

# Daily Journal

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## Rightful Redress Carriers Have a Number of Remedies Against Fraud

By Michael M. Pollak

The insurance industry is plagued with fraudulent claims for arson, burglary, boat sinking, auto accidents and other types of claims. The public winds up paying billions of dollars each year as a result of insurance fraud. But an insurance carrier has a number of remedies to use when it can prove that it was the victim of insurance fraud.

■ **Rescission.** A carrier can rescind a policy based on a false statement in the insurance-policy application or a misrepresentation in the presentation of the claim.

If a statement in an insurance-policy application is both false and material, the carrier can rescind even if the insured did not intend to provide false information. Insurance Code Sections 331, 359; *Thompson v. Occidental Life Ins. Co. of Cal.*, 9 Cal.3d 904 (1973); *Imperial Cas. & Indem. Co. v. Sogomonian*, 198 Cal.App.3d 169 (1998). The standard for materiality is subjective, the critical question being the effect of truthful answers on the insurance carrier that issued the policy. *Thompson; Sogomonian.*

Where the false statement is made in the presentation of the claim, the carrier can rescind based on a "false swearing" clause in the policy authorized by Insurance Code Section 2071. However, the carrier can rescind only if the false statement was intentional (*Miller v. Fireman's Fund Ins. Co.*, 6 Cal.App. 395 (1907)) and material (*Cummings v. Fire Ins. Exch.*, 202 Cal.App.3d 1407 (1988)). The test for materiality is an objective one and depends upon the effect the false statement would have on a reasonable insurer. *Cummings.*

■ **Claim denial.** A carrier presented with a fraudulent claim is not required to rescind. Rather, it can deny the claim based on a false statement in the policy application (*Resure Inc. v. Superior Court*, 42 Cal.App.4th 156 (1996)) or in the presentation of the claim (*Cummings*).

An insurance carrier, having spent money to investigate a fraudulent claim, is permitted to recover those amounts, and perhaps more, from those who presented the claim. Where proof of the insured's fraud is strong enough, the insurance carrier may seek to file a cross-

complaint in an action brought against it or even file a separate action against the insured.

■ **Breach of contract.** An insured may be liable to its insurance carrier for losses suffered by the carrier as a result of the insured's breach of contract. But an insured's breach of contract leads only to contract remedies, not attorney fees or punitive damages. *Liberty Mut. Ins. Co. v. Altfillisch Constr. Co.*, 70 Cal.App.3d 789 (1977).

■ **Negligence.** An insured's breach of duties is not actionable as negligence. "[A]ny negligence law duty of care which might devolve upon an insured when that insured enters into an insurance contract would be coterminous with the insured's contractual duties." *Agricultural Ins. Co. v. Superior Court*, 70 Cal.App.4th 385 (1999).

■ **Reverse bad faith.** A covenant of good faith and fair dealing is implied in all insurance contracts. It binds the insured as well as the insurance carrier. *Altfillisch; Commercial Union Assurance Cos. v. Safeway Stores Inc.*, 26 Cal.3d 912 (1980). However, the insurance carrier cannot bring a bad-faith cause of action against its own insured (reverse bad faith). *California Fair Plan Ass'n v. Politi*, 220 Cal.App.3d 1612 (1990). Tort liability based on a contract breach has been limited to instances where the insurance company — not the insured — acts in bad faith. *Politi.*

■ **Fraud.** A carrier can sue its own insured for common-law fraud. The elements of a fraud claim are misrepresentation (false representation or concealment); scienter (knowledge of falsity); intent to defraud; justifiable reliance; and resulting damage. *Agricultural.*

In *Agricultural*, the insurance carrier issued a policy that included earthquake coverage for the partner of an upscale health club in Los Angeles. At the time of the earthquake, the health club's building allegedly was already in need of building-code upgrades and other remedial work. The insureds' public adjuster submitted a report to the insureds estimating the earthquake damage at about \$2 million. The insureds then fired their adjuster and obtained a second estimate from a construction supervisor for about \$9 million. The second estimate, unlike the first, provided for substantial remodeling. The insureds concealed the first estimate from their insurance company and gave it only the second estimate. The insurance carrier, unaware of the first damage estimate, paid nearly \$3 million as a partial

payment.

The insureds sued for bad faith. The trial court stayed the case to allow the insurance carrier to conduct examinations under oath and otherwise investigate the claim. The carrier then denied the claim and demanded a refund of money already paid. When the insureds refused, the carrier filed a cross-complaint against the insureds, alleging reverse bad faith and fraud. The trial court sustained the demurrer without leave to amend as to both causes of action. The court of appeal, citing *Politi*, refused to allow the reverse-bad-faith cause of action. However, the court of appeal allowed the fraud claim.

The *Agricultural* court cited Civil Code Section 1542, which defines fraud, and held that it encompasses fraudulent misrepresentations made during the insurance-claims process by either party to the contract. The court noted that of the various elements of fraud, discussion in other opinions focused on justifiable reliance. The court stated that when an insured makes a claim to its carrier, the carrier has a duty to investigate. When the carrier investigates a false claim, it incurs unnecessary expenses and is therefore damaged so that the justifiable-reliance element is satisfied.

The *Agricultural* court criticized the opinion in *Orient Handel v. U.S. Fid. & Guar. Co.*, 192 Cal.App.3d 684 (1987). In *Orient Handel*, the court stated essentially that because an insurance carrier has a duty to investigate a claim anyway, the carrier cannot suffer damage by incurring costs in investigating a fraudulent claim. The *Agricultural* court stated that the reasoning of *Orient Handel* was ambiguous and of "dubious validity." The *Agricultural* court allowed the insurance carrier to plead its fraud claim and to seek punitive damages against its insured.

No court has yet had the opportunity to take sides between the *Orient Handel* decision and the recent *Agricultural* opinion on the element of detrimental reliance. Thus, there is a split of authority. Commentators have agreed with *Agricultural* that *Orient Handel* is of "dubious validity." H. Walter Croskey, et al., "California Practice Guide: Insurance Litigation" (The Rutter Group 1999). The reasoning of *Orient Handel* — that a carrier is obligated to investigate a fraudulent claim anyway — limits an insurance carrier's remedies to denying the claim and

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## Remedies for Fraud Available to Insurance Carriers

does not go far enough to discourage insurance fraud. Because *Agricultural* is the better reasoned and more recent view, courts are more likely to follow it.

■ **RICO.** The Racketeer Influenced and Corrupt Organizations Act, a series of federal statutes, is an effective tool in the fight against insurance fraud. RICO's attraction is that a prevailing plaintiff gets attorney fees and tripled damages.

RICO was originally designed to prevent organized crime from infiltrating legitimate business through racketeering. However, courts have expanded RICO to include insurance fraud. *Aetna Cas. Sur. Co. v. P&B Autobody*, 43 F.3d 1546 (1st Cir. 1994). RICO outlaws four categories of activities. 18 U.S.C. Section 1962. The most common provision is subdivision (c), which prohibits a person or entity from conducting an interstate enterprise through a pattern of racketeering activity.

As applied to insurance fraud, the primary wrong under RICO is "mail fraud." 18 U.S.C. Section 1961. The term "mail fraud" is misleading because it requires only a "scheme to defraud" and the use of the mail to execute or further the scheme. *P&B Autobody*. The intentional filing of false insurance claims constitutes

a "scheme to defraud." A plaintiff does not need to prove that each defendant personally used the mail but only that the defendant acted under circumstances where the defendant could reasonably foresee that use of the mail would follow in the ordinary course of the activity. *P&B Autobody*.

In *P&B Autobody*, the leading RICO insurance-fraud case, Aetna sued its insureds, claimants and auto-repair shops over a widespread fraudulent scheme. The court stated that for a defendant to be liable under Section 1962(c), Aetna had to show that Aetna was an enterprise affecting interstate commerce; the defendant was associated with Aetna; the defendant participated in the conduct of Aetna's affairs; and the defendant's participation was through a pattern of racketeering activity. As used in the statute, "enterprise" includes legitimate businesses such as Aetna.

The *P&B Autobody* court held that the "interstate commerce" requirement of the first element was satisfied where an insurance carrier does business in many states. It is not necessary that the transactions forming the basis for the RICO claim be conducted across state lines.

The second element, association, includes not just an insured or an employee of the plaintiff enterprise, but anyone

connected with the plaintiff enterprise. The court held that the Aetna insureds, claimants and body-shop operators all were "associated with" Aetna.

The third element, participating in the conduct of Aetna's affairs, was satisfied where the defendants acted intentionally to cause Aetna to make payments on false claims. Finally, the fourth element, a "pattern," was satisfied where each defendant committed two acts of racketeering activity — such as mail fraud — in a 10-year period.

A benefit of RICO is that, unlike fraud, justifiable reliance is not an element. Also, unlike an award of punitive damages, which requires that a plaintiff prove malice, fraud or oppression, as well as the defendant's wealth, an insurer can obtain triple damages under RICO without such proof. On the other hand, unlike fraud, RICO requires proof of a "pattern," which requires more than one act of racketeering activity.

In view of the differing elements of proof and recovery, an insurance carrier bringing an action based on insurance fraud should consider suing for both fraud and RICO violations. Regardless of the claim pleaded, an insurance carrier that has been defrauded should consider suing, both to obtain a recovery and to deter insurance fraud.