example, the legal rate of interest in New York is 6%, N.Y.C.P.L.R. § 5004 (McKinney Supp. 1976), whereas the prime rate of interest rose as high as 12% in August of 1974. Wall Street J., Aug. 22, 1974, at 4, col. 3.


21. Id. at 145.


In addition to the *Hadley* limitation on consequential damages, the insured's recovery is further restricted by the rule that punitive damages are generally not available in a contract action, regardless of how willful, malicious or fraudulent the breach. Some insurers have been able to flaunt justice by using these traditional and long established rules of contract law as a shield against excess liability.

Recently, a few jurisdictions have begun to recognize the inadequacy of these legal concepts which were developed long before the insurance industry became such a powerful entity and insurance such an important factor in our lives. California, particularly, is molding its law to respond to the need for more equitable recovery. The few jurisdictions allowing recovery beyond policy limits have used three general approaches.

First, there are courts which take a liberal approach to pure contract actions and allow recovery for damages proximately caused by the breach in addition to the amount due under the contract.  

Second, an action for breach of contract can be joined with an action in fraud. While this does not necessarily allow broader compensatory damages than a strict contract action, it will permit recovery of punitive damages.

Finally, an action can be brought on a tort theory which allows recovery of broad consequential damages. This approach enables the plaintiff to bypass rules of contract law which restrict his recovery. Some of these actions involve new applications of pre-existing torts, while one, the tort of bad faith, has been developed specifically for abused insurance claimants.

III. LIBERALIZED RECOVERY FOR BREACH OF CONTRACT

A major obstacle to the imposition of excess liability is the general rule that compensatory damages for breach of a contract to pay money are limited to

In *Haas v. Pacific Mut. Life Ins. Co.*, 70 Ohio App. 332, 335-36, 41 N.E.2d 263, 264-65 (1941), the plaintiff alleged that the insurer knew the plaintiff had entered into a disability policy in order to keep a life insurance policy in force. When the insured became disabled and the insurer delayed payments for one year, the plaintiff, unable to pay the premium on his life policy, was forced to let it lapse. The court held that in spite of the fact that the plaintiff's detriment may have been foreseeable, his damages were limited to the interest on the delayed payments.


25. From a policy standpoint, it is repeatedly argued that the insurer must be able to calculate the risk it assumes and that if liability beyond the face of the policy were imposed, the public would suffer the consequence of higher premiums. *Scottish Union & Nat'l Ins. Co. v. Bejcy*, 201 F.2d 163, 166 (6th Cir. 1953); see *Wm. & Mary*, supra note 22, at 475. This argument is untenable in view of the fact that excess liability has long been imposed in third party insurance cases, apparently without such effect. See text accompanying notes 95-97 infra. Furthermore, if the imposition of excess damages in a proper case serves as a deterrent to unethical settlement tactics, the need for these excess damages would be obviated.

26. See text accompanying notes 30-47 infra.

27. See text accompanying notes 48-73 infra.


29. See text accompanying notes 74-131 infra.
interest on the debt.\textsuperscript{30} This rule is founded on the following rationale. It presumes, first, that the parties to the contract have equal bargaining power and, therefore, are free to provide explicitly in the contract for any foreseeable consequences; second, that money is always available at approximately the legal rate of interest; and, third, that it is desirable to have a simple and certain measure of damages.\textsuperscript{31}

While these assumptions may apply to commercial contracts for profit, they have no application to first party insurance policies. In the first place, the parties to an insurance policy generally do not have equal bargaining power. Insurance policies are contracts of adhesion\textsuperscript{32} and the disparity in economic power between the parties can be staggering.\textsuperscript{33} No matter how foreseeable the consequences of nonpayment may be, the insured has no ability to provide for them in the contract when he obtains his policy.

Secondly, the assumption that money is always available is illusory. Aside from the fact that the commercial rate of interest might be double the legal rate,\textsuperscript{34} it is highly unlikely that a claimant who has recently suffered economic disaster would be able to obtain a loan at all.\textsuperscript{35}

Lastly, it is the very certainty of this rule of damages which enables insurance companies to take advantage of their insureds. Because this rule so severely restricts the maximum available recovery, it is in the insurer's best interest to delay payment as long as possible.

However, even where it is recognized that the rule limiting damages to interest should not be applied in the context of first party insurance,\textsuperscript{36} the insured will still be precluded from recovering in excess of the policy limits unless he can show that his consequential damages were foreseeable within the \textit{Hadley} rule.\textsuperscript{37} Previously the courts had held that consequential damages were too remote as a matter of law.\textsuperscript{38} Recently there has been a trend towards awarding consequential damages when they in fact are foreseeable.

\textsuperscript{30} See text accompanying note 23 supra.
\textsuperscript{32} See Calamari & Perillo, supra note 24, at § 3.
\textsuperscript{33} Assets of property and liability insurance companies in the United States at the end of 1973 totaled about $84 billion. Policyholders' surplus, that is, the difference between assets and liabilities, was approximately $27 billion. Insurance Information Institute, Insurance Facts 1974, at 28 (1974). Assets of U.S. life insurance companies reached $263.3 billion by the end of 1974.
\textsuperscript{34} See note 19 supra.
\textsuperscript{35} See, e.g., Silberg v. California Life Ins. Co., 11 Cal. 3d 452, 521 P.2d 1103, 113 Cal. Rptr. 711 (1974), wherein the plaintiff borrowed some money to pay business expenses shortly after his injury. However, he was not able to borrow additional funds. He was considered a credit risk because he could not pay the medical bills his insurer refused to cover. Ultimately he lost his business. Id. at 459, 521 P.2d at 1107-08, 113 Cal. Rptr. at 715-16.
\textsuperscript{37} See text accompanying notes 20-22 supra.
\textsuperscript{38} Haas v. Pacific Mut. Life Ins. Co., 70 Ohio App. 332, 335-36, 41 N.E.2d 263, 266 (1941),
The plaintiff in *Reichert v. General Insurance Co. of America* owned a motel which had been substantially destroyed by fire. Although the insurers were aware that the property was heavily mortgaged, they denied the plaintiff's claim for indemnity. The plaintiff was forced into bankruptcy five months after the fire because of his inability to meet the mortgage payments. At its initial hearing of the case, the Supreme Court of California was confronted with the defendants' contention that damages were limited to interest on the debt. The court examined the underlying rationale of the rule limiting damages to interest and concluded that since the rationale did not apply, the rule itself must be rejected. It reasoned that:

[where the owner of a heavily mortgaged . . . business property suffers a substantial fire loss, the owner . . . may be in jeopardy of losing his property and becoming a bankrupt. A major, if not the main, reason why a businessman purchases fire insurance is to guard against such eventualities . . . . Insurers are, of course, chargeable with knowledge of the basic reasons why fire insurance is purchased, and of the likelihood that an improper delay in payment may result in the very injuries for which the insured sought protection by purchasing the policies.]

The court concluded that since the plaintiff's bankruptcy was foreseeable, the defendants would be liable for consequential damages caused thereby. Unfortunately, this decision was vacated upon rehearing when the court held that plaintiff did not have a right to recovery since this cause of action had vested in the trustee in bankruptcy.

The court in *Asher v. Reliance Insurance Co.* held that, in addition to the amount due under the policy, the plaintiff could recover lost rents based solely on the insurer's breach of the policy as long as he could show that such damages were within the contemplation of the parties at the time the contract of fire insurance was made and were proximately caused by the breach. The foregoing cases indicate the willingness of some courts to recognize that when consequential damages are foreseeable they should be recoverable.

Once the courts see their way through the mire of misapplied rules of contract law, plaintiffs will hopefully be able to recover consequential damages for breach of first party insurance contracts. Because a majority of courts

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40. Id. at 863, 59 Cal. Rptr. at 727.
41. Id. at 865, 59 Cal. Rptr. at 729.
42. Id. at 866, 59 Cal. Rptr. at 730.
43. Id. at 864, 59 Cal. Rptr. at 728.
44. Id. at 866-67, 59 Cal. Rptr. at 730-31.
45. 68 Cal. 2d 822, 442 P.2d 377, 69 Cal. Rptr. 321 (1968) (en banc). Nevertheless, Justice Peters, who wrote the court's original opinion reiterated, in a vigorous dissent, his contention that the plaintiff was entitled to consequential damages. Id. at 839, 442 P.2d at 386, 69 Cal. Rptr. at 330.
47. Id. at 852.
have not yet taken this step, insureds have attempted, with increasing success, to recover excess damages by suing on tort theories.

IV. Torts Causes of Action

A. Fraud

A cause of action for fraud has been approached from two distinct standpoints—fraud in the inducement and fraudulent breach of contract.

When an insurer fails to pay a legitimate claim, some courts have allowed excess recovery on the theory that the insured was fraudulently induced to enter the contract or at least to keep it in force. This action is referred to as fraud in the inducement. As a tort cause of action, it enables the plaintiff to recover punitive damages. By joining a contract claim with this tort claim, the plaintiff can recover the proceeds of the policy as well as punitive damages for fraud.

To prove fraud in the inducement, the plaintiff must show he was induced to pay premiums in reliance on a representation or promise which the insurer knew to be false or never intended to fulfill. Occasionally it may be shown that the insurer made a representation which was patently false at the time. For instance, in Sharp v. Automobile Club, the plaintiff renewed his automobile policy in reliance on the insurer's representation that the policy covered medical expenses of the insured and his family, regardless of whether he had other insurance. In fact, a year earlier, the carrier had discontinued the practice of paying claims where the claimant had other coverage. When the company refused to pay a subsequent claim, the plaintiff sued in contract and for fraud. He was awarded punitive damages in addition to recovering the amount due under his policy.

In Sharp it was clear that the insurer never intended to fulfill its representation as to medical coverage. However, an insurer is rarely able to prove that an insurer made a representation, at the time the contract was made, which it intended not to fulfill. Normally, the insurer's intent not to pay becomes evident only after the insured submits a claim. Proof of an insurer's intent at the time the claim arises, however, is not sufficient to support fraud in the inducement. Since it must be shown that the plaintiff paid his premiums in

49. 265 Cal. App. 2d at 930, 71 Cal. Rptr. at 769-70.
52. Id. at 650, 37 Cal. Rptr. at 587.
53. Id. at 651, 37 Cal. Rptr. at 587.
54. Id. at 651, 37 Cal. Rptr. at 587.
reliance on the insurer's fraud, it is necessary to prove the insurer's fraudulent intent at the time the contract was made. To overcome this obstacle in the insured's burden of proof, some courts permit the insurer's fraudulent intent to be inferred so long as the plaintiff can prove that some representation was made at the time of contracting which turned out to be false after a claim was presented.

Such a case was *Wetherbee v. United Insurance Co. of America*. This case involved a seventy-year-old woman who had purchased a disability policy. After keeping the policy in force for five and one half years, she suffered a stroke which kept her confined to her home except for occasional visits to her doctor. Even though the policy provided "that the insured's right to recover . . . shall not be defeated because [she] visits [her] physician for treatment," the insurer claimed that the insured was not continuously confined as required by the policy and terminated its payments to her. Mrs. Wetherbee sued for the unpaid proceeds under the policy and for fraud. She was ultimately awarded $1,050 in compensatory damages and $200,000 in punitive damages.

The fraud involved the fact that shortly after she purchased the policy, Mrs. Wetherbee, fearful that the contract could be terminated at the whim of the insurer, returned the policy and requested reimbursement of her premium. The defendant wrote her a letter assuring her that the policy could not be terminated if she became disabled. As a result, plaintiff was induced to keep the policy in force and subsequently purchased another policy to obtain even higher benefits.

The court in *Wetherbee* held that the defendant's fraudulent intent not to live up to the representation in its letter could be inferred from its subsequent discontinuance of benefits. Thus, the court greatly relaxed the plaintiff's burden of proof regarding the element of intent. By doing so it indicated it would not tolerate conduct which victimizes the weak and unsophisticated who normally feel the greatest impact of financial harm.

*Miller v. National American Life Insurance Co.* went even further than *Wetherbee* in liberalizing the required proof for fraud in the inducement. In *Miller* the plaintiff recovered punitive damages for fraud, based solely on the insurer's contractual promise to make payment in case the plaintiff became disabled. The defendant insurer claimed that a representation contained only in the insurance policy is insufficient as a matter of law to support fraud in the

57. Id. at 926, 71 Cal. Rptr. at 766.
58. Id. at 932, 71 Cal. Rptr. at 770.
59. Id. at 927, 71 Cal. Rptr. at 767.
60. Id. at 924, 71 Cal. Rptr. at 765.
62. 265 Cal. App. 2d at 925, 71 Cal. Rptr. at 766.
63. Id. at 932, 71 Cal. Rptr. at 770.
64. 54 Cal. App. 3d 331, 126 Cal. Rptr. 731 (1976).
inducement. It insisted that, as was the case in Wetherbee, specific false representations distinct from the policy are required. The court rejected this argument stating that an inducement is equally apparent whether it occurs in the policy or a separate letter.

In response to the insurer’s argument that there was no proof the insurer did not intend to honor the policy at the time the agreement was made, the court responded that, “[s]ubsequent conduct of an insurer in processing a claim may support an inference of prior intent not to fulfill its representations.” In this case the insurer had physicians complete an ambiguous questionnaire. The insurer would then construe the physician’s response against the insured as an excuse to automatically terminate payments. The court held that this practice was sufficient to support the inference that the insurer intended not to honor its promised coverage.

Because recovery would otherwise be totally inadequate, fraud in the inducement should be available to plaintiffs who can prove the requisite elements. However, it is by no means an ideal remedy. The insured's detriment in these cases is deemed to be his premiums, not the consequential losses he suffered because of the carrier’s refusal to pay. Thus, rather than recovering his specific losses, the plaintiff’s redress must be cloaked in the form of punitive damages.

Moreover, this remedy is not based on the conduct which gave rise to the insured’s grievance. The plaintiff must prove that he paid premiums in reliance on a misrepresentation by the insurer. Thus, plaintiffs have had to go through ludicrous machinations to find some fraudulent act relating to the making of the contract when, in actuality, the plaintiff’s grievance concerns the abusive settlement tactics which took place after his claim arose.

As an alternative to fraud in the inducement, fraudulent breach of contract is a more logical and adequate theory of recovery because it is based directly on the conduct which gave rise to the insured’s grievance and it allows compensation for all the detriment proximately caused by the insurer’s wrongful refusal to pay a legitimate claim.

South Carolina is the primary jurisdiction allowing recovery for fraudulent breach of an insurance contract. Its cases repeatedly affirm the requirement that some wrongful activity beyond mere nonpayment accompany the breach. There must be a fraudulent act. But the term “fraudulent” is used in a very loose sense. Apparently any deceitful tactics on the part of the insurer,

65. Id. at 338-39, 126 Cal. Rptr. at 735.
66. 265 Cal. App. 2d at 931, 71 Cal. Rptr. at 769-70.
67. See S.C.L.Q., supra note 8, at 445. However, other jurisdictions have also allowed recovery on fraudulent breach of contract. See, e.g., Davenport v. Mutual Benefit Health & Accident Ass'n, 325 F. 2d 785 (9th Cir. 1963) (applying Oregon Law); Physicians Mut. Ins. Co. v. Savage, 296 N.E.2d 165 (Ind. App. 1973).
69. See, e.g., Corley v. Coastal States Life Ins. Co., 135 S.E.2d 316 (S.C. 1964), where the
accompanied by a failure to pay a legitimate claim, which results in further
damage to the insured will support an action for fraudulent breach in South
Carolina.\textsuperscript{70}

Very few jurisdictions, however, are willing to accept the theory of fraudu-
ient breach. With fraud in the inducement, the tortious conduct arises at the
time the contract is made and is independent of the breach of contract.\textsuperscript{71}
Thus, there are two distinct causes of action with two separate measures of
damages. The fraud cause of action allows recovery of punitive damages,
while breach of contract allows recovery of the proceeds of the policy. On the
other hand, fraudulent breach of contract muddles the distinction between
tort and contract. In essence it allows a tort measure of damages for breach of
contract and thereby directly contradicts the general rule that a tort will not
lie for breach of contract no matter how malicious or fraudulent the breach.
Although tort damages are available for the breach of certain contracts where
the breaching party is deemed to owe a public duty,\textsuperscript{72} courts have been, until
recently, unwilling to apply this concept to insurance.\textsuperscript{73}

\section*{B. Intentional Infliction of Mental Distress}

In jurisdictions which recognize the tort, intentional infliction of emotional
distress presents a fertile theory on which first party insureds can base an
action for damages in excess of policy limits. The elements of the tort include
extreme and outrageous conduct by the defendant, defendant's intent to
cause, or reckless disregard of the probability of causing, emotional distress\textsuperscript{74}

plaintiff was the beneficiary of a life policy on her husband. After her husband's death, the
plaintiff was told by the insurance company that the amount due under the policy was $5,096.80.
Later, a friend of the plaintiff, who was engaged in the insurance business, inquired with the
insurance company and was told that the amount due was actually $7,296.75. Plaintiff then
forwarded her copy of the policy to the insurance company and received a check for $6,371.25.
Id. at 318. On these facts the plaintiff was held to have a cause of action for fraudulent breach of
contract. Although the insurer may have made fraudulent statements by misrepresenting the
amount due under the policy, it is difficult to see how the plaintiff suffered pecuniary loss in
reliance on these statements.

\textsuperscript{70} Wm. & Mary, supra note 22, at 472.
\textsuperscript{72} "There are certain classes of contracts . . . from which the law implies duties, a breach of
which will constitute a tort, and 'in such cases an injured party may sue either for breach of the
contract or in tort' for breach of the implied duty. This rule applies in certain contractual
relations between principal and agent, bailor and bailee, attorney and client, physician and
patient, carrier and passenger or shipper, master and servant, and similar well-recognized
relations; but it is not every contractual relation which involves a public duty, the breach of
\textsuperscript{73} Id.; see also Merrin Jewelry Co. v. St. Paul Fire & Marine Ins. Co., 301 F. Supp. 479,
\textsuperscript{74} It is not necessary that defendant's purpose is to cause mental distress. In most cases the
defendant's purpose is to coerce the plaintiff to do something against his will and the coercion
results in mental distress. For example, in State Rubbish Collectors Ass'n v. Siliznoff, 38 Cal. 2d
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and severe emotional distress proximately caused by the defendant's conduct.\textsuperscript{75}

Extreme and outrageous conduct is not defined by the nature of the defendant's conduct alone. Certain factors make conduct tortious in one situation which would not be so in another. One such factor is the defendant's abuse of a position of actual or apparent power to damage the plaintiff's interests.\textsuperscript{76}

An even stronger basis for finding extreme outrage exists when the defendant knows or should know that the plaintiff—because of sickness, age, or mental condition—is especially vulnerable to mental distress.\textsuperscript{77}

The presence of these two factors—defendant's position of power and plaintiff's vulnerability—make the tort of intentional infliction of mental distress particularly applicable to abusive settlement tactics by insurance companies where severe emotional distress results.\textsuperscript{78}

When an insurance claim is submitted, the carrier is indisputably in a position of power to damage the plaintiff's contractual rights. This is true because of the grossly disproportionate economic resources of the parties,\textsuperscript{79} and because of the nature of the contract itself. Since an insurance policy is a reverse unilateral contract of adhesion,\textsuperscript{80} the plaintiff has little bargaining power when he enters into the contract and virtually none after a claim arises. At that time he has already performed his end of the bargain and must depend on the insurance company to fulfill its obligations. The plaintiff's only recourse, litigation, is little threat to a defendant that knows its liability is limited to its original obligation under the contract.

Furthermore, the very risks insured against presuppose that the claimant will be in an emotionally vulnerable position due to sickness or fears of economic ruin when a claim has been filed.\textsuperscript{81}

Thus, the two essential factors which contribute to a finding of extreme outrage are present in most first party insurance contracts. When an insurance

\textsuperscript{75} 330, 240 P.2d 282 (1952) (en banc), the defendants were held liable for inflicting mental distress because of threats to beat up the plaintiff and put him out of business unless he paid them the proceeds he received from a territory which the rubbish collector's association had assigned to one of its members. See Prosser, supra note 50, at 60.


\textsuperscript{77} Eckenrode v. Life of America Ins. Co., 470 F.2d 1, 4 (7th Cir. 1972); Prosser, supra note 50, at 56.

\textsuperscript{78} Eckenrode v. Life of America Ins. Co., 470 F.2d 1, 4 (7th Cir. 1972); Prosser, supra note 50, at 58.

\textsuperscript{79} Eckenrode v. Life of America Ins. Co., 470 F.2d 1, 4 (7th Cir. 1972); Fletcher v. Western Nat'l Life Ins. Co., 10 Cal. App. 3d 376, 403, 89 Cal. Rptr. 78, 95 (1970).

\textsuperscript{80} See note 33 supra.

\textsuperscript{81} Eckenrode v. Life of America Ins. Co., 470 F.2d 1, 5 (7th Cir. 1972); Fletcher v. Western Nat'l Life Ins. Co., 10 Cal. App. 3d 376, 404, 89 Cal. Rptr. 78, 95 (1970).
company's settlement conduct is truly abusive, the insured who suffers severe emotional distress should be able to recover damages.82

Initially, recovery from an insurance company for mental distress was granted only as an element of damages in suits for independently actionable torts.83 However, in Fletcher v. Western National Life Insurance Co.,84 California became the first state to award damages based solely on the tort of intentional infliction of mental distress.85 Since then, recovery on this basis has also been granted by the Seventh Circuit, applying Illinois law,86 and by the District Court of Appeal of Florida.87

Although intentional infliction of mental distress may be perfectly suitable to certain first party actions, it does not apply to all cases where consequential damages should be available. Since the tort is designed to redress invasions of emotional tranquility,88 the plaintiff will be precluded from recovering unless he can prove his distress was severe.89 Furthermore, recovery is normally limited to damages for the mental suffering itself and possibly punitive damages.90 It is conceivable that an insurance company's abusive tactics

82. "It is recognized that the outrageous character of a person's conduct may arise from an abuse by that person of a position which gives him power to affect the interests of another; and that in this sense extreme 'bullying tactics' and other 'high pressure' methods of insurance adjusters seeking to force compromises or settlements may constitute outrageous conduct. . . . It is also recognized that the extreme character of a person's conduct may arise from that person's knowledge that the other is peculiarly susceptible to emotional distress by reason of some physical or mental condition or peculiarity." Eckernrode v. Life of America Ins. Co., 470 F.2d 1, 4 (7th Cir. 1972) (citations omitted).

83. In Asher v. Reliance Ins. Co., 308 F. Supp. 847, 853 (N.D. Cal. 1970), damages for mental distress were held recoverable in an action for fraud in the inducement. In Continental Cas. Co. v. Garrett, 173 Miss. 676, 161 So. 753 (1935), the plaintiff was allowed recovery for mental distress in an action against the insurer for trespass when its agent came to the plaintiff's home and verbally abused him, knowing he was ill.

84. 10 Cal. App. 3d 376, 89 Cal. Rptr. 78 (1970); see note 6 supra.


86. Eckernrode v. Life of America Ins. Co., 470 F.2d 1 (7th Cir. 1972).


90. In Eckernrode v. Life of America Ins. Co., 470 F.2d 1, 5 (7th Cir. 1972), the court held that punitive damages were not recoverable since compensatory damages were sufficiently punitive. A strong argument has been made that punitive damages should be available in such a case because compensatory damages are not commensurate with the defendant's misconduct and
alone could cause severe mental distress. In these cases an action for intentional infliction of mental distress is appropriate. However, most frequently the insured's mental distress is not a direct result of the insurer's conduct but the result of financial losses or compounded physical injuries caused by the insurer's wrongful failure to pay. In such cases, intentional infliction of mental distress permits recovery only for the invasion of emotional tranquility while leaving the invasion of economic interests uncompensated. A more realistic approach would base recovery directly on the economic losses, allowing mental distress to be considered as a possible element of damages.

C. The Tort of Bad Faith

The tort of bad faith offers first party insurance claimants the most promising theory of recovery. The tort theories discussed thus far have been strained interpretations of existing concepts. None have been thoroughly suitable remedies either because they are not based on the conduct which gave rise to the plaintiff's grievances or because they do not compensate the plaintiff's specific losses. The tort of bad faith overcomes both of these shortcomings.

 Courts in most jurisdictions impose an implied-in-law duty of good faith and fair dealing in third party liability insurance contracts. During negotiations of a third party claim, the insurer may have an opportunity to settle a

are, therefore, not an adequate deterrent. See Lambert, Commercial Litigation, 35 Am. Trial Lawyer's Ass'n L.J. 164, 223 (1974).


92. Id. at 402, 89 Cal. Rptr. at 94. The plaintiff in Fletcher proceeded solely on a theory of mental distress and did not attempt to prove the value of his losses which were considerable. Id. at 402 n.10, 89 Cal. Rptr. at 94 n.10. The plaintiff's family lacked food and clothing; the plaintiff became delinquent in his house payments; he lost a real estate investment; his utilities were turned off; and his wife, a mother of eight children, had to return to work. Id. at 398, 89 Cal. Rptr. at 91.

In view of these losses, the court held that the insurer's conduct which gave rise to the tort of intentional infliction of emotional distress likewise constituted a tortious interference with a protected property interest of the insured. Id. at 401, 89 Cal. Rptr. at 93-94.

This second tort would permit compensation for both economic losses and emotional distress resulting therefrom as well as punitive damages. The court reasoned that a cause of action which allowed recovery for all proximately caused detriment would engender greater public respect and confidence in the judicial process. Id. at 402, 89 Cal. Rptr. at 94.

Intentional interference with a protected property interest, however, has not gained popularity. See Parks, Recovery of Extra-Contract Damages in Suits on Insurance Policies, 9 Forum 43, 52 (1973). This is probably due to the development in California of a more adequate theory of recovery—the tort of bad faith. See text accompanying notes 93 et seq. infra.

93. See text accompanying notes 66-67 supra.

94. See text accompanying notes 66 & 88-92 supra.

claim against its insured within the policy limits. Where there is a strong possibility that the injured party will recover a judgment against the insured in excess of the policy limits and the insurer refuses an offer to compromise, the insurer is deemed to have breached its duty of good faith and can be held liable to its insured for a resulting excess judgment. While some cases base recovery of the excess judgment on contract law, others hold that the insurer's bad faith refusal to settle is a tort.

The courts generally draw a sharp distinction between first and third party insurance and refuse to impose this duty of good faith where a first party policy is involved. Recognizing, however, that the duty of good faith must apply to all contracts of insurance, the Supreme Court of California has extended the tort of bad faith to first party insurance cases.

As elsewhere, the evolution of the tort of bad faith in California began with cases involving third party insurance. In Comunale v. Traders & General Insurance Co., the defendant had wrongfully refused to defend a liability claim against its insured and a judgment in excess of the policy limits was entered against him. In awarding the excess judgment to the insured, the Supreme Court of California explained that a duty of good faith and fair dealing is implied in contracts of insurance and that the company would be held liable for detriment caused by its breach. Comunale was based on contract law, and the court did not award consequential damages beyond the excess judgment. However, this concept of good faith and fair dealing was taken one step further in Crisci v. Security Insurance Co. There the plaintiff lost her property, became indigent, suffered severe emotional conse-

96. See St. John's, supra note 95, at 544; see cases cited in 40 A.L.R.2d, supra note 95, at 196.
97. See R.E. Keeton, Basic Text on Insurance Law 509 (1971) [hereinafter cited as Keeton].
99. The insured under a third party liability policy generally waives his right to defend and settle claims covered by the policy. Since the insurer has control over the insured's rights, it has a duty to protect the interests of the insured. Brassil v. Maryland Cas. Co., 210 N.Y. 235, 240-41, 104 N.E. 622, 624 (1914); see Keeton, supra note 97, at 508-09; St. John's, supra note 95, at 545; Dubois & Bronson, The Spectre of Punitive Damages in First Party Actions, 40 Ins. Couns. J. 290, 293 (1973). Because this factor is absent in first party insurance, it has been held that the insurer owes no such duty to its first party insured. Cf. Leonard v. Firemen's Ins. Co., 100 Ga. App. 434, 437, 111 S.E.2d 773, 776 (1959). However, this reasoning is devoid of logic. In both cases the insurer has contracted to protect the insured against loss. In both cases it has control over the settlement of claims. See text accompanying notes 75-76 supra. It should be liable for all loss resulting from its bad faith, whether the loss to the insured occurs from legal liability or otherwise. See Note, Damages: Compensating the Insured for Injury Resulting from Insurer's Misconduct in Claims Dispositions—Is It Tort or Contract?, 28 Okla. L.R. 394, 396 (1975).
101. 50 Cal. 2d 654, 328 P.2d 198 (1958).
102. Id. at 659-60, 328 P.2d at 200-01.
103. Id. at 661, 328 P.2d at 203.
quences and even attempted suicide because of an excess judgment against her.\textsuperscript{105} The court awarded plaintiff the excess judgment in an action against her insurance company. This case was significant because it held that the defendant's conduct was a tort\textsuperscript{106} and permitted consequential damages for mental distress caused by the insurance company's unreasonable refusal to settle the third party claim against the plaintiff.\textsuperscript{107}

The most significant step in the development of the tort of bad faith was \textit{Gruenberg v. Aetna Insurance Co.}\textsuperscript{108} There the Supreme Court of California held that the duty of good faith and fair dealing applied to all insurance contracts, first party as well as third party.\textsuperscript{109} "These are merely two different aspects of the same duty."\textsuperscript{110}

The duty of good faith and fair dealing creates an obligation in the insurer not to deprive its insured of the benefits of the policy by withholding payment maliciously and without probable cause.\textsuperscript{111} The duty is imposed because insurance policies are not ordinary commercial contracts.\textsuperscript{112} An insurer has a special relationship to its insured which derives from the great disparity in bargaining positions of the parties and from the insurer's traditional role as protector of its insured.\textsuperscript{113} Insurance promotes economic stability by enabling individuals to provide for circumstances which might otherwise burden society.\textsuperscript{114} For these reasons the insurance industry is "affected with a public interest"\textsuperscript{115} and has a legal responsibility to perform its contractual obligations in good faith.

\textsuperscript{105} Id. at 428-29, 426 P.2d at 176, 58 Cal. Rptr. at 16.
\textsuperscript{106} Id. at 432, 426 P.2d at 178, 58 Cal. Rptr. at 18.
\textsuperscript{107} Id. at 427, 426 P.2d at 175, 58 Cal. Rptr. at 15.
\textsuperscript{108} 9 Cal. 3d 566, 510 P.2d 1032, 108 Cal. Rptr. 480 (1973).
\textsuperscript{109} Id. at 573, 510 P.2d at 1037, 108 Cal. Rptr. at 485. A court of appeals case decided between Crisci and Gruenberg actually bridged the gap between first and third party cases. Richardson v. Employers Liab. Assur. Corp., 25 Cal. App. 3d 232, 102 Cal. Rptr. 547 (1972), involved plaintiffs who were seriously injured by an uninsured motorist. Their insurer was aware that the claim was worth more than the policy limit, but pursued its practice of paying such claims "only as a last resort," even refusing payment after an arbitration award. Id. at 237, 102 Cal. Rptr. at 550, 551. The plaintiffs were granted compensatory and punitive damages on the tort of bad faith. Id. at 244, 246, 102 Cal. Rptr. at 555, 557. This case did not strictly involve a first party claim since the company "stood in the shoes" of the uninsured motorist. See DuBois & Bronson, The Spectre of Punitive Damages in First Party Actions, 40 Ins. Couns. J. 290, 293 (1973). Nevertheless, the plaintiffs recovered beyond the policy limits directly from their own insurance carrier, and the way was opened for applying the tort of bad faith to first party claims.
\textsuperscript{110} 9 Cal. 3d at 573, 510 P.2d at 1037, 108 Cal. Rptr. at 485.
\textsuperscript{113} Fletcher v. Western Nat'l Life Ins. Co., 10 Cal. App. 3d 376, 404, 89 Cal. Rptr. 78, 95 (1970).
\textsuperscript{114} See Wm. & Mary, supra note 22, at 475.
\textsuperscript{115} Fletcher v. Western Nat'l Life Ins. Co., 10 Cal. App. 3d 376, 403, 89 Cal. Rptr. 78, 95 (1970).
The tort of bad faith embraces the first theory which adequately protects the insured. Unlike "fraud in the inducement," it is proven by the specific conduct which caused detriment to the plaintiff. Its primary purpose is to redress all economic harm or compounded physical injuries proximately caused by an insurer's bad faith settlement tactics. Unlike intentional infliction of mental distress, a cause of action can be stated without alleging severe distress. Since mental distress becomes only one element of damages rather than the foundation of the tort, the plaintiff can recover for mental distress on a lesser burden of proof. Furthermore, where plaintiff cannot prove mental distress at all, he will not be precluded from recovering other consequential damages.

No doubt this tort will initially be attacked as being too nebulous. As with all new theories of recovery, defendants will claim that the line between tortious and non-tortious conduct is ill-defined. However, as in all tort actions, the determination ultimately will be one of degree. Juries should have no more difficulty in recognizing the bad faith insurer than in recognizing the reasonably prudent person in negligence actions. Furthermore, courts will be aided by the bad faith standards which they have long applied to claims for excess judgments under third party policies.

The minimal elements of the tort should include: 1) at least some economic loss or compounded physical injuries, which are 2) proximately caused by the insurer's unreasonable delay, and are 3) aggravated by circumstances which evidence a bad faith intent to deprive the insured of his rights under the contract.

This third element should not be interpreted to mean that the insurer is to be denied its privilege to investigate claims thoroughly or deprived of legitimate means to attain settlement. Settlement is a desirable goal of law, society, and the parties involved. However, abusive tactics do not encourage settlement. Instead their purpose is to force the insured to litigate or to waive his claim completely because of the economic impracticality of bringing suit.

116. See text accompanying notes 66-67 supra.
118. Id.; see text accompanying note 89 supra.
124. Id. at 389 n.5, 392, 396, 89 Cal. Rptr. at 85 n.5, 87, 89-90; see also Gruenberg v. Aetna
Examples of bad faith which should give rise to excess liability include: denial of benefits or procurement of a waiver based on wholly fabricated defenses; unfounded instigation of criminal prosecution; requiring insureds to incur the expense and trouble of submitting to examinations of books and records once a decision to deny a claim has been made; repeated requests for identical information during an investigation; interference with an arbitrator's award. Unreasonably extended delay should be sufficient without extraneous circumstances where the insurer has a practice of forcing its insureds to litigate in order to recover obviously meritorious claims.

In addition to the amount due under the policy, excess liability should be imposed for all proximately caused detriment, including mental distress and, in a proper case, punitive damages.

V. CONCLUSION

There is a strong feeling among writers that the prevailing measure of damages is grossly inadequate. One commentator has phrased the problem as follows:

A person who buys ... insurance is a consumer and deserves legal protection which is realistic. If the law does not vindicate his reasonable consumer's expectations until only years after battling well-heeled corporate entities and then only gives him policy proceeds (plus interest) from which he must deduct the contingent fee and gnawing

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128. See cases cited at note 12 supra.


expenses of litigation, then the insurance industry has every illicit incentive in the world to fight the Bad Fight and nothing to lose (but policy proceeds plus interest). In this context, compensatory and contract damages don't really compensate. . . . Reparation plus admonition are urgently required. . . . 133

The causes of action described herein indicate that enlightened courts have responded to this need. Recognizing that the proper goal of the law is to provide adequate relief to the injured, these courts have molded the law to provide just recovery rather than conforming the recovery to rigid legal rules. They have liberalized contract law by allowing compensatory damages which were previously not recoverable. 134 Where contract law was not entirely adequate, these courts have allowed recovery of compensatory and exemplary damages under tort theories such as fraud 135 and intentional infliction of mental distress. 136 California, which is in the forefront of the trend towards allowing excess recovery, has developed the most suitable theory of recovery, the tort of bad faith. 137 Undoubtedly, it is merely a matter of time before excess recovery is available to first party claimants throughout the country.

This Note began by affirming the importance of insurance to society generally. It is surely to no one's advantage if the industry is weakened by repeated payments of excessive awards. On the other hand, the advantages of insurance are severely diminished if policyholders must frequently battle to obtain the benefits which are rightfully theirs. It is the responsibility of the judiciary to adequately balance the rights of the insurance industry against the needs of the insured.

Phyllis Savage

134. See text accompanying notes 30-43 supra.
135. See text accompanying notes 44-69 supra.
136. See text accompanying notes 70-87 supra.
137. See text accompanying notes 88-126 supra.