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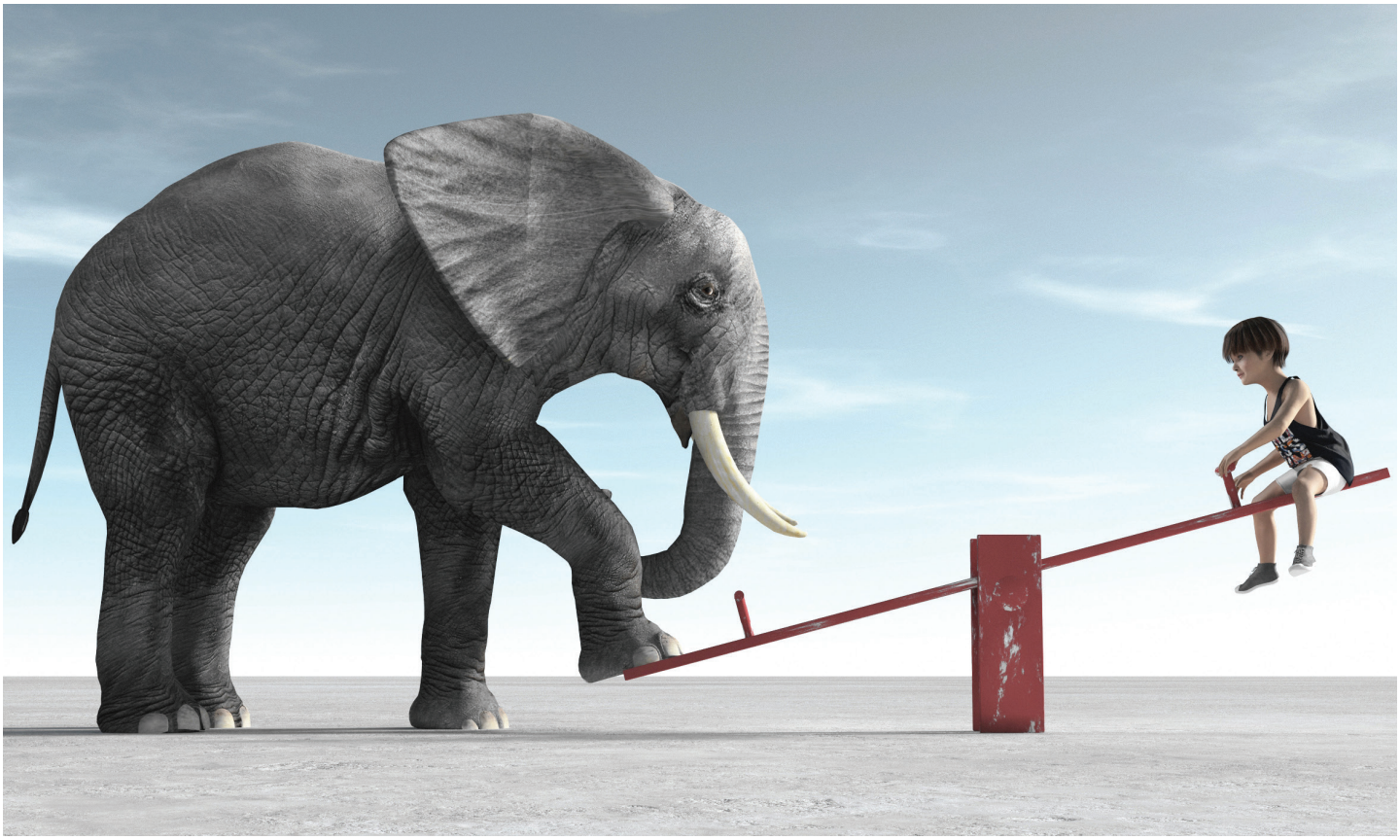

Rethinking damages for breach of an insurance contract

RESTORING BALANCE BETWEEN INSURERS AND THEIR INSUREDS. WHY MUST WE PROVE THAT THE CARRIER ACTED UNREASONABLY?

Insurance-claims handling has changed radically in the 43 years since the California Supreme Court's decision in *Egan v. Mutual of Omaha Ins. Co.*, and California law has failed to keep up. Instead of leveling the playing field between insurance carriers and their insureds, current California law reinforces the unfair advantage that insurance carriers have over insureds when they make claims. Insureds who must litigate their claims and who can prove that the carrier breached the contract but who cannot prove that the carrier acted "unreasonably" will not be made whole. This undermines the principle of indemnity, which is central to the insurance contract.

California law can – and should – do better.

In this article I briefly summarize the importance of the *Egan* decision and how the insurance industry has transformed claims handling in the 43 years since *Egan*. I then explain how current California law reinforces the imbalance of power between insurance carriers and their insureds who have made claims. Finally, I propose two changes to California law regarding damages for breach of an insurance contract.

Two notes before I begin. First, the discussion in this article is limited to first-party claims – that is, claims by policyholders or insureds against their insurance carriers. Though much of the reasoning in this article would apply equally to an insurance carrier's failure to accept a third-party's policy-limit demand, there are meaningful differences between first-party claims and third-party claims. Second, I mostly use the term "insureds" rather than "policyholders." Insurance carriers owe obligations to "insureds," and many insurance contracts protect "insureds" who are not "policyholders."

Leveling the playing field between insurance carriers and their insureds: *Egan v. Mutual of Omaha Ins. Co.*

The California Supreme Court first recognized an implied covenant of good faith and fair dealing in insurance contracts in 1958 in *Comunale v. Traders & General Ins. Co.*, 50 Cal.2d 654. *Comunale* was a third-party case. The carrier failed to provide a defense and failed to accept a settlement demand within policy limits. Fifteen years later, in *Gruenberg v. Aetna*

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
November 2022

Ins. Co. (1973) 9 Cal.3d 566, the Court recognized the implied covenant in a first-party claim. But it was the Court's 1979 decision in *Egan v. Mutual of Omaha Ins. Co*. (1979) 24 Cal.3d 809, that most effectively addressed the imbalance of power between insurance carriers and their insureds who have made claims.

In *Egan*, the California Supreme Court held an insurance carrier that had breached the implied covenant of good faith and fair dealing could be held liable for punitive damages. (24 Cal.3d at 819-20.) The majority in *Egan* concluded that the possibility of a verdict for punitive damages would level the playing field between insurance carriers and their insureds who have made claims:

> [T]he relationship of insurer and insured is inherently unbalanced; the adhesive nature of insurance contracts places the insurer in a superior bargaining position. The availability of punitive damages is thus compatible with the recognition of insurers' underlying public obligations and reflects an attempt to restore balance in the contractual relationship.

(*Egan*, 24 Cal.3d at 820.)

Egan is a crucially important decision in California and is highly influential nationwide. The International Risk Management Institute has identified *Egan* as one of the "50 insurance cases every self-respecting attorney or risk professional should know." (See "50 Insurance Cases Every Self-Respecting Attorney or Risk Professional Should Know," Int'l Risk Management Inst., Inc., 2012 (https://www.irmi.com/online/50-insurance-property-casualty-insurance-cases.pdf).)

An anecdote illustrates *Egan*'s impact: In 2006, I attended an insurance seminar attended primarily by defense attorneys. One of the speakers began his presentation with a story about the changes he had seen over the decades he had been representing insurance carriers. Back in the 1980s, he said, "you would open a claim file, and you'd see a comment like this . . . 'Send him to see Dr. Smith. But if Dr. Smith doesn't give us what we need, send him to Dr. Jones. He wants our business.' You don't see that anymore." But history didn't end with *Egan*. Insurance carriers adapted.

How claims-handling has changed in the 43 years since *Egan*

Jay M. Feinman, a professor of law at Rutgers University School of Law, has described insurance as "the great protector of the standard of living of the American middle class." (J. Feinman, *Delay, Deny, Defend* (Portfolio 2010), at 3.)

> Insurance provides a social safety net for individuals and businesses, particularly for the middle class. Most Americans are only a car accident, a fire in the home, a lawsuit, or an injury away from having the wealth, the comfort, and the lifestyle accumulated over a lifetime of work wiped out. Insurance does not remove all of the consequences of a catastrophic loss, but [insurance] can make [the loss] something other than a catastrophe.

(*Delay, Deny, Defend*, at 23.)

But insurance is "the great protector of the standard of living of the American middle class" only if it works. And for insurance to work as it should, the "essential function" of an insurance carrier's claim department must be "to fulfill the insurance company's promise, as set forth in the insurance policy," to pay the insured for a covered loss. (J. Markham, et al., *The Claims Environment* (Insurance Institute of America 1993), at 5.)

The insurance industry began redefining the purpose of their claims departments in the mid-1990s. Insurance carriers shifted their priorities, "from orientation toward policyholders to orientation toward stockholders." (*Delay, Deny, Defend*, at 47-48 (quoting Richard Stewart, former superintendent of insurance for New York State and president of the National Association of Insurance Commissioners).) Insurance carriers chose to disregard the fundamental principle of claims handling – fulfilling the insurance carrier's promise to pay – and redefined the claim department as a profit center.

> The claims process [was] radically altered. Traditionally companies pay what they should pay, with "should" defined by what the policyholder was owed. Transforming claims into a profit center . . . require[d] focusing on leakage, or on where they paid more than they should, where "should" was measured by the goal of reducing costs and increasing profits. The solution was to reduce payments to policyholders and other claimants. The solution [was] implemented by redefining every step of the claim process and creating a new, systematic claim process . . . .

(*Delay, Deny, Defend*, at 66.)

Delay, deny, defend

Insurance carriers instituted a strategy of "delay, deny, defend": "The company delays payment of a claim, denies all or part of a valid claim, or aggressively defends litigation the policyholder is forced to bring to get what he is rightfully owed." (*Delay, Deny, Defend*, at 4.) This strategy of delay, deny, defend has become so common that the insurance industry has developed a product – "Claims Dispute Insurance" – that consumers may buy to insure against the risk that insurance companies will deny their claims. (*Delay, Deny, Defend*, at 36.) This coverage "will pay the legal expenses associated with contesting the denial of insurance coverage by an insurance company." ("Swett & Crawford Introduces Claims Dispute Coverage," June 05, 2008 (https://www.insurancejournal.com/news/national/2008/06/05/90641.htm))

The carriers adapted. Unfortunately, California law has not.

Damages for breach of an insurance contract

Under current California law, an insured who proves that the insurance carriers breached the contract but who cannot prove that the carrier acted unreasonably will not be made whole. There are two reasons why. Under current California law, to recover damages beyond the insurance contract's stated

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
November 2022

limits, the insured must prove that the carrier acted unreasonably. To recover the additional damages that California law allows – typically, though not exclusively, damages for emotional distress and the attorney fees incurred to recover the insurance policy's benefits (CACI 2350, Damages for Bad Faith) – a policyholder must prove not only that the carrier breached the insurance contract by denying benefits that were owed, but also that the carrier acted "unreasonably" in doing so.

Requiring a policyholder to prove that the insurance carrier acted unreasonably enshrines in California law the right of insurance carriers to be wrong, a right for which no other industry "would even dare argue." (Eugene R. Anderson, "Foreword," in *From "Good Hands" to Boxing Gloves: How Allstate Changed Casualty Insurance in America* (Trial Guides, L.L.C. 2006), at 19.)

If an employer mistakenly underpays employees or mistakenly pays them late, the employees can recover not only their wages but also substantial penalties and attorney fees. (See, e.g., Lab. Code, § 2699, subds. (f) & (g).) If a car manufacturer makes a "lemon," the owner of the defective car can recover damages, civil penalties, and attorney fees. (See Civ. Code, § 1794, subds. (d) & (e)(1).)

Yet, despite the fact that a policyholder has already paid premiums for a covered loss, and despite the fact that an insurance carrier completely controls the claims process (the carrier determines whether to pay, when to pay, and how much to pay), California law allows insurance carriers to impose on insureds who have made claims most of the financial harm caused by the insurance carriers' mistakes. Simply put, California law forces insureds to bear the cost of their insurance carriers' mistakes.

Current California law assumes punitive damages level the playing field between insurance carriers and their insureds who have made claims (*Egan*, 24 Cal.3d at 820), but after the U.S. Supreme Court's 2003 decision in *Campbell v. State Farm*, this is no longer so. (*Campbell v. State Farm*, 538 U.S. 408, 123 S.Ct. 1513.)

In *Campbell*, the Court ruled that a $145 million punitive-damages award that had been upheld against State Farm by the Utah Supreme Court was excessive under the Due Process Clause of the 14th Amendment. The Court held that even in the most extreme circumstances, the multiplier for punitive-damage awards should not exceed a "single-digit" multiplier of the contract damages. What this means is that a multiplier of nine times the actual damages is as much as the Supreme Court believes is reasonable under the U.S. Constitution.

Caselaw on punitive damages

The *Campbell* decision's impact on punitive-damage awards in California is clear. Before *Campbell*, California appellate courts had upheld punitive-damage awards against insurance carriers with ratios of 32-to-1 (*Downey Sav. & Loan Ass'n v. Ohio Cas. Ins. Co.* (1987) 189 Cal.App.3d 1079, 1099 [affirming $5 million punitive damages award on compensatory damages of $153,000]), 40-to-1 (*Pistorius v. Prudential Ins. Co. of America* (1981) 123 Cal.App.3d 541, 552 [affirming punitive damages award of $1 million on compensatory damages of $45,000]), even 83-to-1 (*Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 641) [affirming punitive damages award of $2.5 million on compensatory damages of $30,000].) The highest affirmed ratio I've been able to find in a case involving an insurance carrier post-*Campbell* is 10-to-1, in *Nickerson v. Stonebridge Life Insurance Co*. (2016) 5 Cal.App.5th. 1.

But the lesson of *Nickerson* goes beyond the court's approval of a 10-to-1 ratio of punitive damages to compensatory damages. *Nickerson* demonstrates how ineffectual punitive damages have become in the context of litigation by insureds against their insurance carriers.

In *Nickerson*, the appellate court reduced the punitive-damage award from $19 million (just over five percent of the carrier's net worth) to $475,000 (less than 0.13 percent of the carrier's net worth). The court wrote that the law compelled this outcome:

> While we agree with Nickerson and amicus curiae that Stonebridge may fold this award into its cost of doing business, we also agree with the trial court that we are constrained by case law and the Constitution.

(5 Cal.App.5th at 26-27.) Although the court noted that "punitive damage awards should not be a routine cost of doing business that an industry can simply pass on to its customers through price increases, while continuing the conduct the law proscribes," (*id*. at 27-28 (citations and internal quotation marks omitted)), the result in *Nickerson* was just that – a cost-of-doing-business award that the carrier could "absorb . . . with little or no discomfort." (*Id*. at 28 (citations omitted).)

Small claims suffer the most

A public adjuster with decades of experience and who has handled claims in more than 20 states observes how the decision in *Campbell* is especially pernicious for smaller claims.

> Even more disturbing is that the smaller the amount of the dispute, the more unlikely it is that the customer will receive justice. For instance, let's assume that your claim was significant – say, $100,000 – but through a painstaking process of battling with your insurer, you have gotten the difference down to $20,000. What attorney is going to take on an insurance bad-faith case for $20,000? While you might get lucky and find one, the chances are [this attorney] will not be a top-tier attorney, because there is simply not enough potential recovery to make this fight worth the attorney's time. . . . Insurance companies fully realize they are unlikely to be held accountable for wrongdoing on these smaller claims, which essentially gives them a license to steal.

(D. Skipton, *The Claims Game* (Lulu Publishing Services 2015), at 6-7.)

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
November 2022

It gets worse. In the case that established the right of California insureds to recover their attorney fees if the insured proves that the carrier acted unreasonably – *Brandt v. Sup. Ct.* (1985) 37 Cal.3d 813 – the California Supreme Court implicitly assumes that insureds will recover judgments that include large punitive damages awards, thus allowing insureds to pay their contingent-fee counsel and still be made whole for their carriers' failure to pay the benefits owed. After *Campbell*, this is only rarely true (and I write "only rarely" instead of "never" only because never is a long time).

The result of current California law is this: A California insured who can prove that the insurance carrier breached the contract but who cannot prove that the insurance carrier acted unreasonably will not be made whole. Current California law allows insurance carriers to impose on insureds the financial burdens that result from the carriers' denials of benefits.

Why this matters: Insurance contracts are different

Insurance differs from any other good or service you buy in a critical way. It's the only thing we buy hoping we never wind up using it. We buy food intending to eat it. We buy clothes intending to wear them. We buy cars intending to drive them. But we buy insurance hoping we never need it – because if we need it, something bad has happened, and we don't want anything bad to happen.

Moreover, in our modern society, we are often required to buy insurance. We must buy insurance to drive a car. If we have a mortgage, we must buy homeowner's insurance to protect the lender's collateral – the house. The Affordable Care Act requires us to buy health insurance.

When an insurance carrier fails to keep its promise to pay a covered loss, the consequences are more severe than when any other kind of company fails to keep its promise. A simple example makes this clear:

Imagine I hire someone to paint my house, but the painter fails to show up. I can take my money and hire someone else. If I must pay the second painter more than the agreed price for the first painter, I might even be able to recover that difference in a breach-of-contract action against the first painter. In contrast, if the insurance carrier refuses to pay my claim, it's too late for me to pay another insurance carrier to provide coverage for my loss. No carrier will write a policy that will pay for damage that has already occurred.

Now, my proposals:

Proposal 1: Allow an insured who proves the carrier breached the contract to recover attorney fees, expert costs, and ordinary costs without requiring proof that the carrier acted unreasonably

The model for my proposal can be found in the last sentence of section 12965, subdivision (b) of the California Government Code. This provision allows a plaintiff who prevails in a claim brought under California's Fair Employment and Housing Act ("FEHA") to recover attorney fees, expert witness fees, and costs:

> In civil actions brought under this section, the court, in its discretion, may award to the prevailing party, including the department, reasonable attorney's fees and costs, including expert witness fees, except that, notwithstanding Section 998 of the Code of Civil Procedure, a prevailing defendant shall not be awarded fees and costs unless the court finds the action was frivolous, unreasonable, or groundless when brought, or the plaintiff continued to litigate after it clearly became so.

(Gov. Code, § 12965, subd. (b).)

Unlike attorney fees under *Brandt*, under my proposal, the attorney who represents an insured who prevails in a breach-of-contract action against an insurance carrier would submit a fee application to the court, and the court would award fees for time worked multiplied by the attorney's hourly rate. Courts would have the discretion to use a multiplier. Also, as in cases prosecuted under FEHA, the attorney fees awarded could be substantially greater than the contract benefits the insured recovers. Allowing this fee- and cost-shifting would make it economically viable for skilled, experienced attorneys to prosecute breach-of-contract claims against insurance companies even when contract damages are modest.

This proposed fee- and cost-shifting serves the central principle embodied in the insurance contracts that most consumers deal with – namely, the principle of "indemnity." "Indemnity" is "compensation for loss." (H. Rubin, *Barron's Dictionary of Insurance Terms* (6th ed. 2013), at 241.)

> In a property and casualty contract, the objective is to restore an insured to the same financial position after the loss that he or she was in prior to the loss. But the insured should not be able to profit by damage or destruction of property, *nor should the insured be in a worse financial position after a loss*.

(*Id*. (emphasis added).)

Under current California law, if an insured is forced to litigate to recover benefits owed under an insurance contract, even if the insured proves that the carrier breached the contract, the insured will *always* be in a worse financial position than before the loss because, at a minimum, the insured must pay the attorney out of her share of the recovery.

This result undermines the principle of indemnity that's expressed in the insurance contract. Moreover, given the costs of litigation, most insureds will forego prosecuting even meritorious claims unless they are large. This is good for insurance carriers but lousy for their insureds. Allowing a successful insured to recover attorney fees and expert fees would do nothing more than fulfill the insurance contract's promise of "indemnity" – that is, restoring the insured "to the same financial position after the loss that he or she was in prior to the loss."

This shifting of fees and costs is also fair. Insurance carriers completely control

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
November 2022

the claims process – they determine whether to pay, when to pay, and how much to pay. Consequently, they also determine whether an insured must prosecute litigation to recover the benefits that the insured is owed under the contract. Litigation is difficult enough. An insured should not have the added burden of proving that the carrier acted unreasonably just to receive the contract benefits for which they paid and to be restored to the same financial position after the loss as they were before the loss.

Proposal 2: Allow an insured who proves the carrier breached the contract to recover damages for emotional distress without requiring proof that the carrier acted unreasonably

In conducting research for this article, I read the following comment in The Rutter Group's Practice Guide for "Insurance Litigation": Certain cases "suggest that emotional distress damages *may* be recoverable for *any* refusal to pay policy benefits. But the issue has not been extensively litigated or analyzed by the courts." (*California Practice Guide: Insurance Litigation* (The Rutter Group 2022), ¶ 13:26, at 13-7 (emphasis in original).)

I dug into the caselaw. The observation is correct. Indeed, it understates the state of California law regarding recovery of emotional distress for breach of certain contracts. A fair reading of California caselaw establishes that insureds may recover damages for emotional distress based solely on breach of contract without proving that the carrier acted unreasonably. Thus, unlike my first proposal, which would require a change in California law, this second proposal requires only that the courts fairly apply longstanding – though overlooked – California law.

This line of authority begins with the California Supreme Court's decision in *Chelini v. Nieri* (1948) 32 Cal.2d 480. In *Chelini*, the plaintiff's mother had died, and the plaintiff reached an oral agreement with a mortician to prepare his mother's body for burial. The plaintiff "repeatedly informed defendant [the mortician] that he 'wished to have his mother's body preserved, because she had a horror . . . of bugs and water,' and defendant assured plaintiff that 'it would last almost forever.'" According to the Court, the defendant "knew, at or about the time he agreed to preserve the body 'almost forever,' that plaintiff was highly preoccupied with the importance of such preservation and that at some indefinite future date plaintiff intended to move the casket and expected the body to be in such a state of preservation that defendant could place a ring and slippers on it." (*Id*. at 482-83.) After the plaintiff began to suspect that perhaps his mother's body had not been preserved as the mortician has promised, he insisted that the mortuary open his mother mother's casket. (*Id*. at 483-84.) When the casket was opened, the plaintiff saw that the flesh of his mother's body "had disintegrated and the skeleton was covered with insects." (*Id*. at 484.)

The plaintiff sued the mortician for breach of contract. The jury awarded the plaintiff $10,000 for general damages, and the California Supreme Court affirmed the award even though the only cause of action the plaintiff had pled was breach of contract. The jury's award was "predicated on defendant mortician's breach of a contract to preserve the body of plaintiff's mother and on plaintiff's physical illness, suffering and disability resulting from his discovery that because of such breach of contract the body became a 'rotted, decomposed and insect and worm infested mass.'" The Court held that recovery of general damages was proper "under the rule, laid down in *Westervelt v. McCullough* (1924) 68 Cal.App. 198, 208-09, and included in the instructions to the jury, that

> [w]henever the terms of a contract relate to matters which concern directly the comfort, happiness, or personal welfare of one of the parties, or the subject matter of which is such as directly to affect or move the affection, self-esteem, or tender feelings of that party, he may recover damages for physical suffering or illness proximately caused by its breach.

(*Chelini*, 32 Cal.2d at 481-82 (quotation marks omitted).)

Nineteen years later, in *Crisci v. Security Ins. Co*. (1967) 66 Cal.2d 425, the California Supreme Court relied on its holding in *Chelini* to affirm an award of damages for "mental suffering" in an action against an insurer for the insurer's refusal to settle a claim against the insured within policy limits. The Court held that the insured's recovery of such damages was appropriate even though the underlying contract was a liability policy.

> Recovery of damages for mental suffering in this instant case does not mean that in every case for breach of contract the injured party may recover such damages. Moreover, plaintiff did not seek by the contract involved here to obtain a commercial advantage but to protect herself against the risks of accidental losses, including the mental distress which might follow from the losses. Among the considerations in purchasing liability insurance, as insurers are well aware, is the peace of mind and security it will provide in the event of an accidental loss, and recovery of damages for mental suffering has been permitted for breach of contracts which directly concern the comfort, happiness or personal esteem of one of the parties.

(*Crisci*, 66 Cal.2d at 434 (citing *Chelini*, 32 Cal.2d at 482).)

Three years later, the court of appeals in *State Farm Mut. Auto Ins. Co. v. Allstate Ins. Co*. (1970) 9 Cal.App.3d 508, relied on *Chelini* and *Crisci* to affirm an award of $2,500 for "pain and distress" even though the insured had only alleged breach of contract. Rejecting Allstate's argument that such damages were not recoverable in an action for breach of contract, the court wrote:

> The theoretical distinction [between contract damages and tort damages] is of no moment at this point because the $2,500 award was proper *even under a*

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
November 2022

> *breach of contract theory*. 'Whenever the terms of a contract relate to matters which concern directly the comfort, happiness, or personal welfare of one of the parties . . . he may recover damages for physical suffering . . . caused by its breach.' . . . A liability insurance policy is such a contract.

(9 Cal.App.3d at 527-28 (quoting *Chelini*, 32 Cal.2d at 482, citing *Crisci*, 66 Cal.2d at 434) (emphasis added).)

In *Egan*, the California Supreme Court cited *Crisci* and extended this reasoning to an insured seeking to recover under a disability policy.

> The insured in a contract like the one before us does not seek to obtain a commercial advantage by purchasing this policy – rather, he seeks protection against calamity. As insurers are well aware, the major motivation for obtaining disability insurance is to provide funds during periods when the ordinary source of the insured's income – his earnings – has stopped. The purchase of such insurance provides peace of mind and security in the event the insured is unable to work.

(*Egan*, 24 Cal.3d at 819 (citing *Crisci*, 66 Cal.2d at 434).)

In *Frazier v. Metropolitan Life Ins. Co*. (1985) 169 Cal.App.3d 90, the court of appeals affirmed an award of $150,000 for emotional distress for the beneficiary of a life insurance policy even though the beneficiary had elected to proceed on a contract theory, not a tort theory. (*Id*. at 105 ["plaintiff is entitled to seek damages for emotional distress despite an election to proceed on a contract theory"].)

Based on this line of cases, California courts should allow insureds to recover damages for emotional distress based solely on the carrier's breach of contract without requiring the insured to prove that the carrier acted unreasonably.

Conclusion

California law governing damages for breach of an insurance contract has failed to keep pace with changes in the insurance industry's handling of claims in the 43 years since *Egan*. To restore the balance that *Egan* had once established between insurance carriers and their insureds, insureds should be allowed to recover their attorney fees (on a fee-shifting basis, as in FEHA cases) and damages for emotional distress if they prove that the carrier breached the contract. Insureds should not be required to prove that the carrier acted unreasonably to recover these damages.

Insurance carriers should be forced to bear the financial burdens caused by their mistakes. Their insureds should not. Fairness demands at least this much. It requires nothing less.

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