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THE TORT OF BAD FAITH IN FIRST-PARTY INSURANCE TRANSACTIONS: REFINING THE STANDARD OF CULPABILITY AND REFORMULATING THE REMEDIES BY STATUTE

Roger C. Henderson*

INTRODUCTION

The opportunity to witness the appearance of a wholly new tort in the legal universe is rare indeed. Although tort law has undergone extensive change since the 1800s, there may not have been more than three or four completely new torts recognized this century. Contrary to what one might conclude from all the activity in this area, particularly since World War II, courts have not been quick to create wholly new causes of action. Most often, courts simply have removed barriers to suit or have modified the law so as to extend existing tort duties to cover somewhat similar fact situations. Aside from the developments in the areas of strict liability for products, invasion of privacy, and intentional infliction of emotional distress, there may be only one other kind of situation that legitimately can be viewed as giving rise to a truly new cause of action in tort law. This situation involves the wrongful failure of an insurance company to pay benefits to its insured and was first recognized by a court of last resort in the early 1970s.¹

For over a century from the time it was decided, the courts followed the common-law rule announced in *Hadley v. Baxendale*² that damages for breach of contract were limited to those in the contemplation of the parties at the time the bargain was struck.³ Consequential damages, as a general

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1. See *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032, 1037-38 (Cal. 1973).

2. 156 Eng. Rep. 145 (Ex. 1854).

3. *Id.* at 151.

rule, were more exclusively within the realm of tort law⁴ than that of contracts, and it was no tort for a party to breach a contract, even when the breach was intentional.⁵ So firmly was this rule fixed in the Anglo-American legal firmament that some even asserted that a party may have a "right" to breach by standing ready to pay for any loss of bargain.⁶ It is in society's interest, so went the argument, that a party should be permitted to elect to breach without incurring consequential damages, so that a more efficient allocation of resources would result.⁷ Predictability was the watchword; one should be able to count on the courts to adhere closely to the terms of the bargain in defining the damages to be recovered for any breach. Rights arising *ex contractu* were not to be as expansive, or as uncertain, as those arising *ex delicto*, at least as far as damages were concerned.

Perhaps there are still situations where a willful refusal to perform a contract may be economically advantageous because of this limitation on damages, but there clearly is one group of contracting parties that no longer may indulge themselves under the guise of *Hadley*. Today, in most jurisdictions, no well-informed insurance company possibly could see anything to be gained by such conduct. On the contrary, insurers are exposed to significant damage awards beyond the traditional contract measure for intentional breaches under what has come to be known as the tort of bad faith.⁸ In a steadily growing

4. See DAN B. DOBBS, HANDBOOK ON THE LAW OF REMEDIES § 12.3, at 812 (1973). It is recognized that modern courts have expanded the right to recover consequential damages in contract cases, but this is still the exception and is rationalized under the rubric of being within the contemplation of the parties. *Id.* at 812-14. Moreover, the awards are still primarily for pecuniary loss only. See 11 SAMUEL WILLISTON, A TREATISE ON THE LAW OF CONTRACTS § 1341 (Walter H.E. Jaeger ed., 3d ed. 1968).

5. See E. ALLAN FARNSWORTH, CONTRACTS § 12.8, at 874-75 (2d ed. 1990).

6. For a discussion of the so-called "efficient breach" theory in contract law, see FARNSWORTH, *supra* note 5, § 12.3, at 847-49; RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW § 4.8 (4th ed. 1992); John H. Barton, *The Economic Basis of Damages for Breach of Contract*, 1 J. LEGAL STUD. 277 (1972); Robert L. Birmingham, *Breach of Contract, Damage Measures, and Economic Efficiency*, 24 RUTGERS L. REV. 273 (1970).

7. See FARNSWORTH, *supra* note 5, § 12.3, at 847; see also *Patton v. Mid-Continent Sys., Inc.*, 841 F.2d 742, 750-51 (7th Cir. 1988) (Posner, J., adopting efficient breach theory).

8. This new tort is established so clearly that it has already spawned several treatises. See, e.g., STEPHEN S. ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES (1984); JOHN C. MCCARTHY, RECOVERY OF DAMAGES FOR BAD FAITH (5th ed. 1990); WILLIAM

number of jurisdictions, insurers not only are exposed to consequential damages for economic loss and emotional distress for failing to deal with their insureds fairly and in good faith,⁹ but they also may be subject to substantial awards of punitive damages.¹⁰ The tort of bad-faith breach of contract—an incongruous concept only a short time ago—now routinely is alleged in cases brought by insureds against their insurers. Moreover, in many cases, insureds succeed in recovering substantial tort damages under this new cause of action.¹¹

Some commentators consider this development to be salutary, an evening of the playing field so long dominated by the insurers.¹² Others view it as having a most baleful effect.¹³ Perhaps it is too early to make a final judgment about the overall effects, but one thing is clear. What initially was dubbed as a new intentional tort appears to be hemorrhaging. It is no longer apparent, if it ever was, that the tort of bad faith lies only for a conscious violation of the insured's rights. Some courts appear to have gone beyond this intentional tort standard to include reckless, if not negligent, conduct as additional bases for the new tort.¹⁴ This is a cause for concern because it raises considerable doubts as to what the standard of culpability includes. The lack of certainty does not bode well for those who must shape their conduct so as to be able to adhere to the new rule. Moreover, an extension of the basis of culpability beyond conscious wrongdoing into areas of

M. SHERNOFF ET AL., *INSURANCE BAD FAITH LITIGATION* (1991); DENNIS J. WALL, *LITIGATION AND PREVENTION OF INSURER BAD FAITH* (1985).

9. See *infra* notes 101–24 and accompanying text.

10. See *infra* notes 101–24 and accompanying text.

11. One study involving litigation in San Francisco, California and Cook County, Illinois for a 25-year period from 1960 through 1984 concluded that the most dramatic increases in punitive damage awards occurred in the area of contract cases, many of which involved the tort of bad faith. See MARK PETERSON ET AL., *THE INSTITUTE FOR CIVIL JUSTICE, PUNITIVE DAMAGES: EMPIRICAL FINDINGS* 19–24 (1987); see also DEBORAH R. HENSLER ET AL., *THE INSTITUTE FOR CIVIL JUSTICE, TRENDS IN TORT LITIGATION: THE STORY BEHIND THE STATISTICS* 12–21 (1987) (discussing reasons for the general increase in the size of jury verdicts).

12. See, e.g., Amy G. Langerman & Richard W. Langerman, *Arizona Insurance Bad Faith and the Doctrine of Strict Liability*, 22 ARIZ. ST. L.J. 349, 359, 363–65 (1990); Mary E. Phelan, *The First Party Dilemma: Bad Faith or Bad Business?*, 34 DRAKE L. REV. 1031, 1035–37 (1985).

13. See, e.g., Glenn L. Allen, *Insurance Bad Faith Law: The Need for Legislative Intervention*, 13 PAC. L.J. 833, 852–54 (1982); Paul B. Butler, Jr. & Robert V. Potter, Jr., *The Primary Carrier Caught in the Middle with Bad Faith Exposure to Its Insureds, Excess Carriers and Reinsurers*, 24 TORT & INS. L.J. 118, 121–22 (1988).

14. See *infra* notes 166–68 and accompanying text.

inadvertency may be unwarranted, particularly if a full-blown measure of tort damages is made available to the insured.

After hundreds of appellate court decisions, the common law surrounding this new tort shows little prospect of "working itself pure."¹⁵ Many questions have arisen and remain to be answered. Should the tort lie only for intentional conduct, or should recklessness also suffice? If so, what is "reckless" conduct in the insurance claims-processing context?¹⁶ Should there also be room for a cause of action based upon negligence or even some role for strict liability in this area? Should a full-blown measure of tort damages be available, regardless of the level of culpability; and should the law permit awards for prejudgment interest and attorneys' fees, even where the insurer is not guilty of bad faith? Appropriate answers to these and other questions¹⁷ are long overdue, and it is beginning to appear that the courts may not be able to derive all of the answers from the traditional common-law pronouncements on remedies. At the very least, it is time to consider answers and alternatives that may best be approached through the legislative process.

This Article explores the common-law and statutory background of the tort of bad faith in first-party insurance situations, analyzes the varying standards of culpability that have been developed by the courts, and suggests a uniform statutory solution to the problems created by the varying standards.¹⁸ The statute also tailors the remedies more closely to the

15. Over a century ago, one court argued that a virtue of the common-law system is its ability to correct its own mistakes over time:

One excellence of the common law is, that it *works itself pure*, by drawing from the fountain of reason, so that if errors creep into it, upon reasons, which more enlarged views and a higher state of enlightenment, growing out of the extension of commerce and other causes, proves to be fallacious, they may be worked out by subsequent decisions.

Shaw v. Moore, 49 N.C. (4 Jones) 37, 39 (1856).

16. For example, how should the traditional standards of culpability, which fall short of the orthodox definition of an intentional tort, be applied in a situation where the insurer-actor almost always acts intentionally when passing on claims, that is, consciously refuses to pay an insured, knowing that economic and other harm probably will flow from the refusal?

17. For example, should the tort be limited to wrongful refusals of insurers to pay claims of their insureds or should it apply to other obligations of insurers, including third-party insurance contracts?

18. See *infra* Appendix.

particular type of insurer wrongdoing. The proposed remedies recognize the dual nature of the insurer-insured relationship, that is, one based upon contract and tort concepts. Such a statute would eliminate many of the ambiguities and other deficiencies in the common law of those states that already have adopted the new tort. In addition, the proposed statutory solution would provide clear guidelines to those states where the courts so far have refused to adopt the new tort or have not faced all of the issues.

A uniform act like the one suggested would provide even-handed and fair treatment to insurers and insureds alike across the country. There is no reason why the parties to an insurance contract should be treated differently depending on their location. After all, it is the insureds that ultimately pay for the losses, and their rights ought to be the same. It also is essential to a healthy insurance industry that insurers face the same obligations across the country. The most efficient method of accomplishing these goals is through legislation because the courts simply have not come to the type of consensus that is necessary to preserve the rights and obligations of the parties and the public interest in a balanced fashion. In short, the state legislatures are in the best position to assure that a fair and consistent set of rules is being applied in all the states by adopting a uniform act.

I. COMMON-LAW AND STATUTORY BACKGROUND

A. *Insurance Contracts at Common Law*

Until relatively recently, policies of insurance ordinarily were not accorded any special treatment in the law of contracts.¹⁹

19. Perhaps the law of warranties would be viewed as an exception. Before Lord Mansfield's tenure as Chief Justice of the Court of King's Bench, which began in 1756, courts treated a warranty in an insurance contract the same as warranties in general. A warranty was merely a condition that had to be strictly performed, but there was nothing to indicate that an immaterial breach would work a forfeiture. Lord Mansfield, however, soon created a difference with regard to contracts of insurance. In a line of cases beginning in 1763 with *Woolmer v. Muilman*, 96 Eng. Rep. 243 (K.B. 1763), and culminating in 1786 with *De Hahn v. Hartley*, 99 Eng. Rep. 1130 (K.B. 1786), the Chief Justice eliminated any materiality requirement by holding that even an immaterial breach of warranty would permit an insurer to avoid the contract. See William R.

For example, although the rule that ambiguities are to be construed against the drafter—*contra proferentum*—may be referred to most frequently in insurance cases, it is applied routinely in all types of contract disputes.²⁰ Likewise, the doctrine of reasonable expectations²¹ probably is identified most closely with the interpretation of insurance policies, but it is recognized by the American Law Institute as falling within generally accepted principles regarding the enforcement of all standard form contracts.²² Even the rule that there is an

Vance, *The History of the Development of the Warranty in Insurance Law*, 20 YALE L.J. 523, 524-32 (1911).

Even though a number of states have attempted to change Lord Mansfield's rule by statute, and some courts have in some respects ameliorated its harsh consequences by common-law decision, it still has vitality today. See ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW* § 6.6 (1988).

20. The first Restatement of Contracts declares, "Where words or other manifestations of intention bear more than one reasonable meaning an interpretation is preferred which operates more strongly against the party from whom they proceed, unless their use by him is prescribed by law." RESTATEMENT OF CONTRACTS § 236(d) (1932).

21. A noted insurance law scholar first articulated the doctrine of reasonable expectations in 1970: "The objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations." Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967 (1970).

22. The American Law Institute subsumed the doctrine of reasonable expectations under the provision that deals generally with form contracts:

§ 211. Standardized Agreements

(1) Except as stated in Subsection (3), where a party to an agreement signs or otherwise manifests assent to a writing and has reason to believe that like writings are regularly used to embody terms of agreements of the same type, he adopts the writing as an integrated agreement with respect to the terms included in the writing.

(2) Such a writing is interpreted wherever reasonable as treating alike all those similarly situated, without regard to their knowledge or understanding of the standard terms of the writing.

(3) Where the other party has reason to believe that the party manifesting such assent would not do so if he knew that the writing contained a particular term, the term is not part of the agreement.

RESTATEMENT (SECOND) OF CONTRACTS § 211 (1981).

At least two courts have justified their recognition of the doctrine of reasonable expectations on the authority of the Second Restatement. See *Darner Motor Sales, Inc. v. Universal Underwriters Ins. Co.*, 682 P.2d 388, 396 (Ariz. 1984); *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169, 172, 176 (Iowa 1975). It remains to be seen, however, whether the Restatement formulation provides the outer boundaries of the doctrine, at least with regard to insurance contracts. See Roger C. Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823, 852-53 (1990).

implied covenant of good faith and fair dealing—a rule relied on by a number of courts as the basis for the tort of bad faith—is applied to all contracts and all contracting parties, not just insurance contracts and insurers alone.²³ As mentioned earlier, courts have applied to all contract breaches the rule limiting damages to those foreseeable by the breaching party when the contract was made.²⁴ Consequential economic loss and emotional distress were not compensable except under exceptional circumstances.²⁵ There was no exception for insurance policies. Nor was there an exception for damages that would punish the breaching party. As a general rule, punitive damages were not available for breach of contract,²⁶ and this held true for breaches by insurers.²⁷

The similarities between insurance contract disputes and all other contract disputes were also buttressed by another time-honored position under American common law. In the event of a legal dispute, each party is to bear the expense of his own attorney regardless of who prevails.²⁸ Thus, traditionally the impact on an insured who had to resort to legal process to remedy an insurer's breach of an insurance policy was no more or less serious than the impact on any other person who had to resort to legal process to remedy the breach of a contract. In over two hundred years of insurance contract litigation, no distinctive set of common-law rules emerged to govern the relationship between an insurer and its insureds.

This commonality, however, between insurance and other contracts was not to endure and probably could not have endured, given the role that insurance has come to play in this country. In fact, insurance contracts are not like other

23. The Second Restatement of Contracts provides, "Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." RESTATEMENT (SECOND) OF CONTRACTS § 205 (1981); see also 5 WILLISTON, *supra* note 4, § 670, at 159 (1961) ("The underlying principle is that there is an implied covenant that neither party will do anything which will have the effect of destroying or injuring the right of the other party to receive the fruits of the contract . . ."). The essence of the duty is that neither party will act to impair the right of the other to receive the benefits which flow from their agreement or contractual relationship. *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 200 (Cal. 1958); *Brown v. Superior Court*, 212 P.2d 878, 881 (Cal. 1949).

24. Cf. RESTATEMENT (SECOND) OF CONTRACTS § 351 (1981).

25. See *id.* §§ 347, 353 & commentary.

26. *Id.* § 355.

27. See FARNSWORTH, *supra* note 5, § 12.8, at 876–77.

28. See DOBBS, *supra* note 4, § 3.8, at 194.

contracts because, in the aggregate, they occupy a unique institutional role in any modern, capitalistic society. Consequently, forces and conditions not of their making have had a great impact on the parties to insurance contracts and have provided the social basis for the distinctive legal treatment accorded breaches of first-party insurance contracts today.

B. *Economic Development and the Role of Insurance*

Professor Edwin Patterson once opined that the peculiarities of an insurance contract derive from its nature as an *aleatory*, as distinguished from a *commutative*, contract:

In making the latter type of contract, the parties contemplate a fairly even exchange of values. In a sale, which is a typical commutative contract, the seller thinks that the price paid is about equal to the value of the goods, and the buyer expects to get goods about equal to his price. On the contrary, in making an insurance contract, the insured knows that he is paying a sum far less than the insurer is to pay him *under certain conditions* that will probably not occur. Insurance is an aleatory contract; the conditions are a part of the bargain. They define the risks that the insurer agrees to bear for a group of persons exposed to similar risks and paying similar contributions to the fund from which losses are to be paid. The law looks back of the contract to the institution of which it is a part.²⁹

In other words, insurance contracts are private arrangements for hedging against the possibility of loss, and it is this risk-transfer-and-distribution quality that distinguishes them from other kinds of contracts with regard to economic consequences. But, institutionally speaking, the sum of the parts is greater than the whole, for they serve an even broader purpose.

On the one hand, insurance contracts, like other contracts, consist of individual exchange relationships as a matter of private agreement between insurers and insureds. On the other

29. EDWIN W. PATTERSON, *ESSENTIALS OF INSURANCE LAW* 62 (2d ed. 1957) (footnote omitted).

hand, their terms reflect matters of interest common to all insureds.³⁰ One object of insurance contracts is to spread the risk of certain perils among the many who are subject to the perils. From the beginning, as stated nearly four centuries ago, the purpose of insurance agreements has been to prevent the "undoing of any Man, but the losse lightethe rather easilie upon many, then heavilie upon fewe."³¹ Thus, insurance contracts always have had an important public purpose in addition to their private purpose. Because of this quality, these arrangements take on more social importance as a capitalistic society develops economically and becomes more affluent. There is more economic risk to be insured against and the insurance industry, as a social institution, therefore plays an increasingly vital role in the process of economic development.

In a free enterprise system, economic development steadily increases the number of situations in which individuals can suffer "loss." At the same time, economic development enhances the ability to avoid the prospect of "loss." In other words, in a relatively affluent society, there is much more to lose in the way of property and other economic interests as the human condition improves. In such a society, however, individuals are more likely to have the requisite discretionary income to transfer and to spread the attendant risks of loss. Disruptive losses to society, as well as to the individual, are obviated or minimized by private agreements among similarly situated people. In this way, the insurance industry plays a very important institutional role by providing the level of predictability requisite for the planning and execution that leads to further development. Without effective planning and execution, a society cannot progress.

In contrast, to take the more extreme case, in a hand-to-mouth society there is relatively less at risk. Life is a chore in any event. Moreover, to the extent that there is risk of loss, the

30. Professor Lon Fuller observed that there are two fundamental forms of social order. One is a relationship based upon reciprocity or exchange where people tend to deal more or less at arm's length. The other relationship is one of common ends or a shared interest—for example, building a wall to protect against some common problem or threat. HENRY M. HART, JR. & ALBERT M. SACKS, *THE LEGAL PROCESS: BASIC PROBLEMS IN THE MAKING AND APPLICATION OF LAW* 425-26 (1958). An insurance contract would seem to combine both relationships.

31. An Acte concerninge matters of Assurances, amongste Marchantes, 1601, 43 Eliz., ch. 12 (Eng.).

necessary discretionary income which individuals would pool in any private risk distribution plan is less apt to exist. Thus, when disaster strikes, it is likely to be calamitous because the losses are not shared by those unaffected by the particular event. Nevertheless, planning for the future must be secondary to the more immediate problem of survival.

This perceived social significance has set apart insurance contracts from most other contracts in the eyes of the law. Insurance is purchased routinely and has become pervasive in our society.³² It protects against losses that otherwise would disrupt our lives, individually and collectively. The public interest, as well as the individual interests of millions of insureds, is at stake. This is the foundation for the general judicial conclusion that the business of insurance is cloaked with a public purpose or interest.³³ This perception also

32. According to insurance industry figures, in 1990 premium receipts for all forms of insurance in the United States exceeded \$600 billion. INSURANCE INFORMATION INST., THE FACT BOOK: PROPERTY/CASUALTY INSURANCE FACTS 5 (1992). The United States accounted for 37.45% of the world's premium volume in 1989. *Id.* at 15. Some 96% of the nation's home owners, and 26% of the renters, carried household insurance in 1989 to protect themselves against potential losses. *Id.* at 14. Also during 1989, nearly 87% of the civilian noninstitutionalized population was protected by health-care coverage. HEALTH INS. ASS'N OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 9 (1991). As of 1990, there were over nine trillion dollars of life insurance in force in the United States. AMERICAN COUNCIL OF LIFE INS., 1991 LIFE INSURANCE FACT BOOK UPDATE 4 (1991).

One contracts scholar has observed:

The final and perhaps most significant characteristic of insurance contracts differentiating them from ordinary, negotiated commercial contracts, is the increasing tendency of the public to look upon the insurance policy not as a contract but as a special form of chattel. The typical applicant buys "protection" much as he buys groceries. The protection is intangible, to be sure, but he is reassured by the words of the agent and by the fact that agent and company are regulated by the state and licensed to do business there. . . .

. . . .

In conclusion, for most purposes, insurance must still be considered a contract between insurer and insured, but it is a very special type of contract and one currently involved in a prolonged period of popular and judicial gestation from which it may well eventually emerge as a new and special form of chattel, or perhaps, quasi-chattel.

7 WILLISTON, *supra* note 4, § 900, at 34, 36-37 (1963) (footnote omitted).

33. As early as 1914, the Supreme Court of the United States, in upholding the power of the states to regulate the business of insurance, based its decision on the conclusion that the business had become clothed with a public interest:

The restrictions upon the legislative power which complainant urges we have discussed, or rather the considerations which take, it is contended, the business of insurance outside of the sphere of the power. To the contention that the

explains the extensive regulation of the insurance industry in the United States, not just through legislative and administrative processes,³⁴ but also through the judicial process.³⁵ In fact, as with developments in other areas of tort law, the recognition of the tort of bad faith in insurance cases represents a judicial response to the perceived failure of the other branches of government to regulate adequately the claims processes of the insurance industry. Had the early attempts at regulation been more effective, the tort of bad faith might never have come into existence.

C. Early Attempts at Regulation of Insurance Claims Practices

As discussed above, insurance policies occupy a unique position in the modern law of contracts. This singular status has given rise to a new tort, but this legal development was not inevitable. As in so many other areas, the common law in the area of insurance contract law has responded to a social need that was not met by other institutions. Traditionally, the

business is private we have opposed the conception of the public interest. We have shown that the business of insurance has very definite characteristics, with a reach of influence and consequence beyond and different from that of the ordinary businesses of the commercial world, to pursue which a greater liberty may be asserted. The transactions of the latter are independent and individual, terminating in their effect with the instances. The contracts of insurance may be said to be interdependent. They cannot be regarded singly, or isolatedly, and the effect of their relation is to create a fund of assurance and credit, the companies becoming the depositories of the money of the insured, possessing great power thereby and charged with great responsibility. How necessary their solvency is, is manifest. On the other hand to the insured, insurance is an asset, a basis of credit. It is practically a necessity to business activity and enterprise. It is, therefore, essentially different from ordinary commercial transactions, and, as we have seen, according to the sense of the world from the earliest times—certainly the sense of the modern world—is of the greatest public concern. . . .

. . . The principle we apply is definite and old and has, as we have pointed out, illustrating examples. And both by the expression of the principle and the citation of the examples we have tried to confine our decision to the regulation of the business of insurance, it having become "clothed with a public interest," and therefore subject "to be controlled by the public for the common good."

German Alliance Ins. Co. v. Lewis, 233 U.S. 389, 414–15 (1914).

34. See KEETON & WIDISS, *supra* note 19, § 8.

35. See *id.* §§ 6–7 (describing many instances of judicial regulation by recognizing rights on behalf of insureds that are at variance with the actual terms of the contract).

common law did not penalize insurers either for a delayed payment or for an outright refusal to pay a claim, even when the insurer's conduct plainly was unjustified.³⁶ The insured usually was entitled only to the amount due under the policy, no matter that legal expenses may have been incurred to force compliance by the insurer.³⁷ The possibility of recovering other damages that may have been suffered as a result of the delay was even more remote.

The process of change, however, did not begin with the courts. Around the turn of this century, the legislatures took the initiative and began to enact statutes providing for recovery of attorneys' fees,³⁸ and sometimes penalties or interest,³⁹ when an insurer in some manner defaulted on its obligation to provide the benefits under the policy.⁴⁰ Some statutes provided for recovery of these extra-contractual fees and penalties only when the insurer acted in an unreasonable manner,⁴¹ whereas others made them available simply for not paying claims within a certain time period.⁴² These statutes signaled the onset of a change, albeit a slow one.

36. See *id.* § 7.7(a).

37. *Id.*

38. See, e.g., Act of Feb. 21, 1927, ch. 231, § 40-908, 1927 Kan. Sess. Laws 345; Act of Apr. 21, 1913, ch. 234, § 1, 1913 Neb. Laws 738; see also *Main v. Benjamin Foster Co.*, 192 So. 602, 604-05 (Fla. 1939) (construing the 1917 version of a Florida statute, the original of which was enacted in 1893, providing attorneys' fees against certain types of insurers).

39. See, e.g., Act of Mar. 29, 1905, No. 115, 1905 Ark. Acts 307 (providing attorneys' fees plus 12% damages calculated upon the amount of the loss); Act of Aug. 23, 1872, § 16, 1872 Ga. Laws 43 (providing attorneys' fees plus an amount not to exceed 25% of the insurer's liability); Act of June 29, 1937, § 155, 1937 Ill. Laws 765 (providing attorneys' fees plus an amount not to exceed any one of the following: 25% of the recovery, \$500, or the amount recovered in excess of that which the insurer may have offered to pay in settlement); Act of Mar. 30, 1911, § 1, 1911 Mo. Laws 282 (providing attorneys' fees, interest, and an amount not to exceed 10% of the insured loss).

40. For a collection of cases construing a number of the early statutes providing for attorneys' fees and penalties, see E.B. Morris, Annotation, *What Persons or Corporations, Contracts or Policies, Are Within Statutory Provisions Allowing Recovery of Attorney's Fees or Penalty Against Companies Dealing in Specified Kinds of Insurance*, 126 A.L.R. 1439 (1940).

41. See, e.g., Act of June 29, 1937, § 155, 1937 Ill. Laws 765 (allowing fees and penalties where the insurer's refusal to pay was vexatious and without reasonable cause).

42. See, e.g., Act of Mar. 29, 1905, No. 115, 1905 Ark. Acts 307 (allowing fees and penalties where demand was made by the insured and the insurer failed to pay within the time specified in the policy).

Although the legislative efforts at regulating the claims process were rather minimal, they were not completely insignificant; they constituted the first recognition that a problem existed. Still, many states did not follow suit.⁴³ Moreover, those that did failed to follow any particular pattern.⁴⁴ As a result, most insureds continued to find themselves at a considerable disadvantage in a contest with insurers over unpaid claims.

The insureds' disadvantage persisted as insurance took on more and more importance in this country. In order to purchase a home or a car, or commercial property, most people had to borrow money, and loans were not obtainable unless the property was insured. In addition, the lender often required that the life of the borrower be insured. On another front, the cost of medical care was rising beyond the reach of many people and insurance programs were developed to spread that risk.⁴⁵ The purchase of insurance was no longer a matter of prudence; it was a necessity. Then losses occurred and the inevitable disputes arose. These disputes, however, were not about an even exchange in value.⁴⁶ Rather, they were about something quite different.

Insureds bought insurance to avoid the possibility of unaffordable losses, but all too often they found themselves embroiled in an argument over that very possibility. Disputes over the allocation of the underlying loss worsened the insureds' predicament. In most instances, insureds were seriously disadvantaged because of the uncompensated loss; after all, the insured would not have insured against this peril unless it presented a serious risk of disruption in the first place. The prospect of paying attorneys' fees and other litigation expenses, in addition to the burden of collecting from the insurer, with no assurance of recovery, only aggravated the situation.

43. As late as 1951, only about one-fourth of the states had enacted statutes providing for attorney's fees and penalties. WILLIAM R. VANCE, *HANDBOOK ON THE LAW OF INSURANCE* 46 (1951).

44. *See id.*

45. *See* Sallyanne Payton & Rhoda M. Powsner, *Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need*, 79 MICH. L. REV. 203, 214-48 (1980) (discussing the origins of the private health insurance system and the reasons for rising health-care costs).

46. *See supra* text accompanying notes 29-31.

These additional expenses could prove to be a formidable deterrent to the average insured. For most insureds, unlike insurers, such expenses were not an anticipated cost of doing business. Insureds did not plan for litigation as an institutional litigant would. Insurers, on the other hand, built the anticipated costs of litigation into the premium rate structure. In effect, insureds, by paying premiums, financed the insurers' ability to resist claims. Insureds, as a group, were therefore peculiarly vulnerable to insurers who, as a group, were inclined to pay nothing if they could get away with it, and, in any event, to pay as little as possible. Insurance had become big business. As public resentment of insurance companies increased, the practices of the industry itself helped prepare the way for more pervasive regulation.

In the 1970s, the National Association of Insurance Commissioners (NAIC) began to develop model legislation aimed at unfair claims settlement practices of the insurance industry.⁴⁷ Although this legislation, or some variation of it, has now been adopted by all but a half-dozen states,⁴⁸ it has not materially aided the individual claimant. The model legislation prohibits certain acts by an insurer only when committed flagrantly and in conscious disregard of the statute or with such frequency as to indicate a general business practice.⁴⁹ In such circumstances, the state insurance regulator is empowered to seek injunctive relief or penalties to enforce the statutory provisions.⁵⁰ This language, when coupled with the fact that the legislation is silent as to any remedies on behalf of individual

47. The NAIC had previously developed and promulgated a model act regulating unfair trade practices of insurers which had been adopted in all states by 1959. See KEETON & WIDISS, *supra* note 19, § 8.1, at 932-34. This legislation, ultimately entitled the Model Unfair Trade Practices Act, dealt mainly with the marketing practices of insurers and had little to say regarding claims practices. The model legislation dealing with the latter was developed and incorporated into the NAIC Model Unfair Trade Practices Act by amendment in 1972. See 1 PROCEEDINGS NAT'L ASS'N OF INS. COMMISSIONERS 495-96 (1972). In 1990, the NAIC approved a free-standing act entitled the Model Unfair Claims Settlement Practices Act. See 1A PROCEEDINGS NAT'L ASS'N OF INS. COMMISSIONERS 177-79 (1990). Thus, there are now two separate model acts: the Model Unfair Trade Practices Act and the Model Unfair Claims Settlement Practices Act.

48. See 4 NATIONAL ASS'N OF INS. COMM'RS, MODEL LAWS, REGULATIONS AND GUIDELINES 900-5 to -8 (1992). As of July 1992, only Georgia, Missouri, and Nebraska have adopted the new free-standing model act. *Id.*

49. See UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 3, *reprinted in* NATIONAL ASS'N OF INS. COMM'RS MODEL LAWS, REGULATIONS AND GUIDELINES 900-1, 900-2 (1991).

50. *Id.* §§ 5-7, at 900-3.

claimants,⁵¹ led the courts, with only a very few exceptions, to refuse to recognize that the legislation created a private cause of action on behalf of an insured for money damages.⁵² This was a serious shortcoming.

An individual insured seldom could obtain timely relief by complaining to the state insurance regulator. Without legal assistance, it was difficult for an insured to prove a flagrant and conscious violation of the law or that the insurer engaged in a general practice of abuse. Only after a large number of insureds complained against a particular insurer could the insurance commissioner act. By that time, it was usually too late for many of the insureds. Consequently, the efforts of the NAIC proved to be less than adequate for the task. As a result, many individuals who had been harmed by the wrongful acts of insurers were still without a remedy even when complaints were filed with their state insurance commissioner.

In sum, the legislative and administrative responses, either through provisions for attorneys' fees and penalties or prohibitions on unfair insurer claims practices in general, did not stem the tide of social pressure for relief from unjustified delays in processing and arbitrary refusals to pay claims. This left only one other route open to claimants—the courts. Thus, insureds increasingly began to turn to private attorneys for assistance. This in turn caused the courts to take a more critical look at the claims process and eventually led to a common-law response under the guise of tort law.

51. The Model Unfair Claims Settlement Practices Act, adopted by the NAIC in 1990, contains a "Drafting Note" stating that any jurisdiction choosing to provide a private cause of action should consider a different statutory scheme, and that the Act "is inherently inconsistent with a private cause of action." See *id.* § 1 at 900-1. The 1972 Model Act did not contain such a note.

52. The California Supreme Court initially held that a private cause of action was created for a single violation under its version of the model legislation, see *Royal Globe Ins. Co. v. Superior Court*, 592 P.2d 329, 332 (Cal. 1979), but reversed itself less than 10 years later, see *Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 758 P.2d 58, 68-69 (Cal. 1988). The *Moradi-Shalal* court listed 17 jurisdictions as rejecting the argument that the model legislation creates a private cause of action. *Id.* at 63. Montana and West Virginia have recognized a private cause of action, but only where there are a sufficient number of violations to constitute a general business practice. See *St. Paul Fire & Marine Ins. Co. v. Cumiskey*, 665 P.2d 223, 226 (Mont. 1983); *Klaudt v. Flink*, 658 P.2d 1065, 1068 (Mont. 1983); *Jenkins v. J.C. Penney Casualty Ins. Co.*, 280 S.E.2d 252, 259 (W. Va. 1981); cf. *Farmer's Union Cent. Exch., Inc. v. Reliance Ins. Co.*, 626 F. Supp. 583, 590 (D.N.D. 1985) (holding that North Dakota's unfair claims practices statute may create the basis for a private tort action).

II. THE ORIGIN AND DEVELOPMENT OF THE COMMON-LAW TORT OF BAD FAITH

A. *Early Forms of "Liability" Insurance*

The origins of the tort of bad faith in first-party insurance cases are to be found in third-party insurance contracts, that is, liability insurance. This in itself is interesting because the earliest forms of "liability" insurance were not what we know today as third-party insurance.⁵³ In fact, they were not liability insurance policies at all. They were indemnity insurance contracts, a form of first-party coverage where the insurer only agreed to reimburse the insured for damages the insured actually paid to a tort victim.⁵⁴ If the insured were not liable, the insurer owed nothing, just as would be the case if it were a true liability policy. However, when the insured was liable to a tort victim but was unable to pay because of insolvency or some other reason, the insurer still owed nothing, because the insured had not actually paid money to the victim.⁵⁵ This was true even though the insurer also had promised to defend the insured against tort claimants at the insurer's expense. In the eyes of the law, the insured had not sustained a loss. As a corollary, the tort victim, not being a party to the contract, had no remedy against the insurer either.⁵⁶

In contrast, a real liability policy obligates the insurer to pay the third-party tort victim once the insured's liability has been

53. The first "liability" insurance policies were purchased by employers as protection against tort liability to employees resulting from work injuries. KEETON & WIDISS, *supra* note 19, § 4.8(a), at 376.

54. VANCE, *supra* note 43, at 800-01.

55. See, e.g., *Cousins v. Paxton & Gallagher Co.*, 98 N.W. 277, 278 (Iowa 1904); *Carter v. Aetna Life Ins. Co.*, 91 P. 178, 178-79 (Kan. 1907); *Frye v. Bath Gas & Elec. Co.*, 54 A. 395, 396 (Me. 1903); *Poe v. Philadelphia Casualty Co.*, 84 A. 476, 480 (Md. 1912); *Finley v. United States Casualty Co.*, 83 S.W. 2, 4-5 (Tenn. 1904); *Ford v. Aetna Life Ins. Co.*, 126 P. 69, 71 (Wash. 1912).

56. This position was buttressed by a "no action" clause in the policy which, for example, provided: "No action shall lie against the company as respects any loss under this policy unless it shall be brought by the assured himself to reimburse him for loss actually sustained and paid by him in satisfaction of a judgment after a trial of the issue." *Maryland Casualty Co. v. Peppard*, 157 P. 106, 108 (Okla. 1915) (quoting a common no-action clause).

established by settlement or court action.⁵⁷ It is not a prerequisite that the insured first pay the victim. Although the first contracts insuring against loss by virtue of payments to a third-party tort victim were of the indemnity type, eventually insurers offered policies that protected the insured against mere liability. However, during the transition from indemnity to liability contracts, both types of contracts continued to be treated like any other contract even though the nature of the relationship between the insured and the insurer was changing.

With regard to the possibility of recovery for consequential damages, an indemnity contract of insurance was governed by the rule in *Hadley v. Baxendale*.⁵⁸ Even though the insurer agreed to defend the insured, as well to indemnify him for any damages paid as a result of third-party claims, a breach of these obligations by the insurer only afforded the insured the traditional contract measure of damages. The insured could recover the amount to be indemnified under the policy plus the costs of defending the third-party action, but nothing more.⁵⁹ Although this rule held sway throughout most of the twentieth century, as will be seen below, it eventually was undercut as liability insurance gradually displaced the indemnity policy as the standard policy form. This development occurred as a result of pressure from several fronts.

In the main, the indemnity contract was replaced because the public was dissatisfied with it. This dissatisfaction, in turn, resulted in pressure on the courts and the legislatures. As one authority noted, the indemnity policy and the state of the law upholding it

57. One court explained, "The difference between a contract of indemnity and one to pay legal liabilities is that upon the former an action cannot be brought, and a recovery had, until the liability is discharged; whereas upon the latter the cause of action is complete when the liability attaches." *American Employers' Liab. Ins. Co. v. Fordyce*, 36 S.W. 1051, 1053 (Ark. 1896).

58. See *supra* text accompanying notes 2-3.

59. The case most often cited for this rule is *Mannheimer Bros. v. Kansas Casualty & Sur. Co.*, 184 N.W. 189 (Minn. 1921). There the insured contended that the insurer, who had wrongfully refused to defend a third-party tort claim, owed not only the policy limits and costs of defense, but also the amount of the judgment that was in excess of the policy limits. The court denied the claim for the excess amount, holding that "[t]he question presented is controlled by the general rule that the measure of damages for the breach of a contract for the payment of money is the amount agreed to be paid with interest." *Id.* at 191.

permitted grave abuses; furthermore it offends the common sense of justice to see an insurance company escape liability merely because the assured was unable to satisfy the judgment, when the insurer is usually regarded as the principal debtor within the limits of the policy, and the assured a mere conduit through whom the money passes.⁶⁰

Consequently, some courts began to construe indemnity policies so that the insurer could not easily avoid being obligated to pay the third-party tort victim.⁶¹ Under this approach, unless a policy explicitly and plainly limited the insurer's obligation to indemnification of what an insured actually paid to the tort victim, the policy was treated like a liability policy.⁶² A few courts also held that the insurer was estopped from denying any obligation to a third-party claimant once the insurer assumed control of the defense of its insured, again deviating from the earlier constructions by courts upholding the terms of an indemnity policy.⁶³

On another front, state legislatures began to enact "direct action" statutes that either permitted a tort victim to name both the tortfeasor and the insurance carrier as defendants in a personal injury suit or otherwise gave the victim the benefit of the tortfeasor's insurance policy.⁶⁴ This two-pronged judicial and legislative attack ultimately caused the insurance industry to discontinue the issuance of indemnity policies⁶⁵ in favor of

60. VANCE, *supra* note 43, at 802 (footnotes omitted). There were also allegations that some insurance companies colluded with insureds to secure an adjudication of bankruptcy for the latter so that the insurer could avoid its obligation under an indemnity policy. See *Merchants Mut. Auto. Liab. Ins. Co. v. Smart*, 267 U.S. 126, 130 (1925).

61. See VANCE, *supra* note 43, at 803.

62. In *Maryland Casualty Co. v. Peppard*, the court held that the policy in question was a liability policy because it, unlike the policies in the cases relied upon by the insurer for the proposition it was merely an indemnity policy, did not have a "no action" clause. 157 P. 106, 108 (Okla. 1915). For an example of a "no action" clause, see *supra* note 56.

63. See VANCE, *supra* note 43, at 802-03.

64. *Id.* at 803-04.

65. Directors' and officers' liability insurance may provide one of the few examples of indemnity insurance today in a setting where a covered loss is generated by claims of third parties against an insured or its officers and directors. There are no standard forms, but generally the coverage is written two different ways. First, under the directors and officers insuring clause, the insurer may agree to indemnify the directors and officers directly for loss they are legally obligated to pay to third parties for which they are not indemnified by the corporation. This type of coverage may also be written

the issuance of true liability policies. This development created, as will be explained below, a different kind of relationship between an insurer and its insureds under a true liability policy in comparison with the relationship that was created between the parties under an indemnity policy. This difference in the relationship eventually led to the recognition of a new duty under third-party insurance policies and a concomitant cause of action against liability insurers.

B. The Change in the Insurer-Insured Relationship

The relationship of the insurer to the insured under indemnity insurance did not obligate the insurer to take into account the interests of the insured. In fact, indemnity insurance was a form of first-party insurance. As far as the obligation to indemnify was concerned, the insurer would either pay or deny the claim of its insured after the underlying claim against the insured had been concluded. It was simply a question of whether the insurer was obligated to pay for a loss sustained by its insured.⁶⁶ If a dispute arose over the obligation to indemnify, it was like any other dispute between contracting parties.

Even when the insurer had a duty to reimburse defense costs under an indemnity policy, it did not create any obligation on the part of the insurer to accept a settlement offer from, much less any obligation to negotiate a settlement with, a third-party claimant on behalf of the insured.⁶⁷ Such offers and negotiations were the insured's problem. This also was true after insurers began to provide a defense directly, instead of merely

as true liability insurance, whereby the insurer agrees to pay on behalf of a director or officer those sums for which he may become liable. Second, under the corporate reimbursement insuring clause, the subject of insurance is the amount the corporation is required or permitted to pay as indemnity to the directors and officers for claims made against them. See generally S.S. HUEBNER ET AL., *PROPERTY AND LIABILITY INSURANCE* 380 (3d ed. 1982).

66. See VANCE, *supra* note 43, at 800-01.

67. See, e.g., *Rumford Falls Paper Co. v. Fidelity & Casualty Co.*, 43 A. 503, 505 (Me. 1899); *Auerbach v. Maryland Casualty Co.*, 140 N.E. 577, 578-79 (N.Y. 1923); *C. Schmidt & Sons Brewing Co. v. Travelers' Ins. Co.*, 90 A. 653, 654 (Pa. 1914).

reimbursing defense costs incurred by the insured.⁶⁸ The insurer's obligation with regard to its insured's liability for damages was still reimbursement of the insured, up to the policy limits, for sums the insured had been legally obliged to pay and had in fact paid the claimant.⁶⁹ Essentially, the courts viewed the indemnity relationship as one where the insured and insurer dealt with each other at arm's length.⁷⁰ It was no different from any other first-party insurance situation. Liability insurance contracts, however, did not come to be viewed the same way.

Modern liability policies create a quite different relationship between the insurer and its insured. Under these contracts, the insurer not only agrees to defend the insured, but also agrees to pay any sums within the policy limits that the insured becomes legally obligated to pay as damages to a third-party claimant and to pay those sums directly to the third party.⁷¹ There is no requirement that the insured first pay the damages to the third party. In addition to the obligation to provide the insured with a defense against third-party claims, most liability policies include a provision that permits the insurer to settle any claim within the policy limits.⁷² This feature causes the financial destiny of the insured to be much more dependent on the acts of the insurer. For example, where a claim is made in excess of the policy limits but the claimant offers to settle within the limits, it is within the power of the insurer either to settle and foreclose the insured's exposure or to refuse to settle and continue the insured's exposure to the risk of a judgment in excess of the policy limits.⁷³

68. See majority cases cited in Annotation, *Provision Making Actual Payment of Judgment a Condition of Indemnity Insurer's Liability ("No Action Clause"), as Affected by Insurer Defending Action Against Insured*, 37 A.L.R. 637, 638 (1925).

69. *Id.*

70. See generally VANCE, *supra* note 43, at 800-06.

71. Modern liability policies are interpreted to provide that the third-party claimant may sue on the policy once the liability of the insured is established. See KEETON & WIDISS, *supra* note 19, § 4.8(b), at 378.

72. Both of these features were initiated under indemnity policies. See, e.g., *Auerbach v. Maryland Casualty Co.*, 140 N.E. 577, 578-79 (N.Y. 1923) (interpreting an indemnity policy which provided for defense against third-party actions and an option to settle). Other provisions that evolved from indemnity policies require the insured to give prompt notice of any claim; to forward immediately any demand, notice, summons or other process; and to cooperate in any defense or effort at settling the claim. See KEETON & WIDISS, *supra* note 19, § 7.2.

73. See Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1118-19 (1990).

This discretion in the insurer, if unchecked, allows the insurer, at small additional risk to itself because of the policy limits, to gamble with the insured's money by refusing to accept or negotiate a settlement within the policy limits.⁷⁴ If acceptance of an offer would ensure savings of only a few dollars over any judgment because the offer was for an amount close to the policy limits, why not gamble that a jury would return a verdict for an amount less than the offer? Very little of the insurer's money would be at stake since its liability was limited. The insured would have to pay any amount in excess of the policy limits, not the insurer.

The foregoing scenario is not the only situation where the insured could find that her insurance protection was not quite what she might expect. The insured might also be unduly exposed to the risk of a large excess judgment even when there is no offer to settle within the policy limits. For example, if given the opportunity, the insured might well be willing to pay some amount in excess of the policy limits from the insured's own funds to facilitate the settlement of a dangerous case. In such a case, however, the insurer might refuse to tender the policy limits because it has nothing to lose by going to trial. The insured would bear any loss above the policy limits. The unfairness of such situations was apparent where insurers claimed unfettered discretion over settlement matters. If this position were to be sustained, insureds literally would be at the mercy of the insurers.

The type of situations described above led the courts to recognize the clear conflict of interests that might occur under a liability insurance policy.⁷⁵ Even though such a policy did not, by its express terms, impose upon the insurer a duty to settle claims, courts began to hold that insurers owed a duty to their insureds to refrain from acting solely on the basis of their own interests in settlement, rather than considering the interests of their insureds.⁷⁶ This duty was grounded in the power inherent in the insurer as a result of the relationship created by a third-party insurance contract.⁷⁷ As to the

74. See *id.* at 1128-30.

75. For a description of the different sources of conflict between insurance companies and their insureds, see *id.* at 1126-62.

76. See, e.g., *Radcliffe v. Franklin Nat'l Ins. Co.*, 298 P.2d 1002, 1020-24 (Or. 1956).

77. See *id.* at 1011.

standard of culpability that accompanied this newfound duty, some courts couched it in terms of due care on the part of the insurer.⁷⁸ Others defined the duty as the exercise of good faith or, conversely, as the avoidance of bad faith.⁷⁹ Whatever the standard for assessing liability, it soon became clear that a liability insurer could be held responsible for a wrongful failure to settle. Thus, if tort liability against the insured were found, the insurer would have to pay the entire judgment, including any portion in excess of the policy limits.⁸⁰ Courts were none too clear at the time as to whether this new basis for liability rested in contract, tort, or fiduciary obligations;⁸¹ nonetheless, it made possible the recognition of the tort of bad faith in first-party situations.

C. *The Evolution of the Tort of Bad Faith in First-Party Insurance*

Much of the discussion of the development of the tort of bad faith centers on a series of decisions by the Supreme Court of California. Two decisions dealing with liability insurance were instrumental in bridging the gap from third-party insurance to first-party insurance and in the eventual recognition of an entirely new tort. In *Comunale v. Traders & General Insurance Co.*,⁸² the California Supreme Court recognized that *Hadley v. Baxendale* provided the general common-law rule governing damages for breach of contract and that a mere wrongful refusal to defend by the insurer under a liability policy normally would be compensated like any other breach of contract.⁸³ The liability of the insurer

78. See KEETON & WIDISS, *supra* note 19, § 7.8(b).

79. *Id.*

80. *See id.*

81. See *Radcliffe v. Franklin Nat'l Ins. Co.*, 298 P.2d 1002, 1012-17 (Or. 1956) (reviewing the various theories upon which an insurer may be held liable for wrongfully refusing to settle).

82. 328 P.2d 198 (Cal. 1958).

83. *See id.* at 201. The issue of whether a breach of the duty to defend, as contrasted with the duty to settle, should give rise to an action for extra-contractual damages under the tort of bad faith or some other theory has not been addressed by most courts. Since the *Comunale* decision, Iowa and North Dakota have expressly recognized that the breach of the duty to defend may constitute a tort and that consequential damages are available in such cases. *See North Iowa State Bank v. Allied Mut. Ins. Co.*, 471 N.W.2d 824, 828-29

would be limited to the amount of the policy plus attorneys' fees and costs, even though the judgment was in excess of the policy limits.⁸⁴ When, however, the insurer not only wrongfully refused to defend, but, in addition, refused to accept a reasonable offer of settlement within the policy limits, the *Hadley* rule no longer applied. The fact that the insurer was no longer in a position to entertain the offer because it was not conducting the defense was of no consequence:

An insurer who denies coverage does so at its own risk, and, although its position may not have been entirely groundless, if the denial is found to be wrongful it is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligations of the contract. Certainly an insurer who not only rejected a reasonable offer of settlement but also wrongfully refused to defend should be in no better position than if it had assumed the defense and then declined to settle. The insurer should not be permitted to profit by its own wrong.⁸⁵

Thus, the insurer was held liable for the excess judgment in *Comunale* for having breached its express and implied obligations under the contract.

Comunale, however, did not provide a definitive break with *Hadley* because, arguably, the damages were something that the parties reasonably could have contemplated at the time

(Iowa 1991); *Smith v. American Family Mut. Ins. Co.*, 294 N.W.2d 751, 759 (N.D. 1980). Oregon, however, has declined to recognize such a tort and remedy. See *Farris v. United States Fidelity & Guar. Co.*, 587 P.2d 1015, 1018-21 (Or. 1978); cf. *Timmons v. Royal Globe Ins. Co.*, 653 P.2d 907, 912-13 (Okla. 1982) (holding that a cause of action for violation of an implied covenant of fair dealing and good faith will not lie against an agent who is not a party to the insurance contract).

84. The California Supreme Court stated:

In such a case it is reasoned that, if the insured has employed competent counsel to represent him, there is no ground for concluding that the judgment would have been for a lesser sum had the defense been conducted by insurer's counsel, and therefore it cannot be said that the detriment suffered by the insured as the result of a judgment in excess of the policy limits was proximately caused by the insurer's refusal to defend.

Comunale, 328 P.2d at 201 (citing *Mannheimer Bros. v. Kansas Casualty & Sur. Co.*, 184 N.W. 189 (Minn. 1921)).

85. *Id.* at 202.

the policy was issued. Existing insurance practices would support the proposition that the insured reasonably could expect that the insurer would accept any reasonable offer within the policy limits and that this expectation would remain a reasonable one in the event that the insurer breached its duty to defend.⁸⁶ In fact, the decision, although very important in recognizing that the duty to settle was not avoidable by refusing to defend, did not signal the next crucial development. The decision revealed little about the other kinds of damages that might be recovered by the insured, damages that could not so easily be held to have been within the contemplation of the parties. For example, what if an insured suffered damages distinct from those represented by the amount of the judgment that exceeded the policy limits, that is, damages that appeared more like tort damages? The answer, based on an obscure point in *Comunale*, followed less than ten years later.

The question of whether the insured could recover damages for emotional distress for an insurer's wrongful failure to settle was presented to the Supreme Court of California in *Crisci v. Security Insurance Co.*⁸⁷ In *Crisci*, the insurer had undertaken the insured's defense, but was adjudged to have breached its duty of good faith when it failed to settle with the tort victim.⁸⁸ The insured, however, suffered greater damages from the breach than the amount of the judgment that exceeded the policy limits.⁸⁹ The insured not only sustained severe economic losses, but her health also seriously deteriorated as a result of the financial reverses caused by the insurer's breach.⁹⁰ Consequently, the insured sued her liability insurer for emotional distress, for which she obtained a jury verdict of \$25,000.⁹¹

In reviewing *Crisci*, the California Supreme Court pointed out that *Comunale* had stated that the duty of good faith in

86. The court in *Comunale* pointed out that "[i]t [was] common knowledge that a large percentage of the claims covered by insurance are settled . . . and that this is one of the usual methods by which the insured receives protection." *Id.* at 201. Thus, an insured could reasonably expect the insurer to settle an appropriate case even though the policy did not expressly impose such a duty, even where the insurer was disputing any duty to defend if the insured believed the insurer was wrong in doing so.

87. 426 P.2d 173 (Cal. 1967).

88. *Id.* at 177-78.

89. *Id.* at 176.

90. *Id.*

91. *Id.* at 178.

settlement matters sounded in tort as well as in contract,⁹² a point that the *Comunale* court in fact had made only in a brief discussion whether the tort or contract statute of limitations would apply.⁹³ The *Comunale* court did not even hint at, much less discuss, the point that the recognition of a dual basis for the duty eventually might lead to a broader measure of damages. Nonetheless, this unexplored aspect of the *Comunale* opinion now became the basis for the *Crisci* court to hold that tort damages for mental distress were recoverable against a liability insurer that breached its duty to settle.⁹⁴ Whereas *Comunale* could have been considered somewhat of an exception to *Hadley v. Baxendale*, *Crisci* represented a clear break with the rule that damages for personal injury were not available for breach of contract. From this point, it was but a short step, at least for the California courts,⁹⁵ to the recognition of a cause of action in tort against insurers for failure to pay claims in first-party insurance situations. Six years later California closed the loop.

In 1973, the Supreme Court of California made the landmark decision of *Gruenberg v. Aetna Insurance Co.*⁹⁶ In deciding whether benefits were owed under a fire insurance policy, the court reiterated the principle that there is an implied covenant of good faith and fair dealing in all contracts of insurance and reemphasized the rule that a breach of the covenant may give rise to a cause of action in tort.⁹⁷ Relying heavily on the third-party cases of *Comunale* and *Crisci*, the court stated that the duty of the insurer to act in good faith and deal fairly when handling the claim of a third person against the insured and the duty of an insurer to act in good faith and deal fairly when handling the claim of an insured in a first-party situation "are merely two different aspects of the same duty."⁹⁸ Noting that the insured had alleged substantial damages for loss of

92. *Id.*

93. See *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 203 (Cal. 1958).

94. *Crisci*, 426 P.2d at 179.

95. Not all courts were willing to take that step. See *infra* note 155.

96. 510 P.2d 1032 (Cal. 1973).

97. *Id.* at 1037. The earlier Court of Appeals case of *Fletcher v. Western National Life Insurance Co.* held that a disability insurer could be liable for intentional infliction of emotional distress and stated in dicta that the insurer's conduct might also be viewed as a violation of its implied obligation of good faith and fair dealing. 89 Cal. Rptr. 78, 93-94 (Ct. App. 1970).

98. *Gruenberg*, 510 P.2d at 1037.

property in addition to the damages for mental distress, the *Gruenberg* court held that a tort measure of damages would apply and that consequential damages for mental distress, as well as economic loss, would be available.⁹⁹

With these three decisions, the tort of bad faith was born, and with it a new era in insurance litigation. To date, well over one-half of the states, in one form or another, have come to recognize this break with the rule of *Hadley v. Baxendale* in first-party insurance situations.¹⁰⁰ The amount of litigation in this area is growing apace as more and more claimants turn to this new remedy in an effort to force insurers to pay their claims. Yet aspects of the tort of bad faith remain troublesome because the courts have not addressed many of the questions that must be answered when any new common-law cause of action is created. Moreover, when courts have attempted answers in many instances, they have not been consistent as to some of the most basic questions. Thus, insurers today face a hodgepodge of rationales and rules in this area.

III. STATUS AND IMPACT OF THE TORT OF BAD FAITH AND RELATED ACTIONS

A. *Inventorying the Jurisdictions*

Although a number of jurisdictions have recognized a cause of action for a form of damages beyond the amount owed under the terms of an insurance policy, the rationales for doing so have not been entirely consistent. During the two decades since the Supreme Court of California decision in *Gruenberg v. Aetna Insurance Co.*, at least twenty-three other courts of last resort have held that an insurer may be liable to an insured for consequential or punitive damages under a tort theory, most often referred to as the tort of bad faith:

99. *Id.* at 1040-42.

100. See *infra* notes 101-32 and accompanying text.

Alabama,¹⁰¹ Alaska,¹⁰² Arizona,¹⁰³ Arkansas,¹⁰⁴ Colorado,¹⁰⁵ Connecticut,¹⁰⁶ Idaho,¹⁰⁷ Iowa,¹⁰⁸ Kentucky,¹⁰⁹ Mississippi,¹¹⁰ Montana,¹¹¹ Nebraska,¹¹² Nevada,¹¹³ New Mexico,¹¹⁴ North Dakota,¹¹⁵ Ohio,¹¹⁶ Oklahoma,¹¹⁷ Rhode Island,¹¹⁸ South Carolina,¹¹⁹ South Dakota,¹²⁰ Texas,¹²¹ Wisconsin,¹²² and Wyoming.¹²³

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101. *Chavers v. National Sec. Fire & Casualty Co.*, 405 So. 2d 1, 6 (Ala. 1981).
102. *State Farm Fire & Casualty Co. v. Nicholson*, 777 P.2d 1152, 1156-57 (Alaska 1989).
103. *Noble v. National Am. Life Ins. Co.*, 624 P.2d 866, 867-68 (Ariz. 1981).
104. *Aetna Casualty & Sur. Co. v. Broadway Arms Corp.*, 664 S.W.2d 463, 465 (Ark. 1984).
105. *Travelers Ins. Co. v. Savio*, 706 P.2d 1258, 1267-71 (Colo. 1985).
106. *Buckman v. People Express, Inc.*, 530 A.2d 596, 599 (Conn. 1987).
107. *White v. Unigard Mut. Ins. Co.*, 730 P.2d 1014, 1017-20 (Idaho 1986).
108. *Dolan v. Aid Ins. Co.*, 431 N.W.2d 790, 794 (Iowa 1988).
109. *Curry v. Fireman's Fund Ins. Co.*, 784 S.W.2d 176, 178 (Ky. 1989).
110. *See State Farm Fire & Casualty Co. v. Simpson*, 477 So. 2d 242, 248-52 (Miss. 1985).
111. *Lipinski v. Title Ins. Co.*, 655 P.2d 970, 977 (Mont. 1982).
112. *Braesch v. Union Ins. Co.*, 464 N.W.2d 769, 772-76 (Neb. 1991).
113. *United Fire Ins. Co. v. McClelland*, 780 P.2d 193, 197 (Nev. 1989).
114. *State Farm Gen. Ins. Co. v. Clifton*, 527 P.2d 798, 800 (N.M. 1974).
115. *Corwin Chrysler-Plymouth, Inc. v. Westchester Fire Ins. Co.*, 279 N.W.2d 638, 643 (N.D. 1979).
116. *Hoskins v. Aetna Life Ins. Co.*, 452 N.E.2d 1315, 1319 (Ohio 1983).
117. *Christian v. American Home Assurance Co.*, 577 P.2d 899, 904-05 (Okla. 1978).
118. *Bibeault v. Hanover Ins. Co.*, 417 A.2d 313, 319 (R.I. 1980). In 1978, the Rhode Island Supreme Court rejected a cause of action for first-party bad faith in a case involving a fire insurance policy because the terms of the policy, as is the case with most fire policies in the United States, had been prescribed by legislation. *A.A.A. Pool Serv. & Supply, Inc. v. Aetna Casualty & Sur. Co.*, 395 A.2d 724, 725-26 (R.I. 1978). The court reasoned that it was for the legislature to provide any extra-contractual remedies in such cases. *Id.* at 726. Two years later, in *Bibeault*, the court limited the application of *A.A.A. Pool Service* to fire policies and recognized the tort of bad faith in a case dealing with uninsured motorist coverage, another legislatively prescribed form of coverage. *See* 417 A.2d at 317.
- In 1981, however, the Rhode Island legislature extended the cause of action for bad faith to all insurance contracts. Act of May 20, 1981, ch. 235, § 1, 1981 R.I. Pub. Laws 966. The statute creates a private cause of action for "compensatory damages, punitive damages and reasonable attorney fees" under any insurance policy where the insurer "wrongfully and in bad faith refused to pay or settle a claim made pursuant to the provisions of said policy, or otherwise wrongfully and in bad faith refused to timely perform its obligations under said contract of insurance." R.I. GEN. LAWS § 9-1-33 (1985).
119. *Nichols v. State Farm Mut. Auto. Ins. Co.*, 306 S.E.2d 616, 619 (S.C. 1983).
120. *In re Certification of a Question of Law*, 399 N.W.2d 320, 324 (S.D. 1987).
121. *Arnold v. National County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987).
122. *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 374 (Wis. 1978).
123. *McCullough v. Golden Rule Ins. Co.*, 789 P.2d 855, 856-60 (Wyo. 1990).

A few federal courts and inferior state courts also have recognized such a cause of action.¹²⁴

In contrast, the highest courts of Indiana,¹²⁵ New Hampshire,¹²⁶ Utah,¹²⁷ and West Virginia¹²⁸ have recognized the right to recover damages beyond the policy benefits under some expanded version of the rules prescribing damages for breach of contract. Although the first three jurisdictions mentioned have refused to ground the new remedies against insurers in

124. See *Justin v. Guardian Ins. Co.*, 670 F. Supp. 614, 616 (D.V.I. 1987); *Washington v. Group Hospitalization, Inc.*, 585 F. Supp. 517, 520 (D.D.C. 1984); *Phillips v. Aetna Life Ins. Co.*, 473 F. Supp. 984, 989 (D. Vt. 1979); *Dailey v. Integon Gen. Ins. Corp.*, 331 S.E.2d 148, 153-54 (N.C. Ct. App. 1985), *review denied*, 336 S.E.2d 399 (N.C. 1985). The Illinois appellate courts have split on whether to recognize the tort of bad faith in first-party insurance contracts. Compare *Ledingham v. Blue Cross Plan for Hosp. Care*, 330 N.E.2d 540, 548 (Ill. App. Ct. 1975) (recognizing the tort of bad faith), *rev'd on other grounds*, 356 N.E.2d 75 (Ill. 1976) with *Debolt v. Mutual of Omaha*, 371 N.E.2d 373, 376-78 (Ill. App. Ct. 1978) (refusing to recognize a tort remedy because a statute already allowed the recovery of attorneys' fees when an insurer's refusal to pay was "vexatious and without reasonable cause").

The United States Court of Appeals for the Third Circuit originally predicted that the New Jersey Supreme Court would recognize the insurer's duty to act in good faith and to deal fairly in the settlement of claims, and that such a duty supports a claim for consequential damages. See *Polito v. Continental Casualty Co.*, 689 F.2d 457, 463 (3d Cir. 1982). This position, until recently, was consistently repudiated by the New Jersey Appellate Division. See *Wine Imports, Inc. v. Northbrook Property & Casualty Ins. Co.*, 708 F. Supp. 105, 107 (D.N.J. 1989) (citing New Jersey Appellate Division cases). In 1991, however, the New Jersey Appellate Division, while acknowledging that there was no cause of action for "emotional or physical distress" or for punitive damages for an insurer's wrongful denial of a claim, held that there was a cause of action for economic consequential damages in an action for bad-faith refusal to process and pay an insurance claim when these damages were reasonably foreseeable at the time the contract was entered. *Pickett v. Lloyds*, 600 A.2d 148, 152 (N.J. Super. Ct. App. Div. 1991), *cert. granted*, 606 A.2d 373 (1992); see also *Haardt v. Farmer's Mut. Fire Ins. Co.*, 796 F. Supp. 804, 810-11 (D.N.J. 1992) (following *Pickett v. Lloyds*).

125. *Vernon Fire & Casualty Ins. Co. v. Sharp*, 349 N.E.2d 173, 180 (Ind. 1976) (recognizing that punitive damages may be awarded for breach of contract under special circumstances); see also *Liberty Mut. Ins. Co. v. Parkinson*, 487 N.E.2d 162, 165 (Ind. Ct. App. 1985) (recognizing that compensatory damages for economic losses caused by insurer's unjustified delay in settling a first-party claim may be recovered).

126. *Lawton v. Great S.W. Fire Ins. Co.*, 392 A.2d 576, 581-82 (N.H. 1978) (recognizing that compensatory damages for economic losses, but not for emotional distress, caused by insurer's unjustified delay in settling first-party claim may be recovered); see also *Drop Anchor Realty Trust v. Hartford Fire Ins. Co.*, 496 A.2d 339, 344 (N.H. 1985) (awarding attorneys' fees to an insured for the insurer's wrongful refusal to settle first-party claim).

127. *Beck v. Farmers Ins. Exch.*, 701 P.2d 795, 802 (Utah 1985) (recognizing that consequential damages for economic loss and emotional distress, as well as attorneys' fees, are recoverable for an insurer's wrongful refusal to settle a first-party claim).

128. *Hayseeds, Inc. v. State Farm Fire & Casualty*, 352 S.E.2d 73, 80 (W. Va. 1986) (recognizing the right to attorneys' fees and consequential damages for net economic loss and aggravation and inconvenience when an insured substantially prevails against a property insurer, as well as punitive damages where the insurer knew that the insured's claim was proper, but willfully, maliciously, and intentionally denied the claim).

tort, they have required proof of wrongful conduct on the part of the insurer for recovery of consequential damages.¹²⁹ This conduct is very similar, if not identical, to that required by some courts for the tort of bad faith. West Virginia, on the other hand, appears to employ a test that can only be described as strict liability.¹³⁰

Florida also recognizes extra-contractual damages, but it has created a private cause of action by statute¹³¹ under which

129. *See supra* notes 125–27. The fact that the tort of bad faith was rejected, however, has left these courts with the task of articulating a standard of culpability that would justify the extra-contractual damages. Thus far, that standard is none too clear.

130. West Virginia rejected the concepts of “good faith” and “bad faith,” along with the concepts of “reasonable,” “unreasonable,” and “wrongful,” in enunciating a test for liability for economic loss and aggravation and inconvenience. *See Hayseeds*, 352 S.E.2d at 80. The test, which could be one of strict liability where the insurer took a reasonable, but ultimately incorrect, position in denying a claim, is simply a question of whether the insured “substantially prevails” in a suit against a property insurer. *Id.*

131. The Florida statute states, in pertinent part:

(1) Any person may bring a civil action against an insurer when such person is damaged:

....

(b) By the commission of any of the following acts by the insurer:

1. Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for his interests;

2. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

3. Except as to liability coverages, failing to promptly settle claims, when the obligation to settle a claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

Notwithstanding the provisions of the above to the contrary, a person pursuing a remedy under this section need not prove that such act was committed or performed with such frequency as to indicate a general business practice.

....

(3) Upon adverse adjudication at trial or upon appeal, the insurer shall be liable for damages, together with court costs and reasonable attorney’s fees incurred by the plaintiff.

(4) No punitive damages shall be awarded under this section unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and these acts are:

(a) Willful, wanton, and malicious;

(b) In reckless disregard for the rights of any insured; or

(c) In reckless disregard for the rights of a beneficiary under a life insurance contract.

Any person who pursues a claim under this subsection shall post in advance the costs of discovery. Such costs shall be awarded to the insurer if no punitive damages are awarded to the plaintiff.

....

insurers may be held liable for bad faith in dealing with claims of their insureds.¹³² Thus, in twenty-nine states in this country, insurers are now faced with the prospect of a suit for extra-contractual damages every time they fail to pay the claims of their insureds fully and in a timely manner. In fact, counts containing such claims are included so routinely in lawsuits against insurance companies that one has to wonder if the claims practices of insurers in fact have deteriorated so badly. Common sense would question such a proposition and, at the very least, calls for closer scrutiny of these new causes of action.

B. Are Insurers That Bad?

There is no doubt that insurers do treat individual insureds badly on occasion, and every so often a particular insurer may even engage in a general practice of unfair treatment.¹³³

(7) The civil remedy specified in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state. Any person may obtain a judgment under either the common law remedy of bad faith or this statutory remedy, but shall not be entitled to a judgment under both remedies. This section shall not be construed to create a common law cause of action. The damages recoverable pursuant to this section shall include those damages which are a reasonably foreseeable result of a specified violation of this section by the insurer and may include an award or judgment in an amount that exceeds the policy limits.

FLA. STAT. ch. 624.155 (Supp. 1991).

Although subsection (7) of the Florida statute permits an insured to resort to the "common law remedy of bad faith," the Supreme Court of Florida has never recognized such a cause of action, nor have the lower courts. See *Opperman v. Nationwide Mut. Fire Ins. Co.*, 515 So. 2d 263, 265-66 (Fla. Dist. Ct. App. 1987), *review denied*, 523 So. 2d 578 (Fla. 1988).

132. Rhode Island is the only other state to codify a cause of action for bad faith. See *supra* note 118.

133. See, e.g., *Hawkins v. Allstate Ins. Co.*, 733 P.2d 1073, 1083-85 (Ariz.) (upholding \$15,000 compensatory and \$3.5 million punitive damages awards where evidence supported the conclusion that the insurer engaged in a general practice of routine, automatic deductions, regardless of their validity, in valuing insureds' losses under auto collision coverage), *cert. denied*, 484 U.S. 874 (1987); *Republic Ins. Co. v. Hires*, 810 P.2d 790, 791-93 (Nev. 1991) (upholding a \$410,000 compensatory award but reducing a \$22.5 million punitive award to \$5 million where the insurer made it a practice, particularly with regard to lower- and middle-income policyholders who are less likely to dispute the insurer's position, to offer to settle claims for amounts substantially below their true value and then by delay, harassment, and intimidation force claimants to accept settlement for amounts less than what was actually due). Such cases represent the exception, however, rather than the rule. In reviewing all of the first-party bad-faith decisions by

Although such practices by insurers do occur, they are by no means limited to insurers. On the contrary, they seem to be inherent in any large institution. Government agencies, as well as private corporations, are largely bureaucracies, and bureaucracies by nature fail to take into account individual needs. In an attempt to administer the functions of a large and complex enterprise systematically, be it government or private, there is a need for organization which, in turn, leads to divisions having specialized functions and actions dictated by fixed rules under a hierarchy of authority. That kind of organization often lacks the flexibility needed for attention to unique individual needs. Without such attention, there are opportunities for mistreatment of individuals without and within the organization.

Insurance companies are no exception when it comes to their insureds. In an attempt to be efficient, claims are handled on a mass-production basis. This type of claims process inevitably leads to errors, but it does not mean that every incorrect denial is the result of bad faith. In fact, very few fit in this category if by bad faith one means that the insurer has acted in a completely capricious or, in the language of the model unfair claims practices legislation developed by the NAIC, a flagrant and conscious manner.¹³⁴ Nevertheless, even though abuses may be a predictable and even an understandable phenomenon, they do not have to be tolerated, especially when the public interest is affected seriously. The question, rather, is how to minimize the mistreatment most efficaciously. After all, the insureds ultimately are paying the freight.

C. Undue Exposure Can Be Debilitating

In the context of insurance claims practices, it is clear that some measures were needed to redress the legitimate

the courts of last resort in this country, I found that the overwhelming majority of cases involved allegations of isolated conduct rather than any practice or pattern by a particular insurer, much less by the insurance industry as a whole. As noted previously, this is one of the reasons why the unfair claims practice legislation adopted by most states failed to provide adequate remedies to the individual insured. See *supra* text accompanying notes 47-52.

134. See *supra* text accompanying note 49.

complaints of insureds, but now it appears that the balance may have been tipped too far in their favor by unduly exposing insurers to extra-contractual damages. The judicial filling of the vacuum left by the legislative and administrative processes was justified when it was made; real abuses by insurers need to be identified and corrected. Nevertheless, the new tort remedy, although necessary in some form, now shows signs of being too oppressive on an industry whose financial vitality and efficiency are essential to social well-being. Multimillion dollar awards for wrongfully denying claims not only are unnecessary to correct the situation, but such awards, which often have a windfall nature,¹³⁵ may raise the cost of insurance for the vast numbers of insureds who are not mistreated and may do great harm to the risk-transfer-and-distribution mechanism in our society by making insurance so expensive that it can no longer be purchased like a household commodity. There is a point at which potential insureds will either elect reduced coverage or forgo purchases or other activities because of insurance costs. This negative impact certainly could extend to and affect the standard of living for individuals if too much of their income must be spent on premiums that spread the costs of awards for extra-contractual damages and the related expenses of defending against such claims, in addition to covering the primary risks insured against. On a larger scale, it could negate that which may otherwise be economically and socially achievable in this country, particularly if the punitive awards are not better regulated.

There is a delicate balance in the interdependent relationship between risk distribution and the economic development of any society.¹³⁶ If the relationship becomes unbalanced in either direction, it could retard economic development. When insurance costs absorb a disproportionate amount of the gross national product, particularly when a substantial part of that cost goes to pay for noneconomic consequential harm and

135. Very frequently bad-faith awards contain punitive damages that are many times the amount of compensatory damages. See, e.g., *Eichenseer v. Reserve Life Ins. Co.*, 934 F.2d 1377, 1380, 1386 (5th Cir. 1991) (awarding \$1000 in compensatory damages and \$500,000 in punitive damages); *Gourley v. State Farm Mut. Auto. Ins. Co.*, 806 P.2d 1342, 1344 (Cal. 1991) (awarding \$16,000 in compensatory damages and \$1.5 million in punitive damages). Although there are sound policy reasons for awarding some amount of punitive damages, it still must be recognized that such damages do not compensate any loss and that some insureds are made wealthy quite fortuitously.

136. See *supra* notes 30-32 and accompanying text.

punitive awards as contrasted to losses against which the insurance was purchased, the cost of spreading loss may hinder, rather than facilitate, economic development. This arrested development will adversely affect the ability to achieve social goals. Thus, a proper balance must be struck between the interests of insureds and insurers.

Achieving that balance through the common-law development of the tort of bad faith has not been completely satisfactory. The common-law process is, at best, fitful; and there is no guarantee that the courts will develop a definitive and timely answer to the problems. The issues must be recognized first and then properly framed at the trial level. Even when the issues are preserved properly, there is no assurance that they will be resolved on appeal. As to appellate resolutions, so much depends on the participants and their abilities to define the issues and to articulate clear solutions. Moreover, the judicial process of common-law decision making is not designed to develop all the information necessary to make informed choices as to the proper solution to a perceived problem. The legislative process is often the best vehicle. Thus, judges cannot and should not do it all. Largely because of the unpredictability of and the inherent limitations on the judicial process, the new causes of action have proven to be a relatively crude and oppressive remedy for a situation that requires the interests at stake to be balanced more delicately, and to be balanced the same way throughout the United States. At the very least, there is definitely room for improvement, particularly with regard to the standard of culpability and the available remedies.

IV. THE STANDARD OF CULPABILITY

A. *What Constitutes "Bad Faith"?*

In their attempts to impose new obligations in the relationships established by an insurance contract, the courts seized on the basic principle that there is a duty of good faith and fair dealing arising from every contract.¹³⁷ In the context of

137. See *supra* note 97 and accompanying text.

insurance contracts, neither the insured nor the insurer is to do anything to prevent the other from receiving the benefit of his bargain.¹³⁸ This principle obviously influenced the label given by most courts to the new cause of action, the "tort of bad faith." The term "bad faith," however, is not self-defining, nor has it historically been a recognized, independent basis of culpability in tort law. It has come to mean different things to different courts.¹³⁹ Consequently, its use has caused definitional problems from the outset.

Early on, in the attempt to define the duty of a liability insurer to settle claims against its insureds, courts struggled to articulate the appropriate standard of culpability when the insurer was alleged to have breached its duty of good faith and fair dealing.¹⁴⁰ Did the cause of action require a conscious disregard of the insured's interests, or did it only require a failure of the insurer to exercise due care in the settlement process?¹⁴¹ Was "bad faith" just the converse of "good faith" or did the former involve a different standard?¹⁴² Did the standard encompass both a duty to exercise due care, an objective standard, and a duty to act in good faith, a subjective standard?¹⁴³ Did "bad faith" mean that the insured had to prove the insurer acted maliciously or from evil motives?¹⁴⁴ All of these issues were raised in the context of third-party insurance situations, but there were no definitive answers.

B. The Third-Party Cases

A number of courts, in the course of addressing third-party insurance issues, concluded that the standard had to be

138. See *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 200-01 (Cal. 1958).

139. See *Hilker v. Western Auto. Ins. Co.*, 235 N.W. 413, 414 (Wis. 1931) (discussing the duty of good faith that an insurer owes to an insured).

140. See *Crisci v. Security Ins. Co.*, 426 P.2d 173, 176 (Cal. 1967); *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 200-01 (Cal. 1958); *Brown v. Guarantee Ins. Co.*, 319 P.2d 69, 75 (Cal. Dist. Ct. App. 1957); *Eastham v. Oregon Auto. Ins. Co.*, 540 P.2d 364, 367 (Or. 1975), *reh'g denied*, 542 P.2d 895 (Or. 1975); see also Robert E. Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1139-48 (1954) (discussing various standards used to define the duty to settle).

141. See KEETON & WIDISS, *supra* note 19, § 7.8(b).

142. See *id.*

143. See *id.*

144. See *id.*

defined by reference to the fact that the relationship between the insured and insurer under a liability policy may be viewed as fiduciary in nature.¹⁴⁵ Nonetheless, this conclusion did not lead to agreement among the courts that the test for liability should be framed in traditional terms. The decision whether the liability insurer did or did not have a duty to defend typically required only answering a relatively simple question of contract law: Did the alleged facts upon which the third-party claim was based fall within the coverage provided to the insured?¹⁴⁶

In comparison, the decision whether the insurer should have settled the claim against its insured required more complex work. The latter required an evaluation of how the insurer should have acted. Even after the facts were found as to how the insurer did act, there still had to be some judgment regarding the decision of the insurer whether or not to settle the claim against its insured, a decision that involved such imponderables as what the trier of fact might decide as to the merits of the claim if the case were not settled. This decision, usually to be rendered by a jury of laypersons, quite often would involve the issue of liability as well as that for damages. How should the insurer's prediction regarding the resolution of these issues be reviewed once a verdict was in fact rendered that exceeded the policy limits? Was the test to be one of whether the insurer honestly believed there would be a very small risk that the jury would find the insured to be liable or that, even if found liable, the risk of a verdict in excess of the policy limit was remote? Or was the test to be what an ordinarily prudent liability insurer would have done under the circumstances? The former involved a factual inquiry alone while the latter required that the facts, once found, be compared with a norm. The test to be selected was not self-evident, nor could it have been because the duty had a schizophrenic quality to it.

Resolution of the issue seemed to be stymied by the fact that the new duty arose out of a contractual relationship, the

145. See, e.g., *Farmers Group, Inc. v. Trimble*, 691 P.2d 1138, 1142 (Colo. 1984).

146. Some courts have given a broader interpretation to the duty to defend, including situations where the insurer is aware of facts that may give rise to coverage even though not pled by the third-party claimant. See, e.g., *Lanoue v. Fireman's Fund Am. Ins. Cos.*, 278 N.W.2d 49, 53 (Minn. 1979); *Fitzpatrick v. American Honda Motor Co., Inc.*, 575 N.E.2d 90, 92-94 (N.Y. 1991).

breach of which usually is not determined by any standard of culpability. Yet the court had to select a standard by which the duty to settle could be judged, a duty that called both for good faith and fair dealing.¹⁴⁷ The duty seemed to call for two inconsistent tests: (1) an evaluation of the insurer's conduct in comparison with some norm in order to determine whether the insurer had dealt with the insured fairly; and (2) a determination whether the insurer honestly believed that what it was doing was the correct thing to do. A normative standard is, in effect, an objective standard and is inconsistent with the possibility of framing the issue in terms of whether the insurer had acted in an honest belief, that is, in good faith. Good faith is a subjective standard that involves a test of what the actor knew and thought and does not require any comparison with a norm. Thus, good faith is more consistent with a test that inquires whether the harm to the insured has been caused intentionally or recklessly, whereas a test of fair dealing is more consistent with the use of a standard such as that for negligence. The courts could have opted for a subjective test that would have made the breach of the duty to settle an intentional or reckless tort, or they might have chosen an objective test that would have made the breach a negligence-based tort. They did neither.¹⁴⁸

Rather than employing these more orthodox tort terms exclusively, the courts also talked about the amount of consideration the insurer should give to the insured's interests,¹⁴⁹ injecting notions of loyalty that arose from the fiduciary aspects of the relationship. Viewing the relationship as fiduciary in nature may have obfuscated, if not confounded, the resolution in tort terms. It was obvious that both the insurer and the insured had legitimate interests in the

147. See *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 200-01 (Cal. 1958) (holding that the implied covenant of good faith and fair dealing that arises in every contract requires the insurer to settle in an appropriate case even though the express terms of the policy do not impose such a duty).

148. Although two courts have discussed the possibility of adopting a standard of strict liability where an excess verdict is returned after a liability insurer fails to accept a settlement offer, such a standard has yet to be adopted. See *Crisci v. Security Ins. Co.*, 426 P.2d 173, 177 (Cal. 1967); *Rova Farms Resort, Inc. v. Investors Ins. Co. of Am.*, 323 A.2d 495, 510 (N.J. 1974).

149. Most courts have held that the insurer must give equal consideration to the insured's interests in deciding whether to accept a settlement offer. A few have held that the insurer must give greater consideration to the insured's interests than it gives to its own. See KEETON & WIDISS, *supra* note 19, § 7.8(b)(2).

settlement question. Just as obviously, their interests did not necessarily lead to the same answer.¹⁵⁰ The imposition of a requirement that the insurer demonstrate greater fidelity to the interests of the insured than to its own interests, a requirement traditionally imposed on a fiduciary,¹⁵¹ appeared to be the imposition of a duty to settle in any case where there was any appreciable risk of an excess judgment. A settlement would be required even when the risk was very low that the claimant would win at all or that there would be an excess judgment even if the claimant won. Thus, imposition of the traditional obligations of a fiduciary would deny to the insurer the ability to look after its own interests, which included the interests of all of its insureds. The particular insured's interest would be paramount, necessitating a settlement unless the third-party claim was clearly groundless.

The courts were not prepared to take the fiduciary theory so far and the resulting tension may have led some courts to speak simultaneously of requirements of good faith and of due care.¹⁵² The articulation of both a subjective and an objective standard, inconsistent as they may be, seemed to be a way of confirming that the insurer did not owe complete fidelity to its insured to the exclusion of any concern for its own interests.¹⁵³ On the other hand, many courts were not convinced that a pure tort analysis produced the appropriate balance between the parties given the position of control of the litigation by a liability insurer.¹⁵⁴ In any event, this was the state of the law defining a liability insurer's duty to settle third-party claims that provided the backdrop against which the courts were to recognize a cause of action for "bad faith" in first-party situations.

150. See *supra* notes 71-75 and accompanying text.

151. See 2A AUSTIN W. SCOTT & WILLIAM F. FRATCHER, *THE LAW OF TRUSTS* § 170 (4th ed. 1987).

152. See, e.g., *Glenn v. Fleming*, 799 P.2d 79, 89 (Kan. 1990).

153. For example, in *Maine Bonding & Casualty Co. v. Centennial Insurance Co.*, the court acknowledged that in the past it had used the terms "good faith," "bad faith," and "due care" in defining a liability insurer's duty regarding settlements, but now said that to do so tends to inject an inappropriate subjective element—the insurer's state of mind—into the formula. See 693 P.2d 1296, 1299 (Or. 1985). The court went on to hold that the insurer's duty is best expressed by an objective test, namely, whether the insurer exercised due care under the circumstances. See *id.*

154. See KEETON & WIDISS, *supra* note 19, § 7.8(b).

Yet even though the third-party decisions were relied on to recognize a new cause of action in first-party cases, they were of little help in defining the duty in first-party cases. The relationship between the insurer and insured in the latter cases did not involve the power of the insurer to control the third-party tort litigation and did not evoke any notions of fiduciary obligations. Thus, there was no occasion to talk in terms of giving equal consideration to the interests of the insured. By hindsight, the third-party cases provided a poor analogy for recognizing a tort duty in first-party cases¹⁵⁵ and it is no wonder that they were of little assistance in developing the standard of culpability for the new cause of action. In fact, the two types of relationships were not "merely two different aspects of the same duty."¹⁵⁶

C. The First-Party Cases

The standard for determining liability in the early first-party cases once again was expressed in terms of a duty of good faith and fair dealing,¹⁵⁷ just as in the original third-party cases. Although the breach of the duty in first-party cases was characterized ambiguously as an act of "bad faith," the early decisions talked more in terms of requiring conscious wrongdoing by an insurer.¹⁵⁸ The refusal to pay a claim in the face of insurer knowledge that there was no reasonable basis for doing so was the paradigm situation. There was no doubt that when the insurer acted in such an unjustifiable manner,

155. Some courts have refused to recognize the tort of bad faith in first-party cases, at least in part, because the first-party insurance relationship does not give rise to a fiduciary obligation on the part of the insurer. See *Lawton v. Great S.W. Fire Ins. Co.*, 392 A.2d 576, 580 (N.H. 1978); *Farris v. United States Fidelity & Guar. Co.*, 587 P.2d 1015, 1019 (Or. 1978). *But cf.* *Drop Anchor Realty Trust v. Hartford Fire Ins. Co.*, 496 A.2d 339 (N.H. 1985) (recognizing that consequential economic loss and attorneys' fees may be recovered in first-party cases for breach of contract).

156. See *supra* text accompanying note 98.

157. See *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032, 1037 (Cal. 1973) (relying on third-party cases).

158. See *id.* at 1038; *Grand Sheet Metal Prods. Co. v. Protection Mut. Ins. Co.*, 375 A.2d 428, 429 (Conn. Super. Ct. 1977); *Ledingham v. Blue Cross Plan for Hosp. Care*, 330 N.E.2d 540, 546 (Ill. App. Ct.), *rev'd on other grounds*, 356 N.E.2d 75 (Ill. 1976); *State Farm Gen. Ins. Co. v. Clifton*, 527 P.2d 798, 800 (N.M. 1974); *Christian v. American Home Assurance Co.*, 577 P.2d 899, 904 (Okla. 1978).

that is, with actual knowledge of no reasonable basis for refusal, the new cause of action incorporated a subjective test that would fit comfortably within the orthodox definition of an intentional tort.¹⁵⁹ If limited to such circumstances, the tort of bad faith in first-party situations would have been a less formidable development in the law and certainly not as devastating to the rule of *Hadley v. Baxendale*. The cases did not follow this path, however. It was not long before the term "bad faith" was employed to mean something more, raising serious questions as to exactly what conduct was included in the meaning of the term.

In 1978, the Supreme Court of Wisconsin decided *Anderson v. Continental Insurance Co.*¹⁶⁰ and took the lead in the area by articulating a detailed standard of culpability. Although the Wisconsin court specifically referred to the new cause of action as an intentional tort,¹⁶¹ the opinion appeared to go beyond the orthodox definition of intent¹⁶² as it sought to delineate the standard of culpability for the new tort:

159. The second Restatement of Torts provides, "The word 'intent' is used throughout the Restatement of this Subject to denote that the actor desires to cause consequences of his act, or that he believes that the consequences are substantially certain to result from it." RESTATEMENT (SECOND) OF TORTS § 8A (1965). The drafters explained:

a. "Intent," as it is used throughout the Restatement of Torts, has reference to the consequences of an act rather than the act itself. When an actor fires a gun in the midst of the Mojave Desert, he intends to pull the trigger; but when the bullet hits a person who is present in the desert without the actor's knowledge, he does not intend that result. "Intent" is limited, wherever it is used, to the consequences of the act.

b. All consequences which the actor desires to bring about are intended, as the word is used in this Restatement. Intent is not, however, limited to consequences which are desired. If the actor knows that the consequences are certain, or substantially certain, to result from his act, and still goes ahead, he is treated by the law as if he had in fact desired to produce the result. As the probability that the consequences will follow decreases, and becomes less than substantial certainty, the actor's conduct loses the character of intent, and becomes mere recklessness, as defined in § 500. As the probability decreases further, and amounts only to a risk that the result will follow, it becomes ordinary negligence, as defined in § 282. All three have their important place in the law of torts, but the liability attached to them will differ.

Id. cmts. a, b.

160. 271 N.W.2d 368 (Wis. 1978).

161. *Id.* at 376.

162. See *supra* note 159.

To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one. "Bad faith" by definition cannot be unintentional. . . .

While we have stated above that, for proof of bad faith, there must be an absence of a reasonable basis for denial of policy benefits *and* the knowledge or reckless disregard of a reasonable basis for a denial, implicit in that test is our conclusion that the knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless disregard of a lack of a reasonable basis for denial or a reckless indifference to facts or to proofs submitted by the insured.

Under these tests of the tort of bad faith, an insurance company, however, may challenge claims which are fairly debatable and will be found liable only where it has intentionally denied (or failed to process or pay) a claim without a reasonable basis.¹⁶³

This formulation has proved to be the most complete by any court to date and a number of jurisdictions have followed it in first-party insurance cases. Nonetheless, not all courts have seen fit to embrace it.

Of the twenty-nine jurisdictions that now permit extra-contractual damages in first-party insurance cases on some basis akin to the tort of bad faith,¹⁶⁴ ten purport to follow the *Anderson* test.¹⁶⁵ These courts have not indicated that they are willing to embrace any standard of culpability other than

¹⁶³ *Anderson*, 271 N.W.2d at 376-77.

¹⁶⁴ See *supra* notes 101-131.

¹⁶⁵ See *Gulf Atl. Life Ins. Co. v. Barnes*, 405 So. 2d 916, 924 (Ala. 1981); *State Farm Fire & Casualty Co. v. Nicholson*, 777 P.2d 1152, 1154 n.3 (Alaska 1989) (approving a jury instruction using, *inter alia*, "reckless indifference" to the interests or rights of an insured); *Travelers Ins. Co. v. Savio*, 706 P.2d 1258, 1274 (Colo. 1985); *Curry v. Fireman's Fund Ins. Co.*, 784 S.W.2d 176, 178 (Ky. 1989) (adopting the dissenting opinion in *Federal Kemper Ins. Co. v. Hornback*, 711 S.W.2d 844, 846-47 (Ky. 1986), which argued for adoption of the *Anderson* test); *Braesch v. Union Ins. Co.*, 464 N.W.2d 769, 778 (Neb. 1991); *Motorists Mut. Ins. Co. v. Said*, 590 N.E.2d 1228, 1235-36 (Ohio 1992); *Bibeault v. Hanover Ins. Co.*, 417 A.2d 313, 319 (R.I. 1980); *In re Certification of Question of Law*, 399 N.W.2d 320, 324 (S.D. 1987); *Fehring v. Republic Ins. Co.*, 347 N.W.2d 595, 600-01 (Wis. 1984); *McCullough v. Golden Rule Ins. Co.*, 789 P.2d 855, 860 (Wyo. 1990).

intentional or reckless conduct. On the other hand, two other jurisdictions have expanded the basis of culpability to include gross negligence,¹⁶⁶ and as many as three others may have extended the tort to encompass negligent conduct.¹⁶⁷ One jurisdiction appears even to have adopted strict liability as the test, albeit on a theory of breach of contract.¹⁶⁸ The courts

166. See *Aetna Casualty & Sur. Co. v. Day*, 487 So. 2d 830, 832 (Miss. 1986); *Jessen v. National Excess Ins. Co.*, 776 P.2d 1244, 1247 (N.M. 1989).

167. South Carolina has held that "the jury is entitled to consider negligence on the issue of unreasonable refusal to pay benefits." *Nichols v. State Farm Mut. Auto. Ins. Co.*, 306 S.E.2d 616, 620 (S.C. 1983). In addition, Iowa and Texas may permit negligent conduct to suffice for a bad-faith claim.

In *Kiner v. Reliance Insurance Co.*, the Supreme Court of Iowa was asked to pass judgment on an instruction that required the jury to find that the insurer "knew or should have known there was not a reasonable basis for denying payment" as the test for bad faith. 463 N.W.2d 9, 12 (Iowa 1990) (emphasis omitted). The insurer argued that under Iowa law the plaintiff was required to prove that the insurer knew or recklessly disregarded the fact that there was no reasonable basis for denying the claim and that this involves an element of intent which was lacking in the instruction. *Id.* In a somewhat confusing opinion, the court first said that in the context of bad-faith claims that "reckless disregard" would exist if an insurer knows or has reason to know that it has no basis for denying the claim but does so anyway. See *id.* (citing RESTATEMENT (SECOND) OF TORTS § 500 (1965)). Then the court intimated that this standard for "reckless disregard" was somehow different from that employed in *Anderson* and that "reckless disregard" in the latter sense was not a necessary element in a bad-faith claim. See *id.* at 13. The court since has stated that the *Kiner* decision modified the second part of the *Anderson* test. See *Reuter v. State Farm Mut. Auto. Ins. Co.*, 469 N.W.2d 250, 253 (Iowa 1991). However, it is not clear how *Kiner* differs from *Anderson* in practice.

Kiner would appear to adopt the Restatement definition of "reckless," which requires the actor to know or "have reason to know" that there is a great risk that harm will ensue from her conduct. See RESTATEMENT (SECOND) OF TORTS § 500 (1965). However, the *Kiner* court cited the Texas Supreme Court case of *Aranda v. Insurance Co. of North America* in support of its holding that the Iowa jury instruction correctly stated the law in that the test used there was substantially the same as that approved in the Texas case. See 463 N.W.2d at 13 (citing *Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210 (Tex. 1988)). In *Aranda*, the Texas court held that the insured must prove that the insurer "knew or should have known" that there was no reasonable basis for denying the claim. 748 S.W.2d at 213.

The Restatement draws a distinction between "having reason to know" and "should know," see RESTATEMENT (SECOND) OF TORTS § 12 (1965), and uses only the former to define "reckless," reserving the latter for lesser forms of culpability such as negligence, see *id.* § 500 & cmts. In any event, if Iowa and Texas permit a finding of bad faith on the basis that the insurer "should have known" that there was no reasonable basis for denying the claim, they are employing a negligence standard. For more discussion on the difference between reckless and negligent conduct, see *infra* text accompanying notes 175-79.

168. The Supreme Court of West Virginia has stated:

It is now the majority rule in American courts that when an insurer wrongfully withholds or unreasonably delays payment of an insured's claim, the insurer is liable for all foreseeable, consequential damages naturally flowing from the delay. Unfortunately, awards of consequential damages currently turn on judicial interpretation of such malleable and easily manipulated concepts as "reasonable," "unreasonable," "wrongful," "good faith" and "bad faith." We believe that the

in the remaining thirteen jurisdictions¹⁶⁹ have not indicated clearly whether they will go beyond some test akin to that for an intentional tort and, if so, whether they will stop at the perimeters of *Anderson*. Moreover, as will be discussed below, on close examination the perimeters of *Anderson* are not all that well defined. Even if more courts were to follow the Wisconsin decision, there is still a great deal of work to be done on the definition of "bad faith."

D. Defining the Levels of Culpability

Although the *Anderson* definition of the standard of culpability for the tort of bad faith has garnered the most support, it is not as clear as it might be. At best, the test is ambiguous as to its inclusion of reckless conduct; moreover, it is unclear what the court means when it says that intent may be inferred

interests of both the parties and the judicial system would be better served by the enunciation of a clear, bright line standard governing the availability of consequential damages in property damages insurance cases. Accordingly, we hold today that when a policyholder substantially prevails in a property damage suit against an insurer, the policyholder is entitled to damages for net economic loss caused by the delay in settlement, as well as an award for aggravation and inconvenience.

Hayseeds, Inc. v. State Farm Fire & Casualty, 352 S.E.2d 73, 80 (W. Va. 1986) (citation omitted).

169. Of the remaining thirteen jurisdictions, Indiana, New Hampshire, and Utah have rejected tort as the basis for consequential damages in bad faith cases. *See supra* text accompanying notes 125–127. At present they have required some type of conscious wrongdoing, even though the cause of action is based on a breach of contract theory. It remains to be seen whether they will follow the lead of West Virginia in eventually applying a test of strict liability. *See supra* text accompanying notes 129–30.

Florida has a statutory right to recover that appears to employ strict liability for failure to provide a statement setting forth the coverage under which payments are being made, but may have limited other claims to conscious wrongdoing. *See supra* note 131.

At one point, Arizona expressly reserved the question of whether negligence will suffice and was conspicuously ambiguous on the issue of whether reckless conduct will support a cause of action for bad faith. *See Rawlings v. Apodaca*, 726 P.2d 565, 576 (Ariz. 1986). However, as this Article was in press, the Arizona Supreme Court, in summarizing its prior decisions on the subject, stated that the tort of bad faith could not be proven by showing mere negligence, but that it required proof that the insurer knew its conduct was unreasonable or acted so recklessly that such knowledge could be imputed to it. *See Deese v. State Farm Mut. Auto. Ins. Co.*, 838 P.2d 1265, 1268–69 (Ariz. 1992).

The other eight states—Arkansas, California, Connecticut, Idaho, Montana, Nevada, North Dakota, and Oklahoma—have not indicated whether they will follow *Anderson* or develop a different basis for liability for the tort of bad faith in first-party insurance cases.

from such conduct.¹⁷⁰ At worst, the *Anderson* test may lead to an unwarranted expansion of the tort of bad faith beyond intentional or reckless conduct because of the court's failure to apply orthodox tort definitions of culpability. In my view, clarification is needed, and there is no better way to begin this task than with a review of the American Law Institute's efforts to summarize American common law through the various Restatements.

The second Restatement of Torts classifies the various types of culpable conduct, distinguishing among them on the basis of cognition. The degree to which the actor appreciates or understands that harm will or may result from his conduct determines the classification of the conduct as intentional, reckless, or merely negligent.¹⁷¹ The classification of intentional torts, the most egregious conduct,¹⁷² is limited to that conduct in which the actor has actual knowledge or knows with substantial certainty that his conduct will result in harm to another.¹⁷³ When this test is set beside that of the next level of egregiousness—recklessness¹⁷⁴—the ambiguity in *Anderson* becomes apparent.

The Restatement defines a "reckless" actor as one who knows or has reason to know facts which would lead a reasonable person to realize not just that his conduct creates an unreasonable risk of harm to another, but that his conduct is highly likely to result in the harm.¹⁷⁵ Without these elements, the

170. This is evidenced by the fact that the Supreme Court of Iowa apparently reads the *Anderson* test for reckless conduct as different from the definition found in the Restatement (Second) of Torts. See *supra* note 167.

171. See *supra* note 159.

172. The second Restatement of Torts makes a distinction between intent and motive, i.e., the reason why a person so acted. See RESTATEMENT (SECOND) OF TORTS § 44 (1965). A bad motive or reason for the conduct in question may affect the damages to be awarded, but, as a general proposition, it is not a required element of most intentional torts. There are exceptions though, such as for malicious prosecution. See *id.* § 653 (1977).

173. See *supra* note 159.

174. The term "reckless" is usually expressed as part of the phrase "willful, wanton and reckless," but today each term is considered to mean the same thing. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 34, at 212 (5th ed. 1984). The second Restatement of Torts uses the one term "reckless" in lieu of the three. See RESTATEMENT (SECOND) OF TORTS § 500, Special Note (1965).

175. The Restatement provides:

The actor's conduct is in reckless disregard of the safety of another if he does an act or intentionally fails to do an act which it is his duty to the other to do, knowing or having reason to know of facts which would lead a reasonable man to realize, not only that his conduct creates an unreasonable risk of physical harm to another, but also that such risk is substantially greater than that which is necessary to make his conduct negligent.

conduct can be no more than negligent.¹⁷⁶ This definition encompasses two different states of mind. First, when a person acts, or fails to act, with awareness¹⁷⁷ of the high degree of risk, the conduct is reckless.¹⁷⁸ Second, when a person acts with awareness of the facts which give rise to the risk, but is not aware of the high degree of risk involved, that conduct still is considered reckless if a reasonable person in his or her place would be aware of such risk.¹⁷⁹ According to the Restatement, the essential difference between intentional and reckless conduct lies in the level of the actor's knowledge of the degree of certainty that consequences will flow from the actor's conduct.¹⁸⁰ Both intentional and reckless conduct involve intentional acts, but the conduct is classified as "intentional" only when the actor knows or knows with substantial certainty that harm will ensue from the act.¹⁸¹ If the actor knows or, from facts which she possesses, has reason to know that there only is a very strong probability, and not a substantial certainty, that harm may result from the act, the conduct is classified as "reckless."¹⁸²

In *Anderson*, the Supreme Court of Wisconsin failed to follow the orthodox distinctions laid down in the Restatement. It confused intentional conduct with reckless conduct, declaring that the tort of bad faith "is an intentional one"¹⁸³ and then

RESTATEMENT (SECOND) OF TORTS § 500 (1965).

Although § 500 speaks of the risk of *physical* harm, one may equate the type of "harm" involved in the tort of bad faith to that in defamation where the United States Supreme Court has adopted the "knowing or reckless disregard" standard in certain situations. See *New York Times Co. v. Sullivan*, 376 U.S. 254, 279-80 (1964) (applying the "knowing or reckless standard" to a libel case involving a public official). In these situations, the degree of knowledge possessed by the actor pertains to the truth or falsity of the matter communicated. In first-party bad-faith situations, the degree of knowledge pertains to the legitimacy of the basis for refusing to pay a claim. In either case, the actor is liable for harm arising from the conduct when the requisite state of mind exists. Thus, the term "harm" is used in this sense in this Article when considering whether the insurer knows or has reason to know that it has no reasonable basis for denying a first-party claim.

176. RESTATEMENT (SECOND) OF TORTS § 500 cmt. g (1965).

177. The Restatement uses the terms "knowing or having reason to know." See *id.* § 500. "Having reason to know" means that the actor has information from which a person of reasonable intelligence or of the superior intelligence of the actor would infer that the fact in question exists, or that such person would govern his conduct upon the assumption that such fact exists. *Id.* § 12.

178. See *id.* § 500 cmt. a.

179. *Id.*

180. See *id.* cmt. f.

181. *Id.*

182. *Id.*

183. *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 376 (Wis. 1978).

adding the statement that the cause of action will lie both when an insurer knows that it has no reasonable basis for denying a claim and when an insurer recklessly disregards the fact that it has no reasonable basis for denial.¹⁸⁴ According to the Restatement, a tort is not exclusively intentional if recovery is also allowed for reckless conduct.¹⁸⁵ Nonetheless, the *Anderson* court went on to explain that knowledge could be "inferred and imputed" when the insurer recklessly disregards the fact that there is no reasonable basis for denial or is recklessly indifferent to facts or proofs submitted by the insured.¹⁸⁶ The court cast doubt on what it really meant to say about the standard of culpability for the tort of bad faith, somewhat like a thirteenth chime of a clock bringing into question the accuracy of the previous twelve. What did the *Anderson* court mean by defining intent to include reckless conduct? There are several possibilities.

One possibility is that the *Anderson* court literally meant what it said. The new cause of action is solely an intentional tort, but it is of a different stripe than that found in the Restatement. In its explanation of how an insurer might be held to know there was no reasonable basis for denying the claim, the court said such knowledge might be "inferred and imputed" where the insurer recklessly disregards the facts.¹⁸⁷ Implicit in this formulation is the notion that the insurer is in possession of the facts. One might interpret the opinion to mean that actual knowledge may be proved by a showing that the insurer possessed the facts without having to prove that the insurer was aware that it possessed them or, if it was aware the facts existed, that the insurer was aware of their meaning. Under such an interpretation, the insurer will not be allowed to ignore or to be indifferent to facts that are in its possession. The insurer could be liable even when it misplaced a claim file, as there would be no requirement that the insurer actually act on the claim at all.

This interpretation of the *Anderson* opinion, of course, flies in the face of the Restatement definition, which requires a high

184. See *supra* text accompanying note 163.

185. See *supra* note 159.

186. See 271 N.W.2d at 377.

187. *Id.*

level of cognition of harm—awareness by the insurer that the facts give no reasonable basis for denying a claim in our case¹⁸⁸—for an intentional tort. Awareness of the meaning of the facts only is imputed under reckless conduct, not intentional conduct, and awareness of their mere existence never is imputed to establish either intentional or reckless conduct. However, awareness of both the existence and the meaning of the facts may be imputed as the basis for negligent conduct.¹⁸⁹ These points are crucial in any attempt to distinguish between a subjective and objective test, as shown below.

One might argue that the *Anderson* court, when it denominated the tort of bad faith as “an intentional one,” meant only that an intentional act was involved, that is, the insurer consciously must deny or refuse to pay the claim rather than inadvertently failing to act on the claim. If the insurer consciously denies the claim, there must have been a reasonable basis for the denial, whether or not the insurer was aware of it at the time of denial. Otherwise, the insurer will be liable, but the insurer would not be liable when it failed to act on a claim at all. This interpretation of the *Anderson* opinion, however, taken to its logical conclusion, would appear to countenance a recovery based on negligence.¹⁹⁰ The insurer could be held liable for failing to exercise due care in assessing the facts or law applicable to its handling of the claim. This outcome would contradict the spirit of the opinion in *Anderson*, if not the letter, because the court seems to contemplate a subjective requirement, rather than a purely objective one. The insurer must to some degree be cognizant of the fact that there is no reasonable basis for denial, even if its knowledge

188. See *supra* note 159.

189. Because the standard of culpability for negligence involves an objective test, i.e., a comparison with the conduct of an ordinary prudent person, the actor may be negligent for failing to appreciate what is observable as well as for the failure to observe in the first place. See KEETON ET AL., *supra* note 174, § 32, at 182–85.

190. This interpretation also could lead to strict liability if the insurer is to be held liable even where an ordinary prudent insurer would not have known that there was no reasonable basis for refusing to pay the claim at the time it was denied. This would be a more extreme reading of the possible meaning of *Anderson* than a test that at least involves some type of fault, such as negligence. There is no intimation that the *Anderson* court intended to adopt any test of liability without fault.

is constructive rather than real, in order to be held liable under the test in *Anderson*.¹⁹¹

Although this interpretation does not contradict the Restatement meaning of intent directly,¹⁹² it fails to conform to the Restatement definition because it omits any requirement that the insurer appreciate the fact that its conduct will result in an invasion of the insured's rights. Moreover, it leaves out what appears to be the court's requirement of some kind of a culpable state of mind, albeit a degree of culpability less than that required for an intentional tort under the Restatement. Thus, the language of the *Anderson* opinion appears to rule out an interpretation that an objective standard, such as is used in negligence actions, would suffice for the tort of bad faith. Perhaps there is a better explanation if one just ignores the label of intentional tort for the moment and examines the conduct described by the court.

Despite the awkward efforts of the court to subsume reckless conduct under the rubric of intentional conduct, a fair reading of the entire case supports the proposition that recovery under the new tort would be permitted when it is shown that there was no reasonable basis for denying the claim and that at least one of two possible culpable states of mind exist. As in a traditional intentional tort context, if the insurer knows or knows with substantial certainty that there is no reasonable basis for denying the claim, the insurer is liable for intentionally violating the insured's rights. Likewise, if the insurer is aware of facts that actually cause it to realize that there is a very high probability that there is no reasonable basis for denying the claim, it is also liable for that conduct. Disregard of such facts and their meaning would constitute the conscious indifference that forms the first prong of the Restatement's definition of reckless.¹⁹³

If the *Anderson* opinion is interpreted this way, it is substantially reconciled with the Restatement definitions of intentional and reckless conduct and also remains internally consistent. Then there is only one question left to be answered. Should the insurer also be liable if the second

191. See 271 N.W.2d at 377.

192. See *supra* note 159.

193. See *supra* text accompanying notes 176-79.

prong—the “having reason to know” test—of the Restatement definition of “reckless” is satisfied? In other words, does the tort of bad faith apply when the insurer is aware of facts that would put a reasonable insurer on notice that there is a very high probability¹⁹⁴ that no reasonable basis exists for denying the claim, but the insurer in question fails to appreciate that this is the situation?

Did the Wisconsin Supreme Court mean to answer this question in the affirmative when it spoke of “inferring and imputing” knowledge to the insurer? Or was the court simply referring to the actual knowledge of a very high probability required under the first prong of the Restatement definition of reckless? On this issue, the opinion certainly is less than clear. The word “infer” means that one should deduce the existence of fact *D* once aware of the existence of facts *A*, *B*, and *C*.¹⁹⁵ This may support an interpretation that only the first prong of the Restatement definition of reckless conduct suffices for the tort of bad faith if the standard for culpability is to require actual or something akin to actual knowledge. For example, if all the circumstantial evidence leads to the conclusion that the insured’s death was accidental, the life insurance carrier will not be heard to say that the claim for double indemnity benefits is fairly debatable on the basis that there is no direct evidence that it was accidental. To know *A*, *B*, and *C* is to know *D* in the eyes of the law because experience dictates such a result.

On the other hand, one may “impute” information for policy reasons without regard to any deduction based on logic.¹⁹⁶ This may argue more strongly for recognition of liability under the second prong, where a reasonable person would be informed by the facts possessed even though the insurer in question actually is not aware of the meaning of the facts. For example, an insurer may refuse to pay a claim on the basis of facts that invoke a particular policy exclusion, unaware that every court to litigate the issue has held the exclusion to be void as violating public policy. This information could be imputed to

194. This would be the minimum requirement. The insurer would also be liable if the known facts would put a reasonable insurer on notice that there was no reasonable basis for denying the claim, not just a very high probability of a basis to deny the claim.

195. Webster’s defines “infer” as “to derive as a conclusion from facts or premises.” WEBSTER’S NINTH NEW COLLEGIATE DICTIONARY 619 (1989).

196. Webster’s defines “impute” as “to credit to a person or a cause.” *Id.* at 607.

the insurer on the policy grounds that to do so will encourage insurers to keep abreast of the law and that insureds should not have to obtain legal assistance needlessly. To know *A*, *B*, and *C* means that the insurer will be held to know *D* even though experience and logic do not dictate such a result. Did the Wisconsin court mean to use the terms in these distinct ways? Or did the court possibly mean to use these words interchangeably, and, if so, which of the two meanings did it have in mind?

It is doubtful that the court really had occasion to think through such fine distinctions, and therefore one should not draw too much meaning from the use of these two words in the opinion. The problem really resolves itself into the broader question of what ought to be the minimum standard of culpability for the tort of bad faith. At this point, then, it may be best to leave the Wisconsin opinion and think freely about the broader question in order to define the complete range of conduct that might qualify for some remedy and what the remedies should be. Since this Article urges a statutory solution to the problems that have arisen under the common-law tort of bad faith, the issue of the appropriate standard for culpability shall be discussed in the context of designing an appropriate statute.

V. DESIGNING A STATUTORY SOLUTION

A. Defining the Standards for Liability

If there is to be a remedy for insureds who are treated unfairly by their insurers in the claims settlement process (and it is the thesis of this Article that there should be), surely this remedy must be available where an insurer actually knows that it has no reasonable basis for denying the claim of its insured, but refuses to pay the claim anyway. If one agrees with this proposition, only two basic questions remain: (1) how far beyond this strict definition of an intentional tort should the standard for liability extend?, and (2) what should the remedies be where the standards are violated?

As to the first question, there does not seem to be any good reason for denying a remedy when the degree of cognition diminishes from that of actual knowledge to the point where

the insurer only appreciates that there is a very high degree of probability that there is no reasonable basis for denying the insured's claim. To define the standard of culpability so as to include the latter as well as former state of mind would encompass not only the type of knowledge that traditionally is required for an intentional tort,¹⁹⁷ both actual knowledge and knowing with substantial certainty that harm will result, but it also would include the first level of cognition under the category of recklessness, as defined by the Restatement.¹⁹⁸ The key is awareness that the claim is not fairly debatable and therefore should be paid.

In all these instances, it would be particularly offensive for an insurance company to appreciate the fact that the claim should be paid, but to refuse to do so on the slim hope that it might succeed in defending a lawsuit brought to collect the proceeds. Such conduct is precisely the kind of conduct that the tort of bad faith should reach because it serves no useful purpose and is destructive to the insured. This behavior presents the strongest possible case for recovery of extra-contractual damages. Failure to recognize a cause of action for such arbitrary conduct not only would frustrate the process of transferring and spreading risks of loss in our society, but it also would permit insurers actually to profit from their wrongful conduct by allowing them to earn income on funds that rightfully belong to their insureds.

Less deliberate conduct poses more difficult questions. Should the second prong of the Restatement definition of reckless conduct¹⁹⁹ also be a basis for liability? When the claimant can prove only that the insurer was in possession of facts that would have put a reasonable insurance company on notice that there was no reasonable basis or a high probability that there was no reasonable basis for denying the claim, should there be liability even though the insurer in question did not appreciate the legal significance of the facts? This question is the one that the *Anderson* decision fell short of answering with any degree of clarity.²⁰⁰ In fact, it is a question to which the answer is quite debatable.

197. See *supra* notes 172-82 and accompanying text.

198. See *supra* notes 172-82 and accompanying text.

199. See *supra* text accompanying note 179.

200. See *supra* text accompanying and following note 194.

The state of mind that is declared to be culpable by the second prong of the Restatement's definition of recklessness is determined in part by an objective standard, whereas the first prong of the definition utilizes a purely subjective standard.²⁰¹ These two forms of culpability are not the same. The objective standard does not require any awareness of harm and sounds more like negligence, a lesser form of egregious conduct, albeit a case of very serious neglect. The subjective standard requires awareness and represents more egregious conduct, a form of conduct involving a conscious disregard for the rights of others. This is not merely a difference in degree, but a difference in the kind of standard.

The insurer's awareness of its tenuous position makes its conduct reprehensible because it knows it is withholding the benefits of the contract that very likely belong to the insured. This permits ulterior motives, such as the desire to enhance investment income, to come into play, which in turn tends to provide incentives to corrupt the system. This is not the case with inadvertent conduct, because there is no conscious decision to deny benefits wrongfully. Thus, one could argue that any cause of action for an insurer's refusal to honor its agreement to pay benefits to an insured should involve only cognitive forms of conduct. The insurer at least should be aware to a very great degree, even though not absolutely sure, that there is no reasonable basis for denying the claim. Mere negligence, no matter how serious, does not involve the conscious manipulation of the claims process and, although deplorable, is less reprehensible. Ulterior motives for denying claims do not exist to provide debilitating incentives. Based on this reasoning, one could conclude that, since the second prong of the Restatement definition of reckless embodies some inadvertent conduct, there should be no liability for the situation where the insurer fails to realize that it has little or no basis for denying the claim. If this position is accepted, it also would follow that a negligent, or even grossly negligent, failure to pay, should not be actionable.

Perhaps this distinction is what the Supreme Court of Wisconsin had in mind in *Anderson*, and, if so, it would be a logical one. It certainly is the type of bright-line distinction that the

201. See *supra* text accompanying notes 177-79.

average juror could understand. The insurer must be aware that what it is doing is unfounded before extra-contractual damages are available. The question remains, however, whether such a distinction would balance the scales fairly between the insured and insurer. Are there any countervailing arguments in favor of extending liability to the type of inadvertent conduct found in the second prong of the Restatement definition of reckless conduct?

Any justification for abandoning the rule of *Hadley v. Baxendale* by allowing recovery for tortious breach of the contract between an insurer and its insured must derive from the broader purposes of tort law. Traditionally, two of these purposes have been the deterrence of antisocial conduct and the compensation of innocent victims of that conduct,²⁰² and they are no less important because the duty underlying the tort of bad faith arises from a contractual relationship. Developments in the law discussed above establish that intentional and other conscious abuses by insurers should be deterred by requiring compensation of insureds who are damaged by such conduct. Without such sanctions, insurers will be tempted to deny claims for ulterior motives.

This reasoning emphasizes the deterrent goal of tort law, but another purpose of tort law is to admonish people to act more responsibly.²⁰³ The developments referred to above indicate that insurers should be liable when they are in possession of facts that would put a reasonable insurer on notice that there was no reasonable basis, or that it was highly unlikely that there was a reasonable basis, for denying an insured's claim. Here the insurer is seriously at fault, and the innocent insured should not have to bear the losses that flow from the insurer's conduct when those losses could have been avoided if the insurer had acted more responsibly. Such a liability rule would encourage insurers to investigate properly and to evaluate accurately claims in a timely manner, paying those that should be paid and denying the others. If an insurer has information in its file that mandates a particular response, the insurer should act on that information as a reasonable

202. See SPECIAL COMM. ON THE TORT LIAB. SYS., AMERICAN BAR ASS'N., TOWARDS A JURISPRUDENCE OF INJURY: THE CONTINUING CREATION OF A SYSTEM OF SUBSTANTIVE JUSTICE IN AMERICAN TORT LAW 4-1 to -225 (1984).

203. *Id.* at 4-3, 4-13.

insurer would. To stop short of including deviations from this standard of conduct in the basis of liability for the new tort will permit insurers to feign ignorance and put an unfair burden on insureds to prove that the insurer was cognizant of the fact it had no reasonable basis for denying the claim. Moreover, there would be fewer incentives for insurers to institute training programs and to take other steps to improve both the skills of their employees and the claims process in general.

On the other hand, the argument does not go so far as to include purely negligent acts by the insurer.²⁰⁴ The requirement that the insurer actually possess the information upon which it should have acted should suffice to rule out claims that the insurer merely should have exercised greater care in handling the claim. This test also would avoid litigation of the requisite degree of appreciation or awareness that would occur if the second prong were not included and one had to draw a distinction between the levels of cognition that distinguish the two prongs.

In addition, if an investigation is inadequate for the purpose of a response and the insurer knows or has reason to know that this is the situation, it should be liable for failing to complete the investigation when an appropriate investigation would have shown that the claim was not fairly debatable. Willful ignorance of the facts should not absolve the insurer from liability. Thus, when the insurer actually possesses the information to draw the correct conclusion or facts that indicate that it needs to go forward to acquire that

204. Although the broader purposes of tort law are also served by holding people liable for negligent conduct, the gravamen of the tortious conduct here is primarily that of economic loss arising out of a breach of contract. Where purely economic loss arises from an interference with contractual relations, courts usually have required that the harm be caused intentionally. See KEETON ET AL., *supra* note 174, at § 129, 997-1002. To extend the statutory basis of culpability to include negligence would greatly increase the number of situations where the jury could "second-guess" the insurer, thereby subjecting the insurer to liability for tort damages where it was barely more probable than not that the insurer had failed to exercise ordinary care in handling a claim. Thus, the insurer, as a practical matter, could be liable for consequential damages in almost every case where a claim is denied and it is subsequently determined that it should have been paid. It would be better to avoid this type of exposure and litigation by providing for strict liability where the claim has not been paid within a certain period of time, but limiting the claimant's recovery to interest and attorneys' fees. See *infra* text accompanying and following note 221. This more fairly balances the interests between the parties while avoiding needless litigation over fault.

information, the insurer should be encouraged to do what is necessary so that a proper response may be given. This is not too great a burden to place on insurers, as the argument does not go so far as to hold the insurer accountable for all mistakes and errors that inevitably arise from a mere failure to exercise due care. Insureds do make inaccurate, groundless, and even fraudulent claims²⁰⁵ and insurers need some margin of error within which to operate, but this margin should not extend into the area of conduct described as reckless under the Restatement of Torts. Moreover, when the goal of compensation is considered, the answer is even clearer. Because this is the type of conduct that could be avoided by encouraging insurers to act more responsibly, there is no good reason for not permitting an insured to collect extra-contractual damages. An innocent insured should not be expected to absorb all the harm that reasonably could have been avoided had the insurer acted in accordance with the standards of the industry.

Having set out the arguments for and against the proposition of limiting the insurer's duty to conscious violations of the insured's rights, it would appear that there is a strong case for going beyond this standard in cases of serious neglect, that is, when the insurer has reason to know that it is wrong in denying a claim. On balance, I conclude that both prongs of the Restatement definition of reckless should be used as a basis for insurer liability. Insurers need to act responsibly, and it is not asking too much to hold them to the standards of their own industry, especially when the insurer has facts in its possession from which a reasonable insurer would determine either that the claim is valid or that more investigation is required to make that decision.

Nonetheless, this does not mean that a full-blown measure of tort damages should be available in every situation, regardless of the nature of the insurer's conduct. In recognizing a tort duty on the part of the insurer, it should be kept in mind that the duty would not exist absent the contractual relationship. The primary risk of harm to the insured involves a pure economic loss, a failure to pay the policy benefits, rather than bodily injury or property damage.

205. It has been estimated that insurance claim fraud exceeds \$17 billion a year. See C. David Sullivan, *Another Perspective: It Takes Teamwork to Fight Insurance Fraud*, NATL UNDERWRITER (Property & Casualty/Risk & Benefits Management ed.), Aug. 17, 1992, at 21.

The tort duty only comes into play with regard to consequential and punitive damages. Even then, the wrong still is one primarily for interfering with a property right, not personal injury.²⁰⁶ Thus, any tort remedy should be appropriately tailored to the wrong, something that the common-law process has not done very well.

*B. The Measure of Compensatory Damages
for Wrongfully Refusing to Pay Claims*

One of the problems with using the common-law process to design a new tort is inherent in the process itself. Courts would not recognize a new tort if they were not presented with fact situations that they find compelling. Typically, these cases present extreme examples of conduct or harm. As the law develops, however, the new cause of action may be extended to cover similar fact patterns that involve less egregious conduct. That is how the process works as the courts flesh out the law, and that is certainly what has happened with the so-called tort of bad faith. It was first recognized as an intentional tort²⁰⁷ and later extended to reckless conduct.²⁰⁸ Some courts have even gone on to include negligence²⁰⁹ and possibly strict liability²¹⁰ as the basis for liability. Yet the possibility of a reduced measure of tort damages, as lesser forms of wrongdoing are recognized as the bases for liability, never has been seriously considered.²¹¹ The courts seem to be guided more by labels, such as "contract" or "tort," when it is the nature of the wrong that should determine the precise measure of damages.²¹² To label something as a tort does not necessarily mean that all tort damages should be available. In the context of the development of the tort of bad faith, the propriety of a full measure of tort damages would seem questionable at the outset. The relationship is primarily an

206. See *Gourley v. State Farm Mut. Auto. Ins. Co.*, 806 P.2d 1342, 1346 (Cal. 1991).

207. See *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032, 1037-38 (Cal. 1973).

208. See *supra* text accompanying note 165.

209. See *supra* notes 166-70 and accompanying text.

210. See *supra* note 168 and accompanying text.

211. This issue is raised in some torts textbooks. See, e.g., DAN B. DOBBS, *TORTS AND COMPENSATION* 601-03 (1985) (listing several possible directions reform of strict liability may take, but not considering a reduced measure of tort damages among the possibilities).

212. Some courts that have permitted recovery of consequential damages under a theory of breach of contract rather than tort have limited the remedy to economic losses. See *supra* note 126.

economic one and the harm is most likely to reflect that fact. Serious economic repercussions may flow from the insurer's denial of a claim, but rarely does the insurer cause bodily harm or physical damage to property. Emotional distress may occasionally result in bodily harm, but any medical expenses, including psychotherapy, would be treated as part of the economic loss. In fact, pure emotional distress is the least important candidate for redress.

Emotional distress recoveries inherently are difficult to administer, and emotional distress caused by the tort of bad faith is no exception. Under this tort, no bodily injury usually exists so there is less evidence to support the existence of serious emotional distress. The courts recognized this problem when they created a cause of action for intentional infliction of emotional distress.²¹³ Two elements of this tort are that the actor's conduct be outrageous by societal standards and that the victim's distress be extreme.²¹⁴ Even with these limitations, the courts have not found it easy to decide when conduct is actionable under this tort.²¹⁵ Yet the courts generally have not applied these or similar limitations in defining the tort of bad faith.²¹⁶ A few courts have required that there be economic harm, other than that represented by the denial of policy benefits, before a recovery may be had for emotional distress,²¹⁷ but the decisions of others may be read to mean that there is no requirement of independent economic harm at all.²¹⁸ Most courts, however, have not discussed whether the recovery of damages for

213. See KEETON ET AL., *supra* note 174, § 12.

214. See RESTATEMENT (SECOND) OF TORTS § 46 (1965).

215. See KEETON ET AL., *supra* note 174, § 12, at 57-64.

216. In *Gruenberg v. Aetna Insurance Co.*, the Supreme Court of California disapproved a prior bad-faith case that had held that there must be evidence of severe emotional distress to support an award for such damages. 510 P.2d 1032, 1042 (Cal. 1973); see also *Farr v. Transamerica Occidental Life Ins. Co.*, 699 P.2d 376, 382 (Ariz. Ct. App. 1984) (rejecting the requirement that the defendant intentionally cause the distress or that the distress be severe); *Smith v. American Family Mut. Ins. Co.*, 294 N.W.2d 751, 761 (N.D. 1980) (rejecting the requirement that distress be severe); *Timmons v. Royal Globe Ins. Co.*, 653 P.2d 907, 916 (Okla. 1982) (rejecting the requirement that conduct be outrageous or distress be severe). *But see* *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 378-79 (Wis. 1978) (requiring that the distress be severe).

217. See *Filasky v. Preferred Risk Mut. Ins. Co.*, 734 P.2d 76, 82-83 (Ariz. 1987); *Gruenberg*, 510 P.2d at 1041-42; *Smith*, 294 N.W.2d at 761; *Anderson*, 271 N.W.2d at 378.

218. See *Tynes v. Bankers Life Co.*, 730 P.2d 1115, 1127 (Mont. 1986); *Braesch v. Union Ins. Co.*, 464 N.W.2d 769, 778-79 (Neb. 1991); *Hayseeds, Inc. v. State Farm Fire & Casualty*, 352 S.E.2d 73, 80 (W. Va. 1986); see also *Frazier v. Metropolitan Life Ins. Co.*, 214 Cal. Rptr. 883, 893 (Ct. App. 1985) (rejecting the insurer's contention that a showing of damages apart from emotional distress and loss of the contract benefits itself was required).

emotional distress should be limited in any of the manners mentioned above.

This lack of limitation is particularly troublesome in bad-faith cases because some emotional distress will almost always accompany the denial of a claim. People get very upset when insurance companies reject their claims, and thus such damages can be claimed in almost every case. Yet emotional distress is by nature not capable of elimination on an ad hoc basis through monetary damages. Consequently, it really does not further the tort goal of compensation, nor is it an efficacious way of assuaging an insured's feelings. People probably do not feel any more charitable towards insurers once they have collected their benefits.²¹⁹ Perhaps this is because much, if not all, of the award for emotional distress may go to pay for attorneys' fees and other costs of the litigation. Rarely do insureds break even. There are other ways to make sure that insurers act responsibly in settling claims and that insureds are adequately compensated. Emotional distress should be omitted as an element of damages in the tort of bad faith in favor of more effective remedies.

Economic losses, on the other hand, including any medical expenses incurred as a result of emotional distress, should be recoverable in addition to the contract benefits. This kind of compensation is capable of returning an insured to her economic status quo ante, insofar as it is possible to do so. Thus, where an insurance company has conducted a thorough and complete investigation of a claim and the facts show that there is either no basis or a very tenuous basis for denying it, and the insurer either knows this or a reasonable insurer possessed of this information would know it, and still denies the claim, the insurance company should be liable for all consequential damages. The same should be true both when the insurance company fails to conduct any investigation at all and when the investigation is inadequate and the insurer knows or has reason to know that it is inadequate.

As discussed above, the compensatory goal of tort law²²⁰ warrants the imposition of damages for any economic losses caused by the insurer's refusal to pay the claim, where the insurer intentionally

219. In a study involving claims for pain and suffering arising from automobile accidents, the findings indicated that "whether one was paid—or how much one was paid—for pain and suffering had no significant relationship in assuaging any feelings of resentment." See Jeffrey O'Connell & Rita J. Simon, *Payment for Pain & Suffering: Who Wants What, When & Why*, 1972 U. ILL. L.F. 1, 46.

220. See *supra* text following note 205.

or recklessly denies a claim. Insurance companies also should be motivated to investigate properly and to respond to claims by being held responsible for any economic losses caused to the insured, but this should not be all the relief to which insureds are entitled. If damages for emotional distress are to be eliminated, two other remedies are needed to complete the picture because not all cases will involve only out-of-pocket economic loss. Some will involve loss of use of the money owed to claimants; in addition, the claimant often will incur attorneys' fees and related costs. Without remedies for these items, insurers still may find that there is some advantage in abusing the system.

C. Interest and Attorneys' Fees

An insured should be entitled to recover interest in any case in which its insurer fails to pay a claim within a statutorily prescribed time period after proof of loss has been submitted to the insurer. The rate of interest should be specified in the statute²²¹ and calculated on the amount due, but not yet paid, under the policy from the time of loss. In addition, the statute should provide for reasonable attorneys' fees and any court costs and related expenses when it has become reasonably necessary for the claimant to seek legal assistance. The award for attorneys' fees and interest should not depend on any tort standard of culpability. Failure to process claims in a timely manner is the trigger. These fees and expenses, however, should be reimbursable only when the insurer, either by settlement or adjudication, is required to pay benefits in excess of any amount that the insurer offered to pay prior to the engagement of such services.

These types of relief would be an appropriate substitute for damages for emotional distress because they should help assuage an insured's feelings. Knowledge by the insured that full economic recovery is available in the event he prevails should assist in the prevention of emotional distress. Recognition of entitlement to

221. The rate could be fixed by statute or it could be a rate that would vary according to the market rate of a particular interest bearing instrument, such as one-year United States Treasury bills. For examples of modern statutes providing specific rates of interest on overdue insurance claims, see ME. REV. STAT. ANN. tit. 24-A, § 2436 (West 1990) (providing 1 1/2% interest per month after the claim due date) and WYO. STAT. § 26-15-124(c) (1991) (providing 10% interest per annum).

interest on the money that is due under the contract and the attorneys' fees when it is necessary to engage a lawyer to collect the benefits not only serves the valuable purpose of reimbursement of expenses, but also the equally valuable purpose of prevention of emotional distress in the first place. Inclusion of attorneys' fees and costs would also provide incentives for insureds to bring meritorious claims, rather than failing to bring an action because of the fear of having to expend a substantial percentage of a relatively small award to collect it. From the insurer's standpoint, there are also advantages. The remedies for interest and attorneys' fees are not subject to manipulation by juries, as are awards for emotional distress, and the relief is more in keeping with that usually found in commercial situations. Thus, these are reasonable remedies to substitute for emotional distress damages.

D. Punitive Damages

The final remedy to be addressed is punitive damages. There are two situations in which this remedy should be available. The first is based on a distinction between knowledge and motive.²²² For the recovery of consequential economic harm, the tort of bad faith should rest on the various levels of cognition described above.²²³ If the requisite knowledge is proved, the claimant may recover for any economic losses caused by the insurer's wrongful failure to pay the claim. Where the insurer is proven to have acted with an evil motive, however, punitive damages should be available.²²⁴

The second situation that should give rise to punitive awards is closely related to the first in that it would strongly imply an evil mind, even if it did not exist in fact. The insurer should be subject to punitive damages when it engages in a general business practice of denying claims in whole or in part without a reasonable basis for doing so. This kind of conduct is similar to the denial of claims for an evil motive for several reasons. When an insurer consistently and arbitrarily forces claimants to resort to legal process, an evil

222. See *supra* note 172.

223. See *supra* text accompanying notes 197-201.

224. This is the traditional basis for awarding punitive damages. See RESTATEMENT (SECOND) OF TORTS § 908 & cmts. a, b (1979).

motive surely is inferable. This result should be the same when an insurer overreaches or makes it a practice to "chisel" claimants, that is, never offers to pay the full amount until forced to do so. This conduct is oppressive to individual claimants because they are less likely to seek legal assistance when an insurer offers to settle for something close to the full value of the claim, even though they are entitled to more.²²⁵ In the aggregate, this can amount to substantial sums of money.²²⁶ Both practices are extremely detrimental to the institution of loss spreading through insurance, an institution that is essential to our economic well-being. Availability of punitive damages in these situations would not only have the effect of punishing insurers for engaging in malicious conduct toward their insureds, but it also would give insureds an incentive to bring the lawsuits that would deter such conduct. Thus, it would serve as an admonition to other insurers while providing a needed sense of vindication for those insureds who have suffered from such callous conduct.

Limiting the availability of punitive damages to these situations, however, does not mean that the present practice of permitting juries to award punitive damages without any particular monetary limit should be continued. Insurers must carry large financial reserves to protect against unexpected, as well as expected, losses if they are to remain solvent. These reserves represent the funds that have been pooled by insureds to protect against losses that they may incur. To the extent these funds are used as a basis for calculating and paying punitive awards against insurers, they are being diverted to a purpose that was never intended by the insureds. Thus, it is inappropriate to assess multi-million dollar awards based largely on an insurer's net worth in order to exact punishment and to deter. This tends to punish the insuring public more than the insurer. It also is unnecessary because the publicity of a significant award is almost punishment enough. Who wants to buy insurance from an insurer that has a reputation for being dishonest when it comes to paying claims?

The purposes of punitive damages would be met if the legislature enacted a provision limiting the recovery of any punitive award to twice the amount of the compensatory award, including the policy benefits, and any other economic harm, or

225. See *Republic Ins. Co. v. Hires*, 810 P.2d 790, 792, 793-95 & nn.1-2 (Nev. 1991).

226. *Id.* at 795.

\$250,000, whichever is greater.²²⁷ This approach provides for flexibility. The claimant who, because of malicious conduct by an insurer, suffers a compensable loss less than \$125,000 would be permitted to recover a substantial punitive award, but the limit of \$250,000 would prevent an excessive award. On the other hand, when the compensable loss exceeds \$125,000, the ceiling on any punitive award would rise commensurately. There would be no limit in a case involving large amounts of money except for the trebling effect provided by the formula. The formula also would be appropriate for awards based on a business practice because the insurer would be subject to multiple awards. Each claimant could sue for punitive damages even though the compensatory award might be relatively small. This approach strikes a fair balance among those concerned. The award would punish and deter and yet not subject the insurer to inappropriately and unnecessarily large awards that are all too likely to be influenced by antagonistic feelings against insurers in general.

Under the proposal outlined above, an insured would have available a reasonable range of remedies based on differences in the seriousness of the wrong. When the insurance company has acted in the most egregious manner, the remedies would include punitive damages, but as the level of culpability diminishes to the point where an insurer is neither in fact aware nor in a position to be held liable as though it were aware that there is no reasonable basis for denying the claim, tort damages would not be available at all. In between these two extremes, compensatory damages should be limited to recoveries for economic loss. Recoveries for emotional distress should not be allowed. In order to make the insured completely whole, however, attorneys' fees should be recoverable where the insurer's failure to respond has necessitated resort to the services of an attorney to collect the policy benefits. In addition, the insured in all situations should be entitled to interest on the amounts due under the policy from the date of loss when the insurance company has not paid the claim within a legislatively prescribed time period. This straightforward approach will provide a clear standard of culpability for the tort of bad faith and strike a better balance between the parties regarding available remedies. It should facilitate loss spreading in our society, rather than hinder

227. This approach was recommended by the American College of Trial Lawyers in its *Report on Punitive Damages*. For this and other recommendations, see AMERICAN COLLEGE OF TRIAL LAWYERS, REPORT ON PUNITIVE DAMAGES OF THE COMMITTEE ON SPECIAL PROBLEMS IN THE ADMINISTRATION OF JUSTICE (1989).

it. It does not, however, appear to be a solution that our courts can adopt. Legislative action will be required.

VI. THE NEED FOR LEGISLATIVE ACTION

Upon reflection, one should not be surprised at the vexed development of the new tort of bad faith. The rocky progress probably was destined by the environment from which the tort sprang. The effective functioning of any free enterprise system requires predictable enforcement of promises involving economic exchange. Parties may enter freely into agreements or not, depending on which route seems most beneficial. They may define the terms of any agreement so as to limit the respective rights and responsibilities in any way they wish, absent some countervailing public policy. Once agreement has been achieved, however, there can be little room for higgling if the system is to function efficiently. The terms must be enforced strictly so that people can depend on the arrangement. Although the law of contracts developed to facilitate and to complement these relationships, in general it adhered to the basic principle that the parties, not society, are in command of the terms. Any notion of unliquidated damages for a breach of the relationship would be antithetical.

This freedom in the contracting parties to establish the terms of their relationship contrasts with tort law, where the duties are largely imposed from without. This body of law was created to adjust losses that arise from human activity, activity other than making and enforcing promises.²²⁸ Therein lies an anomaly, because the tort of bad faith arises only when a promise is broken. For many years there was a relatively clear dividing line; it was not a tort to breach a contract.²²⁹ That, however, was a rule for a different time and place.

As insurance contracts came to be perceived as having significant institutional importance beyond their importance to the contracting parties, first legislative and administrative oversight was attempted.²³⁰ These oversight mechanisms proved insufficient, and eventually courts imposed new duties besides those voluntarily assumed in the contract, duties classified as

228. See KEETON ET AL., *supra* note 174, § 1.

229. See *supra* text accompanying notes 5-6.

230. See *supra* notes 38-52 and accompanying text.

tort duties by most courts.²³¹ The fact that insurers not only draft the contracts but assume the primary responsibility under the contracts means that the tort duties rest primarily, if not exclusively, on insurers.

The imposition of these tort duties has had a dramatic impact on the relationship between parties to an insurance contract, a relationship that now is governed less by the individuals than by society. Insurers may no longer treat insureds arbitrarily, at least where that treatment results in harm beyond a denial of the contract benefits. By deterring arbitrary conduct by insurers, the common law attempted to ensure that the claims process works efficiently and fairly. Nevertheless, this attempt has not balanced fairly the competing interests of the parties. It has foundered to a large degree on the failure to articulate a clear standard by which this new relationship is to be governed. This failure is serious because claims are not always justified. Insureds can be just as greedy as insurers can be miserly. Both can be dishonest. This failure to articulate a clear standard has led to too many unwarranted claims of bad faith and needs to be addressed. If this were the only problem with the new tort, the courts could easily correct it, but it is not the only problem.

Courts can respond only in very limited ways to requests for tort remedies. Traditionally, one of three levels of fault—either intentional, reckless, or negligent conduct—is required. Moreover, in most situations the only viable remedy is damages. Although this is a crude system, it works fairly well when the issue is whether to shift losses from those who suffer bodily injury or property damage to those who have caused it. The system's limitations are more evident in situations that do not involve physical harm. There the stakes are different and the rough engine of tort is not as readily available to allocate losses. For example, tort remedies are recognized more sparingly when the loss is purely economic²³² or emotional in nature.²³³ Although in the last few years courts have been willing to extend tort duties regarding pure emotional distress, this has not been as true for pure economic loss. Before money damages are available for the disruption of an economic relationship, there usually is a requirement that the conduct reach a high level of egregiousness and the remedy of money damages usually is limited to

231. See *supra* notes 101–24 and accompanying text.

232. See KEETON ET AL., *supra* note 174, §§ 128–30.

233. *Id.* §§ 12, 54.

losses that are endemic to the economic relationship.²³⁴ Yet this simple world of tort does not readily apply to breaches of insurance relationships.

The relationship of an insurer to its insured is purely economic in nature, but the risk sought to be transferred by the insured to the insurer is often one of serious bodily harm or property damage. Even when the risk insured against is one of pure economic loss or not easily measured in economic terms at all, the financial and other consequences of absorbing the loss can be staggering and in its own way very debilitating to the insured. Thus, in many instances, an insurance contract has a hybrid quality. On the surface, it reflects a pure economic relationship between the parties, but below the surface it may represent the insured's sole protection against potential catastrophe.²³⁵ This quality of insurance contracts may well call for a remedy of money damages when the insurer acts improperly, but the availability of money damages in some circumstances does not mean that the insurer should be liable for consequential damages in all instances where it fails to pay a claim that it should have paid. Room must be left for legitimate disagreement. Yet, under the present state of the law, it is not clear where the boundary is to be drawn. Moreover, even if the courts eventually were to draw that boundary, the traditional tort remedies applied by the courts are too crude to achieve the fine balance that is needed for this unusual tort. It is doubtful that the courts ever will achieve this balance, and, even if they do, it will be a long and fitful process.

In contrast, legislatures are not limited to the traditional tort standards for defining the various levels of culpability, nor are they limited to the single remedy of monetary damages. They can fashion a solution that is more precisely tailored to the conduct involved and that balances the legitimate interests of insurers and insureds, and of society, and do it all at once. This method of resolution is preferable to that of the common-law process, particularly where insurers continue to face a double-barreled problem—the varying standards under the common law of a number of different states and the incomplete definitions of culpability within any particular jurisdiction, not to mention the prospect of having to pay for emotional distress in every case. This threat is of no mean proportions because it leaves too much

234. See *id.* §§ 128–30.

235. See *supra* text accompanying and following note 45.

leeway within which the trier of fact may maneuver, a maneuverability that is apt to be exercised not in an even-handed way, but in favor of claimants and against insurance companies. The time has come for the legislatures to act and there is no better organization to initiate that action than the National Conference of Commissioners on Uniform Laws.

This organization should appoint a committee to draft a Uniform Act on the subject of insurer claim practices for first-party insurance. Through this process a balanced approach may be developed, and once the Act is approved it can be submitted to the various states for adoption. This method is to be preferred to a state-by-state, piecemeal approach, either through the courts or the legislatures.²³⁶ The attached model of such an act²³⁷ shows how simply and efficiently the rights and obligations of the parties could be addressed. Although this draft may not be perfect,²³⁸ it is a vast

236. In my opinion, there is another reason why a uniform act promulgated by the Commissioners on Uniform State Laws would be salutary. In *Pilot Life Insurance Co. v. Dedeaux*, the United States Supreme Court held that the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1988)), preempts state common-law tort and contract actions asserting improper processing of a claim for benefits under an insured employee benefit plan. 481 U.S. 41, 57 (1987). This impacts claimants who are insured through group contracts provided by their employers and which cover medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. The civil enforcement remedies set forth in ERISA are exclusive. *Id.* at 52. However, were the states to enact a uniform scheme providing standards for wrongful failures by insurers to pay insurance claims, such laws arguably would fall within an ERISA exception for state statutes that regulate the business of insurance and would not be preempted by ERISA. See 29 U.S.C. § 1144(b)(2)(A); see also *FMC Corp. v. Holliday*, 498 U.S. 52, 63-65 (1990) (interpreting the ERISA preemption exemption for state laws regulating the insurance business).

237. See *infra* Appendix.

238. The proposed statute is limited to first-party insurance situations and then only to failures by insurers to pay benefits that are due under the insurance contract. It is arguable that the duty to defend under a liability insurance policy is a type of first-party benefit and that the statute should also include breaches of this duty. Two of the three jurisdictions that have explicitly addressed this issue extended the common-law tort of bad faith to apply to wrongful refusals by liability insurers to defend their insureds. See *supra* note 83.

I do not favor the extension of the tort of bad faith to situations involving promises by insurers that are collateral to the purpose of the insurance contract, i.e., to transfer and distribute the risk of loss from the hazard for perils against which the protection was sought. Promises that are collateral to this purpose deserve no more protection than otherwise provided under contract law. For example, the Supreme Court of Arizona held that a fire insurer's failure to give a copy of the investigation report regarding the cause of the insured's fire to the insured after it had orally promised to do so gave rise to a cause of action for the tort of bad faith, even though the insurer paid the full amount of the benefits under the first-party fire policy in a timely manner. See *Rawlings v. Apodaca*, 726 P.2d 565, 579 (Ariz. 1986). After the insurer made the promise regarding the report, it discovered it also had the liability coverage for the neighbor who was suspected of negligently starting the fire. *Id.* at 568. The promise was clearly collateral,

improvement over the decisional law that attempts to define the tort of bad faith.

CONCLUSION

Although the courts responded to the need for relief from the unfair claims practices of insurers, the common-law remedy has foundered because of the judicial inability to strike an appropriate balance between the parties to an insurance contract. A substantial number of jurisdictions have purported to adopt the tort of bad faith, but there has been altogether too little attention given to defining the standard of culpability. Moreover, traditional tort remedies have not provided for attorneys' fees and interest, relief which should be available in any case where an insurer culpably refuses to discharge its obligation to pay claims in a timely manner. This is a better remedy than permitting insureds to claim damages for emotional distress. The latter really does not compensate the insured for the actual loss suffered, whereas the former would. Therefore, it is time for more decisive action and that action can come only through legislation. There is no more timely project for the Commissioners on Uniform Laws to undertake than to appoint a drafting committee to develop a uniform act on the subject of unfair claims practices by insurers.

as it did not involve any benefit or other obligation under the fire policy. Moreover, it had nothing to do with the central purpose of insurance contracts, i.e., the shifting and distribution of losses. It was only in aid of the insured bringing a tort action against a third party. As the dissent pointed out, the failure to provide the report may have been actionable under another theory, such as breach of contract, fraud, or misrepresentation, but it certainly did not warrant a remedy under tort law. *See id.* at 580 (Holohan, C.J., dissenting). The proposed statute would not provide a remedy for this type of situation.

APPENDIX
MODEL FIRST-PARTY INSURANCE CLAIMS ACT

SECTION 1. PURPOSE AND APPLICABILITY OF [ACT]

The purpose of this [Act] is to regulate the business of insurance in this state. The [Act] applies to all insurers licensed to do business or doing business in this state, but it does not apply to an action by an insured or a third party for wrongful failure to provide a defense or to settle a claim of a third party under a liability insurance contract.

**SECTION 2. INSURER'S DUTY OF GOOD FAITH
AND FAIR DEALING**

An insurer owes a duty of good faith and fair dealing to its insured and to any other claimant seeking benefits under its insurance contract and may be liable for a breach of this duty if it fails to pay benefits that are due under the insurance contract in accordance with this [Act].

**SECTION 3. INTEREST DUE FOR DELAY IN
PAYMENT OF CLAIMS**

If an insured loss occurs and the insurer fails to pay the claim in full within [30] days after proof of loss is submitted to and written demand is made upon the insurer for payment, the insurer shall pay the claimant, in addition to the amount due under the insurance contract, [12] percent interest on the amount due and unpaid. The interest shall be calculated from the date of loss to the date payment in full is tendered to the claimant. The insurer may tender payment to the claimant in cash, check, or draft by delivering the payment to the claimant in person or by mailing the payment to the claimant at the address shown on the claim submitted to the insurer. If the claimant fails to provide an address on the claim submitted, no interest shall be due or payable to the claimant.

SECTION 4. BAD-FAITH REFUSAL TO PAY CLAIMS

(1) An insurer is guilty of bad-faith refusal to pay a claim if it refuses to pay the claim without having a reasonable basis for its refusal and, at the time of the refusal, also:

- (a) knows or knows with substantial certainty that there is no reasonable basis for denying the claim; or
- (b) knows that there is a very high probability that there is no reasonable basis for denying the claim; or

(c) is aware of facts that would put a reasonable insurer on notice that there is no reasonable basis or that there is a very high probability that there is no reasonable basis for denying the claim.

(2) An insurer is not guilty of bad-faith refusal to pay a claim if a reasonable insurer would consider the claim fairly debatable in law or fact.

SECTION 5. DAMAGES FOR BAD-FAITH REFUSAL TO PAY CLAIMS

(1) If an insurer is guilty of bad-faith refusal to pay a claim, the claimant may recover damages for economic loss caused by such refusal.

(2) Punitive damages may also be awarded if the trier of fact finds by clear and convincing evidence that the insurer, in acting in bad faith, either:

- (a) had an evil motive in refusing to pay the claim; or
- (b) engaged in such conduct with claimants as a general business practice.

(3) Punitive damages may not exceed \$250,000 or an amount that is twice the total of any compensatory award for policy benefits and economic losses, whichever is greater.

SECTION 6. ATTORNEYS' FEES

If the services of an attorney are reasonably necessary to prosecute and collect an insurance claim under this [Act], the insurer shall be liable for reasonable attorney's fees. In determining the amount of the fee, all benefits to the claimant, including those to accrue in the future as well as those that have already accrued, shall be taken into consideration. If the claim is settled or prosecuted to judgment and the claimant fails to obtain a settlement or judgment for an amount in excess of that which may have been offered by the insurer, the insurer is not liable for attorneys' fees under this [Act].

SECTION 7. EFFECTIVE DATE

This [Act] shall take effect on