WASHINGTON INSURANCE LAW LETTER™

A SURVEY OF CURRENT INSURANCE LAW AND TORT LAW DECISIONS

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NO DISCLOSURE IS GOOD DISCLOSURE

FACTS:

Janice was rear-ended by Linda. An employee of Janice's attorney told the liability adjuster over the phone that Janice had a closed head injury, loss of memory, $20,000 in medical bills, and past and future wage loss. Neither Janice nor her attorney provided any other information about her injuries. Nevertheless, Janice repeatedly demanded that the insurer disclose its policy limits. The insurer declined, pending receipt of documentation of the claim.

Two years after the incident, Janice sued Linda. Only then did Janice send the insurer a written description of her claim. Plaintiff claimed out-of-pocket special damages in excess of $612,000. The insurer promptly disclosed its limits and a few months later paid the limits to Janice.

Linda later agreed with Janice to a partial judgment of $100,000 and assigned her rights against the insurer to plaintiff in return for a covenant not to execute.
The insurer filed a declaratory judgment action. Janice, in her own right and as Linda's assignee, sued, claiming breach of duty of good faith for the insurer's refusal to disclose Linda's policy limits to Janice. The trial court dismissed all of Janice's claims on summary judgment.

On appeal, Janice first argued that Linda's liability carrier owed her a direct duty and had breached the duty. Second, she argued that the liability carrier breached the duty it owed its own insured. Division II of the Court of Appeals rejected both contentions. It held that the third-party liability carrier owed no duty to a third-party claimant, and that in this case the carrier did not breach any duty owed to its insured.

HOLDINGS:

(1) Third-party claimants may not sue an insurance company directly for alleged breach of duty of good faith under a liability policy.

(2) An insurer owes its insured a duty to act in good faith. When the insured is likely to be found liable, this duty encompasses an affirmative duty to make a good faith effort to settle.

(3) An insurer breaches its affirmative duty to make a good faith effort to settle by negligently or in bad faith failing to settle a claim against the insured within its policy limits.

(4) When an insurer moves for summary judgment in the context that it made a good faith effort to settle, it necessarily claims that a rational trier of fact could not find that the insurer breached its affirmative duty to make a good faith effort to settle. To support such a claim, the insurer must show the reasons why it did what it did. If the insurer makes such a showing, the insured must produce evidence sufficient to support a finding that there was no reasonable basis for the insurer's action, *i.e.*, that the insurer's reasons never existed or were so unreasonable, frivolous, or unfounded that a reasonable person would have considered them not "fairly debatable." This is a "heavy burden." But unless the insured meets it, the insurer is entitled to summary judgment.

(5) Because a reasonable person in the shoes of the insurer could not know whether the disclosure of the limits would help or hurt the insured's interests, Janice cannot show that "there was no reasonable basis for" the company's actions.

COMMENT:

Clearly, the most significant bad faith opinion of 2002. The court applied the *Ellwein* limitations—not as a hammer—but as a scalpel to carve up plaintiff's counsel's arguments.

In addition, the opinion is a veritable treasure trove of citations covering the development of Washington bad faith case law.

Smith v. SAFECO Ins. Co., ___ Wn. App. ___, 50 P.3d 277 (2002).

NOT ENOUGH TIES TO BIND

FACTS:

Gertrude rear-ended a car in which Tara was a passenger. Gertrude had a $100,000 liability policy. The car in which Tara was riding had a $100,000 UIM limit.

Tara sued Gertrude. However, rather than go through the court system, the parties detoured to private arbitration. The UIM carrier did not take part. The arbitrator fixed Tara's damages at more than $300,000.

Tara then demanded that her UIM carrier, Farmers, pay her the $100,000 UIM limit. Farmers declined, pointing out that if was not bound by the arbitration because it had not been notified of Tara's suit against Gertrude.

Tara sued Farmers, claiming that Farmers was bound by the arbitration award. She argued that Farmers had notice of the Tara/Gertrude lawsuit because of: (1) The basic facts of the accident; (2) A phone call between two lawyers who did not discuss the lawsuit; (3) A letter from her lawyer to Farmers discussing another person's claim. That was good enough for the trial court. It was not good enough for the Court of Appeals, which reversed.

HOLDINGS:

(1) A UIM insurer is bound by a judgment or arbitration award against an uninsured or underinsured tortfeasor if the UIM insurer had a reasonable opportunity to appear, and thus to protect its interests, in the proceedings that led up to the judgment or award.

(2) With no more than the letter, the phone call, and the basic facts of the accident, Farmers lacked the information it needed to decide whether an appearance was necessary, the information it needed to make an appearance if it decided one was necessary, and, overall, a reasonable opportunity to appear in the lawsuit.

(3) A claim of bad faith sounds in tort.

(4) The bad faith claimant has the burden of production and the burden of persuasion. To satisfy his or her burden of production, and thus to survive a motion to dismiss made at the end of the plaintiff's case or a motion for directed verdict made at the end of all the evidence, the bad faith claimant must produce evidence sufficient to support a reasonable inference, and thus a finding of fact, that "there was no reasonable basis for the insurer's actions", *i.e.*, that the insurer's reasons never existed or were so "unreasonable, frivolous, or unfounded" that a reasonable person would have considered them not "fairly debatable."

(5) The bad faith claimant does not meet this heavy burden merely by producing evidence sufficient to support an inference that he and the insurer had a legitimate difference of opinion.

(6) Tara's bad faith claim is not supported by evidence sufficient to support a reasonable inference, and thus a finding of fact, that "there was no reasonable basis for the insurer's actions." Farmers had a reasonable basis for contending that it was not bound by the arbitration award.

COMMENT:

After a couple of dreadful Supreme Court opinions on this point, it is reassuring to read that there does exist a Plimsoll line of proof as to which even a UIM claimant must rise before this bastardized version of collateral estoppel will apply.

Beck v. Farmers Ins. Co., ___ Wn. App. ___, ___ P.2d ___ (2002), 2002 Wash. App. LEXIS 2147.

CLAIM MISHANDLING – VERSION 1.01

FACTS:

Mark, while speeding under the influence of alcohol and attempting to elude police, hit a tree. His passenger, Bob, hurt his left foot. (About $20,000 in medical bills' worth.) Mark notified his insurer, Viking, of the accident. Bob hired a lawyer, Mike.

Mike made phone calls and wrote letters to Viking demanding policy limits. After four months, Viking responded saying the limits were $25,000/$50,000. Mike sent more demand letters to Viking. Viking lost the file. Mike copied his earlier letters and sent them again.

Bob sued Mark, and got an order of default. Viking appointed defense counsel who got the default set aside. Bob and Mark settled for an agreed judgment of $175,000 and a covenant not to execute. Mark assigned to Bob all his claims against Viking. The trial court entered an order finding the settlement amount to be reasonable. Viking then gave Bob the policy limits.

Bob sued Viking. The trial court found bad faith but limited recovery to the contractual limit of $25,000. The Court of Appeals reversed, holding that the bad faith damages were not necessarily limited to the $25,000.

Bob went to the Supreme Court arguing that his stipulated judgment, which had been held to be reasonable under the *Chaussee* criteria, was the appropriate measure of damages for Viking's bad faith. Viking did not file a brief. The Supreme Court agreed with Bob.

HOLDINGS:

(1) If an insurer acts in bad faith by refusing to effect a settlement for "a small sum," an insured can recover from the insurer the amount of a judgment rendered against the insured, even if the judgment exceeds contractual policy limits.

(2) An insured may independently negotiate a settlement if the insurer refuses in bad faith to settle a claim. In such a case, the insurer is liable for the settlement to the extent the settlement is reasonable and paid in good faith.

(3) When an insurer refuses, in bad faith, to settle a tort claim asserted by an injured party, the insured could settle the tort claim against him, which far exceeded his liability coverage, and recover from the insurer the amount paid in settlement in excess of the limits of the policy.

(4) We hold the amount of the covenant judgment is the presumptive measure of an insured's harm caused by an insurer's tortious bad faith if the covenant judgment is reasonable under the *Chaussee* criteria. This approach promotes reasonable settlements and discourages fraud and collusion.

(5) The *Chaussee* criteria protect insurers from excessive judgments especially where the insurer has notice of the reasonableness hearing and has an opportunity to argue against the settlement's reasonableness.

COMMENT:

Based on the facts and the claims handling, the result is not at all surprising. Problems will arise from those who view this as a green light for drop-dead windfall settlements generated by fraud, greed, and collusion.

You can find the criteria in *Chaussee v. Maryland Cas. Co.*, 60 Wn. App. 504, 803 P.2d 1339, 812 P.2d 487 (1991).

Besel v. Viking Ins. Co., 146 Wn.2d 730, 49 P.3d 887 (2002).

NO GOOD TURN GOES UNSTONED

FACTS:

Jeremy went through a stop sign and hit Janet's van. Janet sustained severe injuries.

Three days later, Jeremy's liability insurer, Allstate, contacted Janet's family because it was Allstate's policy to provide quality service to anyone who had been involved in an accident with an Allstate insured.

The claims adjuster developed a relationship with Janet's family, and helped them get their medical bills paid and reach a settlement with their own insurer. A year later, the adjuster sent Janet a check for the Allstate policy limits and a release.

Now isn't that how you would want your insurance company to handle claims? ("Like a good neighbor . . ." "You're in good hands," etc.)

Of course, that is the way civilized humans would like things handled. But there is a significant part of the legal community which turned purple when it became apparent that this novel approach to claims handling might cut into their beer and skittles fund. And, being lawyers, they did what lawyers do: they filed a lawsuit.

And, you may ask, what was the gravamen of the complaint? (No, you would not ask what was the "gravamen." Only a lawyer cares about that.) What did they complain about? Are you ready? Here it comes. They complained that the Allstate adjuster was practicing law without a license!!

Well, the lawsuit ended up in the Supreme Court. What happened there is not altogether clear. I am reminded of what Paul said to the folks in Corinth: "Now, we see through a glass, darkly." Or maybe it was Twain: "He saw nearly all things as through a glass eye, darkly." Whatever.

It appears that the five-justice majority held that the Allstate adjuster was practicing law, but it was not going to tell us if it was unauthorized.

It also appears that a very oddly constituted four-person minority ripped the majority opinion into little bitty pieces, and then stomped on the pieces.

And finally, it appears that if you truly want to try to understand, you should log onto http://www.wdtl.org/archive/news/okano/0206.htm and read my partner Pam Okano's analysis.

Jones v. Allstate Ins. Co., 146 Wn.2d 291, 45 P.3d 1068 (2002).

FULLY COMPENSATED

FACTS:

Greg was injured in an auto accident. He sued the other driver, who had $25,000 limits. Greg settled for $21,000.

Greg then submitted a UIM claim to his own carrier. After arbitration, the arbitrator set Greg's damages at $10,000.

Greg filed a motion to confirm the award. The UIM carrier filed a motion to satisfy the award. The trial court ruled that the UIM carrier was entitled to offset the tortfeasor's $25,000 limits against the arbitrator's $10,000 award, and Greg got nothing.

The Court of Appeals held that Greg had already recovered more than twice as much as would fully compensate him.

HOLDINGS:

(1) Entitlement to a credit or setoff is an issue of insurance coverage to be decided by the superior court, not by a UIM arbitrator. *Price v. Farmers*, 133 Wn.2d 490 (1997).

(2) An insurer is entitled to be reimbursed to the extent that its insured recovers payment for the same loss from a tortfeasor responsible for the damage, but the insurer can recover only the excess remaining after the insured is fully compensated for his or her loss.

(3) Greg already recovered twice as much compensation as the UIM arbitrator ruled he was entitled to.

(4) An appeal is frivolous when there are no debatable issues over which reasonable minds could differ and there is so little merit that the chance of reversal is slim. This appeal is frivolous.

COMMENT:

Because the appeal was frivolous, the UIM carrier became entitled to its attorney fees on appeal.

Frivolous appeals do not, in theory, meet the criteria for a published opinion, *i.e.*, they are not precedential. (*See* RCW 2.06.040.) This "Catch-22" situation creates for the average reader of the green books (*i.e.*, Court of Appeals opinions) the impression that

the court does not enforce its frivolous appeals rule. The court needs to periodically publish opinions involving frivolous appeals to dispel this erroneous notion.

Amunrud v. Fire & Cas. Ins. Co., 2002 Wash. App. LEXIS 1972 (2002) (Wash. Ct. App. Aug. 26, 2002).

IT'S THE WRONG CAR IN THE WRONG STATE

FACTS:

Marcus was walking north on the shoulder of I-5 when he stepped directly in front of a car being driven by Chhin. The car was owned by Chhin's friend, Piotr.
Piotr, who was from Colorado, was going to school in Washington. The car was insured in Colorado. Piotr's Colorado State Farm policy provided PIP coverage to pedestrians hit by the car, but only if the accident occurred within Colorado.

Marcus made a PIP claim. State Farm denied it. Marcus sued State Farm. The trial court ruled in State Farm's favor and the Court of Appeals affirmed.

HOLDINGS:

(1) Where the parties dispute which state's law should govern, this court applies the law of the state with the most significant relationship to the transaction and the parties.

(2) We consider the following factors in determining which state's law to apply to an automobile insurance contract:

(a) the place of contracting,

(b) the place of negotiation of the contract,

(c) the place of performance,

(d) the location of the subject matter of the contract, and

(e) the domicile, residence, nationality, place of incorporation and place of business of the parties.

(3) There is no clear public policy that would justify this court in imposing on State Farm additional liability that is not reflected in the insurance policy or premium.

(4) Although PIP coverage must be offered under Washington law, it is not mandatory; a party may reject it in writing.

(5) After considering all the relevant contacts in light of the competing interests, we conclude that Colorado has the most significant relationship to the insurance contract.

COMMENT:

Among the factors singled out by the court were the facts the policy was executed in Colorado, the car was registered in Colorado, the policy makes explicit reference to Colorado law, and in Colorado, PIP coverage is mandatory, not optional as in Washington.

Cowles v. State Farm Mut. Auto. Ins. Co., 2002 Wash. App. LEXIS 1423 (2002) (Wash. Ct. App. June 17, 2002).

ARSON IS NOT VANDALISM

FACTS:

Alex owned a home in Longview. After his daughter and son-in-law moved out, it was vacant for seven months. Then someone (not Alex) set fire to the house and it sustained substantial damage.

Alex had a "Dwelling Fire Policy" with SAFECO. It had a vacancy exclusion which provided that if the house was vacant for more than 30 days, then losses due to "vandalism" and "malicious mischief" were not covered. SAFECO took the position that arson is vandalism, and thus there is no coverage.

Alex sued for coverage, bad faith, and Consumer Protection Act violations. The trial judge dismissed the Consumer Protection Act and bad faith claims but went on to rule that "vandalism" and "malicious mischief" do not include "arson."

And then, in an absolutely bizarre opinion, the Court of Appeals affirmed.

HOLDINGS:

(1) Interpretation of the language in an insurance policy involves a question of law that we review de novo. We construe the policy as a whole to give effect to every clause. We interpret the policy terms as would an average purchaser. We examine the policy to determine whether it provides coverage under the policy's plain meaning. We

interpret policy terms in accordance with the policy definitions, while we give an undefined term its "plain, ordinary, and popular" meaning.

(2) We construe ambiguous terms in an insurance policy in favor of the insured. A term is ambiguous if it is susceptible to two different but reasonable interpretations.

(3) We construe ambiguities contained in an *inclusionary* provision liberally to provide coverage, whereas we construe ambiguities contained in an *exclusionary* provision strictly against the insurer.

(4) Exclusions will not be extended beyond their clear and unequivocal meaning.

(5) SAFECO labeled the policy, "Dwelling Fire Policy." Therefore, the policy covers fire loss unless specifically excluded. Arson is not a named exclusion, nor is it defined. The policy does not define the terms "vandalism" and "malicious mischief."

(6) SAFECO's argument that arson is included within the dictionary definition of vandalism because it is the "willful destruction of another's property" falls short because "the terms at issue are contained in an exclusionary provision." Exclusions will not be extended beyond their clear and unequivocal meaning.

(7) "And because this is a Dwelling Fire Policy that does not unambiguously specify in its listed exclusions, we hold that there is coverage."

(8) We hold that when a homeowner purchases a dwelling fire policy that contains a vacancy exclusion for vandalism and malicious mischief, arson is a covered peril.

COMMENT:

While the opinion sets out many of the rules of insurance policy interpretation, it doesn't mention the one which prohibits a forced or strained interpretation which leads to an absurd or nonsensical result. *Ross v. State Farm*, 132 Wn.2d 507, 521 (1997).

Dixon v. SAFECO Ins. Co., 2002 Wash. App. LEXIS 2146 (2002) (Wash. Ct. App. Sept. 6, 2002).

Remember, selected back issues of the Law Letter are available on our web site at www.rmlaw.com/newsltr.htm ... and Pam Okano's monthly Coverage Column is available at www.wdtl.org/ (see Coverage Uncovered).

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