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edited by William R. Hickman

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IMPORTANT MESSAGE TO ALL OUR FRIENDS AND READERS

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BAD FAITH: EASY TO PLEAD; HARD TO PROVE

FACTS:

Nancy made a left turn in front of Jason's speeding vehicle. She spent two months in the hospital. The eyewitnesses could not agree on who had the red light and who had the green light.

Nancy settled with Jason for $100,000. She then demanded policy limits under a UIM policy purchased by her employer. The limits were $1 million. Based on its investigation, the UIM carrier was of the view that Nancy caused the collision.

Nancy demanded arbitration. The UIM carrier offered $300,000, and then $400,000 at the arbitration. Nancy never came off her million dollar demand.

The UIM arbitrator awarded $929,803.29. Nancy sued for bad faith. She dismissed that. But a year later, sued again. The trial resulted in a hung jury. Prior to a second trial, the court dismissed Nancy's claim on summary judgment.

The Court of Appeals affirmed, finding that the settlement offers were reasonable, that there was no bad faith in this UIM claim, and that the destruction of the home office claim file after Nancy first dismissed her case was not spoliation. The court also said that the "enhanced obligation" considerations were not applicable. UIM coverage is by nature adversarial and at arm's length. An inevitable conflict exists between a UIM carrier and a UIM insured due to the unique nature of UIM coverage.

SUPREME COURT HOLDING:

Now, notwithstanding that the Court of Appeals had written a super out-of-this-world opinion (See XXIII WASHINGTON INSURANCE LAW LETTER, *What Summer?* 1999, p.28), the Supreme Court granted Nancy's petition for review. The case was argued in May 2000, and the opinion came out in January 2001.

The opinion represents a very surprising effort by the court to level the litigation playing field. In a unanimous opinion, written by the former WSTLA judge of the year, the court made it crystal clear that while bad faith may be alleged by a policyholder as a knee-jerk reaction to every disagreement with a company, the policyholder will have a damn tough time withstanding a motion for summary judgment unless the policyholder shows that there was **no** reasonable basis for the company's conduct.

The court said:

(1) A company should not be liable for extra-contractual damages where there is a legitimate controversy as to whether benefits are due or the amount of such benefits.

(2) Claims of bad faith are not easy to establish. Policyholders must meet a "heavy burden."

(3) Policyholders must prove bad faith as a matter of law.

(4) If the evidence produced by either side creates a fact issue with regard to the validity of the claim and, thus, the legitimacy of the denial thereof, the tort claim must fail.

(5) To establish the tort of bad faith, the policyholder must prove as a matter of law that the insurer's conduct was unreasonable, frivolous, or unfounded.

(6) A company is ordinarily entitled to summary judgment of dismissal of a bad faith claim **unless** the insured shows there was **no** reasonable basis for the company's actions.

(7) Where there is no real dispute that an insurer had a reasonable basis for its actions, dismissal of the bad faith claim on summary judgment is appropriate.

(8) The relationship between a UIM insurer and its insured is by nature adversarial and at arm's length.

(9) *Tank's* "enhanced obligation" rule is simply unworkable in the UIM context.

(10) However, the duty of good faith does not simply disappear when a UIM claim is made.

COMMENT:

Clearly the most significant insurance opinion since the court introduced the concept of "enhanced obligation" back in *Tank v. State Farm*, 105 Wn.2d 381, 715 P.2d 1133 (1986)

Ellwein v. Hartford Accident & Indemnity Co., 142 Wn.2d 766,15 P.3d 640 (2001) *affirming in part, reversing in part*, 95 Wn. App. 419, 976 P.2d 138 (1999).

THE INTANGIBLE SPIRIT LICENSE

FACTS:

Northwest operated a "restaurant" called Cheers West. Northwest hired IPA to provide security services.

A minor got into Cheers West and Cheers lost its liquor license.

Northwest sued IPA for negligence and breach of contract because of the loss of liquor license. It alleged that the business had been destroyed and that it had suffered great economic loss.

IPA had a CGL policy with Scottsdale. The company agreed to defend but pointed out that it did not cover breach of contract because that did not fit the definition of "occurrence."

Subsequently, the company told IPA that there was no duty to defend and no duty to pay because the suit by Northwest did not allege "property damage." The company withdrew from the defense and filed a dec action.

The trial court denied the company's summary judgment motion. The company appealed the denial of the summary judgment. The Court of Appeals reversed, concluding that there was no property damage because the complaint did not allege that Northwest lost the use of the premises for any purpose other than one that involves the sale of liquor.

HOLDINGS:

(1) Scottsdale has a duty to defend IPA if the complaint contains any factual allegations which could render the insurer liable to the insured under the policy. We liberally construe the pleadings in favor of the insured. The key consideration in determining whether the duty to defend has been invoked is whether the allegations, if proven true, would render the insurer liable to pay out on the policy.

(2) Scottsdale's duty to indemnify depends upon the insured's actual liability to the claimant and actual coverage under the policy.

(3) We begin our analysis by examining the policy's provisions to see if the complaint's allegations are conceivably covered.

(4) If the allegations are conceivably covered, the court must determine whether a policy exclusion clearly and unambiguously applies to bar coverage. Where an exclusion clearly and unambiguously applies to bar coverage, the court's inquiry ends.

(5) The complaint does not allege loss of use of *tangible* property. "[T]angible property" may fairly be defined as property "that has physical form and substance . . . [, t]hat which may be felt or touched, and is necessarily corporeal[.]"

(6) A liquor license is merely representative of a privilege granted by the state and, as such, is intangible property. A "business" is likewise intangible for it merely describes a "commercial activity engaged in for gain or livelihood."

(7) There is no allegation or evidence in the record that Northwest lost its use of or right to occupy the premises. Even if it had, a right to occupy premises is not a tangible property interest.

COMMENT:

A crystal clear, succinct layout of the law.

Scottsdale Ins. Co. v. International Protective Agency, Inc., ___ Wn. App. ___, ___ P.3d ___ (2001 Wash. App. LEXIS 191).

TO ERR IS HUMAN; TO VACATE DIVINE

FACTS:

Maureen was injured by an uninsured driver. She made a UIM claim. It went to arbitration. The UIM carrier, State Farm, paid the award and Maureen released her personal injury claim.

Maureen sued the UIM carrier for bad faith failure to settle. She served the Insurance Commissioner with a 40-day summons. On the 41st day, she got an order of default, on the 43rd day she moved for a default judgment, and on the 48th day, she obtained a default judgment.

Nine days later State Farm moved to vacate. It showed that it had timely received the complaint from the Commissioner, but an administrative assistant had faxed the complaint to a wrong number. Its counsel had appeared on the 48th day. Its affidavit set forth facts sufficient to support finding that it had not acted in bad faith.

The trial court granted the CR 60(b) motion to vacate. Maureen appealed. The Court of Appeals affirmed.

HOLDINGS:

(1) The granting of a motion to vacate a default judgment requires consideration of four factors:

(a)That there is substantial evidence extant to support, at least prima facie, a defense to the claim asserted by the opposing party;

(b) that the moving party's failure to timely appear in the action, and answer the opponent's claim, was occasioned by mistake, inadvertence, surprise, or excusable neglect;

(c) that the moving party acted with due diligence after notice of entry of the default judgment; and

(d) that no substantial hardship will result to the opposing party.

(2) A trial court does not act as trier of fact when considering a CR 60 motion.

(3) A trial court must take the evidence and reasonable inferences in the light most **favorable** to the CR 60 movant when deciding whether the movant has presented "substantial evidence" of a "prima facie" defense.

(4) CR 60 requires a movant to demonstrate substantial evidence supporting, at least prima facie, a defense to the claim asserted by the opposing party.

(5) State Farm presented evidence which, if later believed by a trier of fact, would be a defense. The trial court was required to rule that State Farm had come forward with "facts constituting a defense" or, "substantial evidence" of a "prima facie" defense.

(6) It is apparent that State Farm's failure to answer resulted from a mistake. State Farm acted with due diligence when it discovered the mistake.

(7) The prospect of trial cannot constitute "substantial hardship." Otherwise, a judgment would never be set aside, for that *always* generates the prospect of trial.

COMMENT:

A stunningly accurate review of a misunderstood area. In recent years, some superior court judges thought they could act as a trier of fact on a CR 60(b) motion. In addition, many of them did not understand that a mistake was a reason to grant, not deny, the motion.

Pfaff v. State Farm Mut. Auto. Ins. Co., 103 Wn. App. 829, 14 P.3d 837 (2000).

OPERATOR!! OPERATOR??

FACTS:

Bob was driving his family's car when Chris reached over from the passenger seat, grabbed the wheel, caused the car to swerve across the center line, and do a head-on with an oncoming car.

The family had an auto policy with North Pacific. North Pacific paid the liability coverage limits to the people injured in the other car.

Bob put in a UIM claim claiming that Chris was the operator of the vehicle and was underinsured. The company responded that Chris's action of grabbing the wheel did not make him an "operator" of the vehicle.

The superior court ruled that Chris was the "operator" notwithstanding a lack of permission, control, or common sense. North Pacific appealed arguing that "operator" means driver, not some nut case passenger who interferes with the driver's operation. The Court of Appeals, in one of the most insightful coverage opinions of the decade, agreed with the company. The Supreme Court reversed.

HOLDINGS:

(1) The interpretation of insurance policy language is a question of law. Undefined terms in an insurance policy must be given a fair, reasonable, and sensible construction as would be given by an average insurance purchaser. The terms of the policy must be understood in their plain, ordinary, and popular sense. To determine the ordinary meaning of an undefined term, our courts look to standard English language dictionaries.

(2) Those definitions contain no suggestion that an "operator" must be a single person who is in command of all the controls of a car.

(3) From a practical standpoint, narrowing the scope of "operator" to a single person who

is in sole command of all the controls of a vehicle does not sufficiently address the real-life situations that arise while driving.

(4) For purposes of UIM coverage, "operator" means a person who is in actual physical control of a vehicle. "Operator" includes a passenger who grabs the steering wheel of a moving car.

COMMENT:

Once more the Supreme Court demonstrates that it has not met a UIM claimant it would not take to extreme lengths so as to find coverage.

However, the silliest part of the opinion was the court's rationalization for the use of a criminal statutory definition. In response to the complaint that a criminal statutory definition should not be used to interpret a civil contract, the court said:

> The fact that the definition is for purposes of a criminal statute actually enhances its value, for a person's liberty may depend upon it.

How's that for a 24 kt. non sequitur?

North Pacific Ins. Co. v. Christensen, 143 Wn.2d 43, 17 P.3d 596 (2001).

YOUR COOPERATION IS APPRECIATED

FACTS:

Linda had renter's insurance with SAFECO. In the event of a claim she was to provide SAFECO with records and documents and to submit to an examination under oath as often as reasonably required.

Linda submitted first a fire loss and then a theft loss. SAFECO got a bit suspicious and asked for an EUO and some more detail about the claims. The EUO was held but Linda provided documentation as to only $1,600 of the $42,000 claim. She did not sign the EUO. SAFECO made several requests for documentation.

After four months SAFECO denied the claim on the basis of misrepresentation, failure to cooperate, and failure to sign the EUO.

Linda sued SAFECO. The trial court dismissed on summary judgment. The Court of Appeals affirmed.

HOLDINGS:

(1) Linda had a duty to provide the company with relevant information it reasonably requested and to submit and sign the EUO.

(2) Linda breached that duty as a matter of law.

(3) Generally, prejudice is an issue of fact. The insurer has the burden of proving that it was prejudiced by the insured's breach.

(4) Prejudice may be found as a matter of law where the insured has failed to cooperate with the insurance company investigation.

(5) SAFECO was prejudiced as a matter of law.

COMMENT:

In this area of duty to cooperate with an investigation the key case remains *Tran v. State Farm*, 136 Wn.2d 214, 961 P.2d 358 (1998).

Herman v. SAFECO Ins. Co., ___ Wn. App. ___, 17 P.3d 631(2001).

AN UNCOVERED CLASSIC

FACTS:

In the summer of 1997, Ben agreed to store a classic car. On May 22, 1999, a fire destroyed the car. Ben asked Allstate if it was covered under his homeowner's policy. It wasn't.

But he did learn that it could be covered if it had been purchased within 30 days of the fire.

A few days later Ben told his agent to be sure the car was listed on his policy. He then made a claim based on a purchase contract dated May 3, 1999.

In July, Allstate asked for authorization to access Ben's personal financial records. Ben refused to sign. In August, Allstate requested an EUO and a list of documents relating to income, debt, and liabilities. A week later Ben sued Allstate. The trial court granted Allstate's motion for summary judgment. The Court of Appeals affirmed.

HOLDINGS:

(1) A policy provision requiring an examination under oath before filing suit is a valid, enforceable contract provision.

(2) An insured's breach of a cooperation clause releases the insurer from its responsibilities if the insurer was actually prejudiced by the insured's breach.

(3) When an insurer has sufficient information to suspect the possibility of a fraudulent claim and the financial condition of the insured is pertinent to the claim, the insurance company is actually prejudiced as a matter of law if the insured fails to provide such information.

(4) Financial records of the insured are "relevant and material" once the insurance company has reason to broaden its investigation into the insured's possible financial motive for overvaluing or misrepresenting his claim.

(5) An insurer owes a duty to conduct a reasonable investigation before denying coverage. An insurer has a statutory duty to "root out fraud." In view of this obligation, it was not unreasonable for Allstate to make its inquiries into Ben's financial condition.

COMMENT:

The court noted that the existence of the purchase contract prevented Allstate from denying coverage outright. However, that contract also gave rise to a duty to investigate, and a corresponding duty to cooperate. Breach of that duty to cooperate will negate coverage.

Keith v. Allstate Indem. Co., (2001 Wash. App. LEXIS 309).

NEVER ENDING APPRAISAL

FACTS:

Lora's house was damaged by fire in 1992. She and her fire insurer then entered into a long dance which should have ended in July 1993, when the insurer (AMMI) petitioned for the appointment of

an umpire to oversee the appraisal process. But it was not until November 1993 that Lora agreed to participate. But then she changed her mind.

In February 1994, the court ordered appraisal. The appraisers met at the property in April 1994, but Lora did not show up. Lora's public adjuster would not let AMMI's appraiser view the property until June 1994. In December 1994, an award for damage to the residence was made.

In December 1995, the appraisal hearings on personal property were held. AMMI offered $36,384.66 RCV, and Lora requested $142,701.19 RCV. The appraiser awarded $69,411.68 RCV. Lora sued AMMI for bad faith and CPA violations. The superior court dismissed when AMMI moved for summary judgment.

The Court of Appeals affirmed.

HOLDINGS:

(1) Whether an insurer acted in bad faith and whether an insurer's acts prejudiced the insured are questions of fact. As the moving party, AMMI has the initial burden of showing the absence of an issue of material fact as to these issues. AMMI could meet its burden of showing the absence of evidence to support Lora's case. The burden then shifted to Lora to set forth specific facts establishing that there was a genuine issue for trial. Lora could not reply solely on the allegations in her pleadings, on speculation, or on argumentative assertions that unresolved factual issues remain.

(2) An insurer must deal fairly with an insured, giving equal consideration in all matters to the insured's interests. The duty to act in good faith is broad and conduct that does not amount to intentional bad faith or fraud may be a breach of the duty.

(3) Generally, an action for bad faith handling of an insurance claim sounds in tort.

(4) To prevail on a CPA claim, one must show (1) an unfair or deceptive act or practice in trade or commerce that impacts the public interest, and (2) resulting injury to the claimant's business or property. The insured may establish the first element by showing a violation of any subsection of WAC 284-30-330.

(5) The elements of a non-CPA bad-faith claim are similar. The violation of a WAC 284-30-330 subsection establishes a breach of duty. But, unlike the injury in the CPA claim, the injury alleged need not be economic and may include emotional distress or personal injury.

(6) Thus, to prevail on a summary judgment motion on either the CPA or non-CPA bad-faith claims, AMMI must show there is no question of fact as to (a) whether it violated any subsection of WAC 284-30-330, or (b) whether such violation caused a recognized injury.

COMMENT:

After setting out the rules, the court then went through each of the policyholder's asserted WAC violations and pointed out that the policyholder had failed to present evidence to support the claim.

This decision is probably modified by the *Ellwein* decision. No longer will it be the company's burden when moving for summary judgment on bad faith to show the absence of an issue of material fact. Instead, it will be the company's burden to show the existence of an issue of material fact, because if there is an issue of material fact as to bad faith, then the policyholder cannot discharge its burden of proving bad faith as a matter of law.

American Manufacturers Mutual Ins. v. Osborn, 104 Wn. App. 686, 17 P.3d 1229 (2001).

THE INVIOLATE RIGHT TO FREEDOM OF CONTRACT

FACTS:

Mr. G. was injured while riding a bus. Because the bus had no insurance (it was "self-insured;" an oxymoron for the ages), he made a UIM claim under his own insurance.

The policy provided that if the parties thereto could not agree as to entitlement or amount of damages, either party could demand arbitration. The policy expressly said that the arbitration decision as to entitlement was final and binding, but the arbitration decision as to the amount of damages was subject to trial if either party demanded it.

The dispute was arbitrated. Mr. G. was awarded $165,000. The company demanded a trial on the amount of damages. Mr. G. opposed that. The superior court held the new trial provision void because of the Arbitration Act.
Division I of the Court of Appeals reversed, upholding the right to freedom of contract and holding that a bilateral nonbinding arbitration agreement was valid.

In January 2001 the Supreme Court issued an opinion reversing the Court of Appeals. The court felt that too much freedom was not a good thing:

HOLDINGS:

(1) Parties are free to agree upon a variety of ADR mechanisms under Washington law to address their disputes.

(2) Parties are free to decide if they want to arbitrate.

(3) Parties are free to decide by contract whether to arbitrate, and which issues are submitted to arbitration.

(4) Parties are not free to decide by contract whether the arbitration is nonbinding.

(5) Washington's Arbitration Statute is so really, really big that it just flattens the written contractual agreements of the little people.

COMMENT:

As noted before, when you are the Supreme Court you are SUPREME. But let us just squeeze a couple of sour grapes: (1) the Arbitration Statute nowhere says it preempts the area of arbitration; (2) the Arbitration Statute nowhere says that nonbinding arbitration is anathema to the public good.

Godfrey v. Hartford Casualty Ins. Co., 142 Wn.2d 885, 16 P.3d 617, (2001)*, rev'g*, 99 Wn. App. 216, 993 P.2d 281 (2000).

THE FIRST SHALL BE LAST; AND THE SUPPLEMENT SHALL BE PRIMARY

FACTS:

Walker rented a car from National. National provided statutory minimum insurance "at no additional cost." The agent also offered "full coverage" up to $1 M for $8.95/day. Walker accepted that, initialing a spot on the car rental form.

A few days later an uninsured driver hit the rental car resulting in serious injury to Walker and three passengers.

Walker asked for PIP and UIM from National. It turned her down. Walker and a passenger sued National. In discovery they learned that the "Supplemental Liability Policy" was underwritten by Philadelphia. They sued Philadelphia.

National and Philadelphia convinced the trial court that the "SLP" was excess insurance and thus exempted from the UIM statute. National owed $50,000 UIM.

On appeal the Court of Appeals affirmed.

On further appeal, the Supreme Court held that the SLP is a primary policy with coverage up to $1 M, and it is National that is liable under it.

HOLDINGS:

(1) A person who rents a vehicle and purchases insurance as part of the transaction is entitled to UIM benefits against the rental agency equal to the total amount of liability coverage.

(2) The UIM statute requires every auto policy issued in Washington to provide UIM coverage.

(3) The UIM statute exempts from the requirement policies which apply only as excess to the insurance directly applicable to the insured vehicle.

(4) The amount of coverage required by the UIM statute equals the maximum limits of liability coverage.

(5) The question is, is the SLP primary and payable up to $1 M or is it excess and exempt.

(6) In resolving whether an insurance policy is primary or excess, we apply a functional approach.

(7) "Primary insurance" is defined as "[i]nsurance that attached immediately on the happening of a loss."

(8) When Walker accepted the SLP and paid for it, National contracted with her to provide primary liability insurance.

(9) Under the rental agreement and extrinsic evidence Walker and National contracted for up to $1 M in primary liability coverage. Since there is no UIM waiver, there is up to $1 M in UIM.

(10) Philadelphia contracted with National. It did not contract with Walker. Philadelphia is not liable to Walker. Only National is.

COMMENT:

How wonderful! For years, the car rental companies have been selling car insurance but were not held to the same standard as any other car insurer. And now to double the pleasure, the court held the rental company solely liable, turning the underwriter loose because there was no privity of contract between the underwriter and the renter.

But every silver lining does have a cloud. Here the court resurrected that old chestnut *Berg v. Hudesman* to support its reliance on extrinsic evidence.

Graphically illustrating the rule that the Supreme Court is SUPREME was the court's view that the brochure was irrelevant when determining the character of the policy, but it was relevant for determining the intent of the parties. I'll bet you did not know they could slice distinctions that thin.

And we do not have space to fully examine the court's utilization of the definition of the word "however" to negate the expensive legal language National had purchased to hide the coverage.

The case demonstrates that the court is willing to go through not just the primary and secondary level of analysis, but the tertiary as well. Accordingly, a coverage analysis which does not reach the tertiary level of analysis may not be complete.

Diaz v. National Car Rental Sys., 143 Wn.2d 57, 17 P.3d 603 (2001).

NO PUNITIVE DAMAGES

FACTS:

In January 1995, Martin Pang set fire to his parents' warehouse in an attempt to collect the insurance proceeds. Four Seattle firefighters died fighting that fire.

Martin fled to Brazil where he was captured. He was returned but with the proviso that he could not be charged with first-degree murder. He plead guilty to four counts of manslaughter and is in jail.

The widow of one of the firemen sued Pang. He admitted starting the fire. The widow moved to amend her complaint to assert a claim for punitive damages. The trial court denied the request. Actual damages of $5.4 million were awarded against Pang.

The widow appealed the refusal to amend to introduce punitive damages to the Supreme Court. That court bounced the case back to the Court of Appeals, which held that punitive damages are generally not available in Washington.

HOLDINGS:

(1) Since the seminal case of *Spokane Truck & Dray Co. v. Hoefer* in 1891, our Supreme Court has allowed punitive damages **only** when expressly authorized by statute.

(2) Our Supreme Court rejected the notion of general punitive damages in the landmark case of *Spokane Truck*. The court denounced punitive damages as "unsound in principle, and unfair and dangerous in practice" for a number of reasons.

(3) First and foremost, the court reasoned, compensatory damages alone were sufficient to make a plaintiff "entirely whole." It determined that the doctrine of compensatory damages was "exceedingly liberal towards the injured party," and covered all losses, including those for injury to person or property, physical pain, and mental suffering.

(4) The court next reasoned that because the object of punitive damages is to impose punishment, they infringe upon "the province of the criminal court."

(5) It also rejected punitive damages on the basis that they allow the plaintiff a windfall, "which is repugnant to every sense of justice."

COMMENT:

Washington is one of the few states which had the good sense to reject punitive damages from the beginning.

Shoemaker v. Pang, (2001 Wash. App. LEXIS 362).

PURE ESCAPISM

FACTS:

Steve owned a home in Missoula. It was insured with American Bankers. One day, Steve told his agent to get a policy from National. He did. No one cancelled the American Bankers policy, and Steve made payments on both.

The house burned down six months later. Steve collected the policy limits from American Bankers. National filed an interpleader and deposited its policy limits into court. Both Steve and American Bankers claimed the money.

The controversy centered on the "Other Insurance" clauses. The American Bankers policy said that "if the insurance provided by this policy is also provided by other insurance, the coverage under this policy will terminate as of the effective date of the other insurance." (That is an escape clause.)

The National policy provided that if there were other insurance, then National would "pay only the proportion of a loss . . . that the limit of liability . . . under this policy bears to total amount of fire insurance."

The trial court concluded that American Bankers had escaped the loss, that it was entitled to be fully reimbursed for what it had paid, less the premiums that Steve had paid.

The Montana Supreme Court affirmed, holding that the clause was not against public policy.

HOLDINGS:

(1) When the language of a policy is clear and explicit, the policy should be enforced as written.

(2) We have held that multiple uninsured and underinsured motorists policies should be stacked when an insured who is named in multiple policies has proven damages that exceed the limits of an individual policy.

(3) Our decisions do not support providing a windfall to an insured who has suffered a property loss and has been fully compensated for that loss under his insurance policy.

(4) The language of American Bankers' insurance policy is clear and explicit, and this Court finds no public policy reason to avoid its provisions.

COMMENT:

The court acknowledged that some courts have deemed escape/other insurance clauses to be unconscionable. And it acknowledged that when dealing with bodily injury and auto policies, it has not been reluctant to disregard language which would limit coverage to one policy. But in a pure property loss, where the insured would reap the windfall, the court said, enough.

National Casualty Co. v. American Bankers Ins. Co., 304 Mont. 163, ___ P.3d ___ (2001 Mont. LEXIS 26).

"AN INSURED" COVERS TOO LITTLE

FACTS:

Joretta had a house, six kids, and a fire insurance policy. One of the kids burned the house down.

The policy excluded coverage for loss resulting from intentional acts by "an insured." "An insured" was defined so as to include Joretta and the six kids. The company denied coverage because of an intentional act by "an insured."

Joretta sued the company. The trial court concluded that because the fire policy excluded coverage for acts committed by "an insured" rather than by "the insured," the policy provided less fire coverage than what was called for in the New York statutory fire policy.

The Appellate Division reversed, concluding that the terms were unambiguous and that the coverage did not fall below the statutory minimum.

The Court of Appeals reversed, holding that the exclusion impermissibly restricted the coverage mandated by the New York standard fire insurance policy as codified by statute.

COMMENT:

The New York standard fire policy has been adopted by most states as the standard minimum level of coverage permissible for a fire insurance company to issue.

The court pointed out that its ruling was limited to matters involving fire insurance where a statutorily mandated minimum coverage was involved. It did not apply to liability insurance. In the recent Washington case of *Mutual of Enumclaw v. Cross*, 103 Wn. App. 52, 10 P.3d 440 (2000), *rev. denied*, 142 Wn. 2d 1025 (2001), the court enforced the "an insured" exclusion holding that coverage for all insureds was excluded when the intentional act of one insured gave rise to the injury.

Lane v. Security Mut. Ins. Co., ___ N.Y.2d ___, ___ N.E.3d ___ (2000 N.Y. LEXIS 174).

FOLLOWING UP

A while back we brought to your attention a case in which a federal court of appeals demonstrated that it was so full of itself that it declared one of its own local rules unconstitutional rather than just changing the rule: *U.S. v. Anastasoff*, 223 F.3d 898 (8th Cir. 2000).

What happened after that was also interesting. The case got picked up by the national media and the whole question of "unpublished" appellate opinions was subject to fierce and scholarly debate. But then the government lawyers pulled a fast one. Although they had won that particular battle, it was clear they might lose the war. What to do? They paid Ms. Anastasoff her claim in full, plus interest.

What happened next? In a published en banc per curiam opinion, the court said the question of the precedential effect of unpublished opinions was really interesting, but the case was now moot; therefore the earlier opinion was vacated and the case was remanded to the trial court with instructions to vacate its earlier judgment. Net result: it is as if none of this ever occurred. *U.S. v. Anastasoff, II*, 235 F.3d 1054 (8th Cir. 2000).

A couple of years back we mentioned the *Squibb* case, where after 16 years of litigation in the district court the case reached the U.S. Court of Appeals for the Second Circuit. And what happened then? The court, on its own, raised a question of jurisdiction because some guys from London were parties, and sent the case back to the trial court. Eventually, it came back up and 16 months after oral argument the court opened its opinion with this stunning piece of understatement:

> For the past eighteen years, this case, a declaratory action brought by the maker of the drug diethylstilbestrol ("DES") to resolve complex insurance coverage issues, has been slowly making its way through the federal courts. While it is, unfortunately, not unusual for a complicated case such as this one to take years to resolve, eighteen years is a particularly long time and the parties are understandably anxious to reach a conclusion. Thus they were, we think it is safe to say, more than slightly miffed when, in our first encounter with the case, we remanded it to the district court for a determination of whether, given the presence, as defendants, of "Certain Underwriters at Lloyd's of London" ("Lloyds"), federal subject matter jurisdiction existed.

E.R. Squibb & Sons, Inc. v. Lloyd's & Cos., 241 F.3d 154 (2nd Cir. 2001).

REED MCCLURE IS PLEASED TO ANNOUNCE

ANAMARIA GIL HAS BEEN ELECTED A SHAREHOLDER IN THE FIRM.

Anamaria joined Reed McClure in 1995. Anamaria concentrates her practice on insurance defense litigation, with a special emphasis on premises liability , products liability, and construction-related claims.

CHERYL ZAKRZEWSKI HAS JOINED THE FIRM AS A PRINCIPAL.

Cheryl brings over 16 years of litigation experience to Reed McCLure. Her practice focuses on employment and health care claims. Cheryl earned her law degree from Tulane Law School in 1984.

LEVI BENDELE JOINS THE FIRM AS A NEW ASSOCIATE.

Levi comes to Reed McClure with a background in the insurance feild. He is a 1994 graduate of the University of Denver College of Law. His Practice focuses on defense of first and third party claims and coverage issues.

JENNIFER MOORE JOINS THE FIRM AS AN ASSOCIATE.

Jennifer is a 2000 graduate, *cum laude*, of Seattle University School of Law. She focuses her practice on appellate issues and general litigation, including medical malpractice and insurance defense.

SUSAN HANDLER JOINS THE FIRM AS AN ASSOCIATE.

Susan Handler joined Reed McClure in February 2001. Susan is a registered nurse and an attorney. She focuses her practice on health care licensing and malpractice matters. Susan is a 1996 graduate, *cum laude*, of California Western School of Law.

We are also pleased to congratulate our Reed McClure colleague, John P. Erlick, on his recent election as a Superior Court Judge for King County.

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WE'VE MOVED UP!

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