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WASHINGTON FEDERAL COURT DENIES INSURER'S ATTEMPT TO ESCAPE WASHINGTON COURTS, BUT FINDS THAT EXTRA-CONTRACTUAL CLAIMS ARE GOVERNED BY LAWS OF ANOTHER STATE

by Margaret A. Duncan

When dealing with a coverage lawsuit in Washington State, insurers often seek to transfer the case to another state or application of another state's law. On April 14, 2016, Judge James L. Robart for the United States District Court for the Western District of Washington denied an insurer's attempt to transfer a case from Washington to New Jersey, but found that the insured's extra-contractual claims of bad faith, violation of Washington's Consumer Protection Act (CPA), and violation of Washington's Insurance Fair Conduct Act (IFCA) would be decided under New Jersey law instead of Washington law.

The facts in *T-Mobile USA, Inc. v. Selective Ins. Co. of Am.,* 2016 U.S. Dist. LEXIS 50479 are as follows: Innovative Engineering, Inc. (Innovative) entered into two agreements with subsidiaries of T-Mobile USA, Inc. (T-Mobile) to perform work on T-Mobile's cell phone towers. As part of the agreement, Innovative agreed to obtain certificates of insurance naming these subsidiaries as additional insureds under Innovative's insurance policy with Selective Ins. Co. of Am. (the Insurer). Both Innovative and the Insurer are New Jersey corporations, and the policy was purchased through a New Jersey broker. T-Mobile is a Delaware corporation, but is headquartered in Washington.

T-Mobile was sued in New York after one of its cell phone towers serviced by Innovative allegedly damaged a building in New York. T-Mobile filed a third-party complaint against Innovative and sought coverage from the Insurer under Innovative's insurance policy. After the Insurer denied coverage to T-Mobile, T-Mobile filed suit against the Insurer in Washington state court, alleging that it was an additional insured under Innovative's policy. T-Mobile brought claims for breach of contract, bad faith, and violations of the CPA and IFCA. The Insurer removed the case to the United States District Court for the Western District of Washington and then filed a motion to transfer venue to New Jersey and for application of New Jersey law. The Court denied the Insurer's motion to transfer venue after finding that the Insurer failed to meet its burden of showing transfer to New Jersey was warranted under the nine-factor balancing test used in the Ninth Circuit. Specifically, the Court found that while the insurance contract was negotiated and entered into in New Jersey, T-Mobile's choice to bring suit in Washington receives "substantial deference."

However, the Court partially granted the Insurer's motion for application of New Jersey Law with respect to T-Mobile's bad faith, IFCA, and CPA claims. While the Court denied the Insurer's motion for application of New Jersey law to the breach of contract claim because there was no apparent conflict in the law between the two states, it found that Washington and New Jersey law conflicted regarding the bad faith, IFCA, and CPA claims. Accordingly, the Court applied Washington's "most significant relationship" test, which analyzes the following four factors to determine which state's law applies: (1) the place where the injury occurred; (2) the place where the conduct causing the injury occurred; (3) the domicile, nationality, residence, place of incorporation, and place of business of the parties; and (4) the place where the relationship, if any, between the parties is centered.

The Court found that although the injury occurred in both Washington and New York, the first factor weighed slightly in favor of applying Washington instead of New Jersey law. The Court found that the second factor weighed in favor of applying New Jersey law because New Jersey was the state in which the Insurer made its coverage decision. The Court determined that the third factor was neutral because the parties had contacts in both Washington and New Jersey. The Court then considered the following for the fourth factor: (1) where the insurer made the coverage decision; (2) where the insurance contract was requested and issued; and (3) where the underlying liability occurred and is being litigated. The Court concluded that the parties' relationship was centered in New Jersey because that was where the policy was issued, where T-Mobile was allegedly added as an additional insured, and where the coverage determination was made. After balancing the four factors, the Court found that the most significant contacts between T-Mobile and the Insurer occurred in New Jersey.

The Court's decision in this case is significant because it demonstrates the reluctance of Washington Courts to transfer cases to other jurisdictions when there is some connection with Washington. On the other hand, it shows that Washington Courts will apply the laws of another state to bad faith claims against insurers in Washington.

WASHINGTON COURT DISMISSES BAD FAITH AND IFCA CLAIMS WHEN INSURED DID NOT PROPERLY OR TIMELY DISCLOSE ALLEGED DAMAGES TO UIM INSURER

by Eliot M. Harris & Sean T. James

On May 11, 2016, Judge Richard A. Jones for the United States District Court for the Western District of Washington rendered an important decision limiting an insurer's potential liability for bad faith and violations of Washington's Insurance Fair Conduct Act (IFCA) arising from its handling of an Underinsured Motorist (UIM) claim. The Court found that when the insured has not fully and adequately advised the insurer of the extent of their damages, the insurer cannot be liable for bad faith or IFCA violations when the insurer makes a reasonable settlement offer based on the information provided by the claimant during the claim investigation.

In Bridgham-Morrison v. Nat'l Gen. Assurance Co., 2016 WL 2739452, the insured was rear-ended and filed a UIM claim with her insurer. The insured provided certain documents including a police report, medical records, and a letter from her employer to support a wage loss claim. The insurer conducted an initial evaluation of the claim, and based on the information provided by the insured, made an initial settlement offer of $17,000, which was rejected. The insurer then made a second settlement offer of $20,000, which was also rejected. The insured demanded $85,000, but refused to provide additional documentation requested by the insurer to support her claim. Despite extensive correspondence between the parties for over a year, they were unable to agree on a settlement amount, and the insured and her husband, who had since asserted a claim for loss of consortium, sued the insurer for bad faith and IFCA violations. In response, the insurer filed a summary judgment motion seeking dismissal of these extra-contractual claims. While this motion was pending, the parties settled the UIM claim after the insured provided additional documents.

The Court noted that a delay in payment because of a dispute over the amount owed does not constitute a denial of payment under IFCA. The Court noted that this is especially true where the insurer is initially unable to adequately assess the insured's claimed damages without additional information. The Court stated that while an unreasonably low settlement offer may serve as a denial of benefits, a good faith effort to appropriately value a loss, such as this case, is not such a denial. The Court questioned whether the insurer's conduct even constituted a refusal to pay benefits, as required for an IFCA claim, as the insurer made multiple attempts to settle the claim, and ultimately did settle the claim after receiving additional information. The Court rejected the insured's argument that the insurer failed to reasonably investigate their claim by not considering certain damages during the initial claim review process. Instead, the Court held that when investigating a claim an insurer is not obligated to consider every possible avenue by which an insured could have theoretically recovered. Thus, to the extent that the investigation and settlement offer did not account for information that the insured had not promptly and adequately disclosed, the insured could not claim that the investigation was unreasonable or in bad faith.

This ruling is significant because it demonstrates that when investigating a claim and determining an appropriate settlement amount, an insurer may act in good faith by making a settlement offer based on the damages that were adequately presented by the insured during the insurer's investigation. The holding also indicates that an insured has some level of responsibility to advise their insurer of the extent of their UIM claim and that a bad faith claim against the insurer may not be supported by damages that are not properly and timely disclosed.

WASHINGTON FEDERAL COURT REFUSES TO EXTEND COVERAGE TO SPOUSE OF NAMED INSURED WHEN NOT QUALIFIED AS AN "INSURED" UNDER PROFESSIONAL LIABILITY POLICY

by Eliot M. Harris & Sean T. James

On May 19, 2016, Judge John C. Coughenour for the United States District Court for the Western District of Washington granted a motion to dismiss a coverage lawsuit filed by an insured, finding the insurers did not have a duty to defend the insured's spouse when the spouse was not a named insured under a professional liability policy and did not otherwise qualify as an insured.

In *Staheli v. Chi. Ins. Co.,* 2016 WL 2930444, the plaintiff, Lana Staheli, purchased professional liability insurance from Defendants Chicago Insurance Company and ACE American Insurance Company (Insurers) for her psychology practice. Both policies contained nearly identical language, identifying Ms. Staheli as the "Named Insured" and obligating the Insurers to provide coverage for claims against the "Insured." In November 2013, a patient sued Ms. Staheli and her husband for damages allegedly caused by her professional negligence. The Insurers agreed to defend Ms. Staheli, but refused to defend her husband. Ms. Staheli and her husband filed suit against the Insurers for breach of contract, bad faith, and violations of Washington's Insurance Fair Conduct Act (IFCA) and Consumer Protection Act (CPA).

The Court held that the Insurers correctly determined that while Ms. Staheli was insured as the "Named Insured" under the policy, her husband was not an "Insured" simply because the complaint sought damages against their marital community. The Court held that the lack of contractual privity between the Insurers and the husband was fatal to his breach of contract claim. The Court further held that despite the fact that Washington is a community property state, which could render the husband and the couple's marital community liable for Ms. Staheli's activities, there was no coverage for the husband under the plain and ordinary language of the Insurers' policies, which only covered an "Insured."

Similarly, the Court held that the husband's bad faith, IFCA, and CPA claims failed because under Washington law, only an "Insured" has the right to assert such claims. Thus, the Court dismissed these claims premised on the Insurers' coverage decision regarding the husband. As to Ms. Staheli's bad faith, IFCA and CPA claims, the Court dismissed these claims because there was no evidence of any unreasonable conduct to support these claims. The Court also rejected Ms. Staheli's breach of contract claim because the Insurers did not deny coverage to her.

This holding is significant because it clarifies that the duty to defend an insured does not necessarily extend to the insured's spouse, even in a community property state such as Washington, simply because the insured's spouse and their marital community are named as defendants in the lawsuit.

WASHINGTON FEDERAL COURT ALLOWS DECLARATORY JUDGMENT ACTION AGAINST EXCESS INSURER TO CONTINUE DESPITE LACK OF EXHAUSTION OF UNDERLYING POLICY LIMIT

by Eliot M. Harris & Sean T. James

On May 27, 2016, Judge Robert S. Lasnik for the United States District Court for the Western District of Washington denied an excess insurer's motion to dismiss a declaratory judgment action despite the fact that the underlying policy limits had not been exhausted.

In *Seattle Times Co. v. Nat'l Sur. Corp.,* 2016 WL 3033498, the Seattle Times had an underlying policy providing $10.5 million in coverage and an excess policy covering costs exceeding that amount. After incurring $9.1 million in cleanup costs for remediation from an environmental contamination on a property it previously owned, the Seattle Times filed suit seeking declaratory relief to establish its rights and duties with respect to its insurance policies and alleging that its excess insurer breached its policy by refusing to provide coverage. Even though it conceded that the underlying limits had not been exhausted, the Seattle Times argued it was entitled to declaratory relief establishing its rights under the excess policy because it appeared likely that the total cleanup costs would exceed the $10.5 million underlying limits.

Regarding its breach of contract claim, the Seattle Times argued that the excess insurer's refusal to even acknowledge its duty to pay upon exhaustion of the underlying policy limits constitutes anticipatory breach of the policy. The Court rejected this argument, stating that "[a]bsent a clear articulation of [the excess insurer's] intent to deny coverage even if the underlying limits are reached, there is no anticipatory breach." Thus, because the excess insurer does not have a present duty to indemnify, and had not affirmatively stated that it would not indemnify the insured upon exhaustion of the underlying policy limits, the Seattle Times' breach of contract claim against the excess insurer was not ripe and was dismissed without prejudice.

However, the Court found that the Seattle Times' declaratory judgment claim against the excess insurer was ripe because the insured presented sufficient evidence that the cleanup costs would likely exceed the underlying policy limits. Despite the excess insurer's argument that the declaratory judgment claim was not ripe because any future clean-up costs were simply speculation, the Court recognized that an insurer's duty to indemnify frequently hinges on future contingencies. In this regard, the Court stated that while "there is no hard and fast rule, courts generally find that a claim against an excess insurer is ripe for adjudication if there is a substantial, reasonable, and/or practical likelihood that the dispute will trigger the excess policies." The Court further concluded that, given the sum already spent and the future cost estimates, it was substantially likely that the excess policy would be triggered.

Another factor cited by the Court in denying the excess insurer's motion for dismissal from the declaratory judgment action was promotion of judicial economy and fairness because keeping the excess insurer in the lawsuit would allow the excess insurer to have a say in the interpretation and application of the language contained in the underlying policy, which would likely be a key area of contention in subsequent litigation. The Court reasoned that "in light of the substantial likelihood that [the excess insurer's] policy will be triggered, its dismissal at this point would place it at risk of having binding precedent established in its absence or would force the [Seattle] Times to litigate…the same issues all over again once the remediation costs exceed $10.5 million."

This holding is significant because it suggests that a breach of contract claim against an excess insurer may not be ripe until the underlying policy limits are exhausted, unless the excess insurer clearly articulates its intent to deny coverage even if the underlying policy limits are exhausted. In addition, it suggests that Washington Courts may consider asserting jurisdiction over an excess insurer, prior to the underlying policy limits being exhausted, under certain circumstances, such as when there is a substantial likelihood that the underlying policy limits will be exhausted.

WASHINGTON SUPREME COURT UNANIMOUSLY FINDS NO COVERAGE FOR WATER DAMAGE IN VACANT BUILDING UNDER ENDORSEMENT IN COMMERCIAL PROPERTY POLICY

by Eliot M. Harris & Sean T. James

On June 9, 2016, the Washington State Supreme Court unanimously found that a commercial property insurer need not provide coverage for water damage in a vacant building when the policy specifically excluded coverage for such damage per endorsement. In *Lui v. Essex Ins. Co.,* 2016 WL 3320769, the insured owned a building that was damaged by a pipe burst, which occurred on or about January 1, 2011. The building was vacant at the time, as the previous tenant had been evicted on or about December 7, 2010. An endorsement to the building owner's policy stated:

> *Coverage under this policy is suspended while a described building…is vacant or unoccupied beyond a period of sixty consecutive days, unless permission for such vacancy or unoccupancy is granted hereon in writing and an additional premium is paid for such vacancy or unoccupancy. Effective at the inception of any vacancy or unoccupancy, the Causes of Loss provided by this policy are limited to Fire, Lighting, Explosion, Windstorm or Hail, Smoke, Aircraft or vehicles, Riot or Civil Commotion, unless prior approval has been obtained from the Company.*

After the claim was filed, the insurer investigated and paid $293,598.05 before discovering that the building was vacant when the loss occurred. The insurer ceased making payments and denied coverage, but did not seek reimbursement of its prior payments. The insured filed suit and claimed that the property damage is covered because the policy's coverage restrictions in the endorsement did not become effective until after the property had been vacant for 60 consecutive days. The insured asserted that the endorsement is ambiguous because the policy is not suspended under the first paragraph until after 60 days from when the property becomes vacant. Thus, the insured argued that the restricted causes of loss contained in the second paragraph also do not become effective until after 60 days of vacancy. The trial court agreed and found that the endorsement was ambiguous because of a conflict in the first two paragraphs so that the term "inception" in the endorsement "does not suspend coverage automatically."

The Washington Supreme Court unanimously disagreed and held that the endorsement was unambiguous. The Court found that under the insured's interpretation of the endorsement, the phrase "effective at the inception of any vacancy" contained in the second paragraph would be meaningless. It also noted that the insured's interpretation of the endorsement would cause the first and second paragraphs to be in direct conflict. The Court held that the endorsement suspends coverage in totality after the initial 60 day period and provides limited coverage for only the enumerated causes of loss listed in the second paragraph for the first 60 days after vacancy.

This holding is significant for commercial property insurers with the same or similar vacancy endorsement in their policies because it shows that Washington Courts are willing to enforce such endorsements when the limitations contained within are clearly stated.

MONTANA FEDERAL COURT FINDS NO COVERAGE FOR STAND-ALONE CLAIMS BY HEIRS OF DECEASED EMPLOYEE WHO WAS INJURED FROM EXCLUDED CAUSE OF LOSS

by Eliot M. Harris & Sean T. James

On June 8, 2016, Judge Carolyn S. Ostby for the United States District Court for the District of Montana held that an insurer owed no duty to defend an insured for stand-alone claims filed by heirs of a deceased person when the injury to the decedent was caused by an excluded cause of loss.

In *Palmer v. Northland Cas. Co.,* 2016 WL 3198235, the insured operated an oil field services company in Montana. Following the death of a contractor caused by exposure to hydrocarbon vapors while on the job, the contractor's heirs filed suit against the insured. The heirs alleged that they personally had suffered negligent infliction of emotional distress and loss of consortium. The insured's policy contained an exclusion titled "Described Hazards-Oil/Gas Industries," which precluded coverage for "any bodily injury, property damage, personal injury, or medical expense which would not have occurred in whole or in part but for the…discharge, dispersal, seepage, migration, release or escape of pollutants or hazardous substances." After the insurer denied coverage, the insured filed suit.

The Court granted the insurer's motion for summary judgment and held that this exclusion not only precluded coverage for the claims asserted on behalf of the decedent's estate, but also precluded the stand-alone claims filed by the decedent's heirs. In doing so, the Court rejected the insured's argument that the exclusion does not create an unequivocal demonstration of no coverage because it is not entirely clear if this exclusion should apply to the stand-alone claims asserted by the decedent's heirs. While the Court found that the Montana Supreme Court has not previously addressed this exclusion, it stated that "it cannot reasonably be disputed that the bodily injury suffered by [the decedent] and the resulting injury or damages to the heirs of [the decedent] would not have occurred but for the existence of a hazardous substance or pollutant as that term is defined in the Policy." Additionally, the Court noted the exclusion specifically states that it applies to "any bodily injury…personal injury…or medical expense." Thus, this exclusion is not limited to excluding coverage for injuries sustained by any particular person. Regarding the novelty of the issue, the Court stated that "the fact that the Montana Supreme Court has not considered the exclusion under this case's facts is not ultimately determinative of whether the exclusion applies, and [the insured] has cited no controlling authority that it is."

The Court's holding is noteworthy because it broadly interprets the phrase "any bodily injury." This is significant for insurers in Montana because the language used in the exclusion at issue in *Palmer* could be contained in either the insuring agreement or policy exclusions. Thus, the broad interpretation of this policy language could have implications beyond this specific exclusion.

WASHINGTON FEDERAL COURT DECLINES TO RULE ON WHETHER NEGLIGENT CLAIM HANDLING AND BAD FAITH CLAIMS ARE DISTINCT CAUSES OF ACTION UNDER WASHINGTON LAW

by Eliot M. Harris & Sean T. James

Despite the fact that no Washington appellate court has explicitly recognized a cause of action for negligent claims handling separate and apart from a claim for insurance bad faith in first-party claims, many policy holders have asserted such claims in the past. On June 6, 2016, Judge Richard A. Jones for the United States District Court for the Western District of Washington declined to rule on this issue by denying an insurer's motion for summary judgment to dismiss a negligence claim premised on an insurer's claim handling practices.

In *Hews v. State Farm Mut. Auto. Ins. Co.*, 2016 WL 3144397, the insured alleged that she was injured when she collided with another car. The insured filed an Underinsured Motorist (UIM) claim and alleged that her UIM coverage was insufficient to cover her injuries. The insurer initially offered $30,000 in UIM benefits and made an advance payment in that amount. The insurer later increased its offer to $58,000, but made no further advance payments. Unsatisfied with this amount, the insured filed suit, asserting numerous claims, including both bad faith and negligent claims handling. The insurer filed a motion for partial summary judgment, asking the Court to dismiss the negligence claim on the theory that Washington has never recognized a cause of action for negligent handling.

The Court noted that in Washington it is not entirely clear if a UIM insured can simultaneously pursue a cause of action for bad faith and negligent claims handling. While other states, such as California, have held negligent handling of claims is not a separate cause of action, Washington law is unclear, as previous case law appears to cut both ways, treating negligent and bad faith claims handling as either a distinction without a difference, or suggesting they may indeed be distinct causes of action. The Court cited *Tyler v. Grange Ins. Ass'n,* 3 Wn. App. 167, 173-79, 473 P.2d 193 (2007) and *St. Paul Fire and Marine Ins. Co. v. Onvia, Inc.,* 165 Wn.2d 122, 132, 196 P.3d 664 (2008) as examples of the unsettled status of the law in this area. Ultimately, in the absence of clear precedent on the issue, the Court was unwilling to decide the issue as a matter of law and denied the insurer's motion for summary judgment.

This case is significant because the Court declined to make a ruling on the issue of whether an insurer may bring separate claims for bad faith and negligent claims handling under Washington law. Given the Court's ruling, this issue remains unsettled under Washington law.

WASHINGTON COURT FINDS NO DUTY TO DEFEND FOR "BODILY INJURY" OR "PROPERTY DAMAGE" THAT HAS NOT YET OCCURRED DESPITE ALLEGATION THAT SUCH DAMAGES ARE LIKELY TO OCCUR IN THE FUTURE

by Eliot M. Harris

Washington Courts generally determine the existence of a duty to defend based on the "eight corners" rule. Given this limited review of just the insurance contract and the underlying complaint, some Washington Courts have found a duty to defend when there are allegations in the complaint that covered damages will occur in the imminent future. However, a recent decision by a Washington Federal Court suggests that not all claims for potential future harm trigger a duty to defend.

In *Am. Mgmt. Servs. E. LLC v. Scottsdale Ins. Co., et al.,* 2016 U.S. Dist. LEXIS 51768, Judge Zilly found that the insurers owed no duty to defend the insured, a property management company and its CEOs, for alleged "falsification of work orders" despite the fact that they allegedly posed and continued to pose a direct risk to the life and safety of the residents of the housing project. The Court found that such allegations, by themselves, do not constitute "bodily injury" or "property damage" under the CGL policies at issue. The Court further stated that without an actual harm suffered, there can be no covered damages awarded in the underlying lawsuits. The Court went on to state that the creation of a risk of harm, without any alleged physical injury to the properties, was insufficient to trigger defense coverage.

In doing so, the Court rejected the argument of the policyholders that money spent to remediate the risk is recoverable under the insurance policies. The Court found that costs incurred to prevent future damage falls outside the definition of "property damage" under CGL policies. Similarly, the Court rejected the argument that the underlying complaints sufficiently pled the possibility that the underlying plaintiffs could introduce evidence of actual "property damage" and/or "bodily injury" in support of their claims. In doing so, the Court reiterated the general rule of Washington that it is not enough to merely speculate that the underlying plaintiffs could, at some later time, allege actual injury or damage.

Lastly, the Court rejected the policyholders' attempt to introduce extrinsic evidence, outside the "eight corners" of the complaint and policy to trigger coverage. Under Washington law, extrinsic evidence on the duty to defend is only considered when either coverage is not clear from the face of the complaint, but could potentially exist, or when the allegations of the complaint conflict with facts known to the insurer or when the allegations are ambiguous. The Court determined that neither exception applied in this case given how clearly the underlying complaint sounded in fraud. Specifically, the Court pointed out that the extrinsic evidence, submitted through employee affidavits, did not reference specific injury, but merely the possibility of future harm.

Based on the Court's ruling in this case, insurers may be able to seek declaratory judgment on their duty to defend when there is no allegation, nor extrinsic evidence, showing either "property damage" or "bodily injury" that has already occurred, but merely the possibility that such harm could occur in the future. This ruling is significant because despite the complaint pleading facts regarding a potential life safety risk in the future, the Court, nonetheless, found no duty to defend existed.

WASHINGTON COURT DENIES CLASS CERTIFICATION FOR PUNITIVE CLASS ACTION REGARDING COVERAGE FOR DIMINISHED VALUE

by Eliot M. Harris

Over the past decade, policyholders across the country have sought recovery for so-called "diminished value" of their vehicles following repairs after a covered loss. Though Washington recognized certain diminished value claims in *Moeller v. Farmers Ins. Co. of Wash.,* 173 Wn.2d 264 (2011), policyholders have not always been successful in seeking class certification for such claims.

In *Achziger v. IDS Prop. Cas. Ins. Co.,* 2016 U.S. Dist. LEXIS 44899, Judge Settle in the United States District Court for the Western District of Washington denied the policyholder's motion for class certification for diminished value property claims finding that the proposed class action failed to meet the requirements of FRCP 23. In this case, the policyholder sought to certify a class that included all insureds of the defendant insurer with Washington policies issued in Washington State where the insured's vehicle damages were covered under the UIM PD, collision and/or comprehensive coverages and the repair estimate on the vehicle totaled $1,000.00. The proposed class was also limited to owners of vehicles no more than six years old and less than 90,000 miles at the time of the accident, and vehicles that had suffered structural (frame) damage and/or deformed sheet metal and/or required body or paint work. The class sought to exclude claims involving leased vehicles or total losses, employees of the defendant insurer, the assigned judge and judge's staff and family, claims paid under the collision or comprehensive coverage where the policy included a specific endorsement and accidents occurring before April 4, 2008. The punitive class action sought not only a claim for breach of the insurance contract, but also violations of the Washington Consumer Protection Act (CPA).

The Court found that the class representative (Achziger) did not have claims that were typical of the claims or defenses of the class because the class would include insureds who had different policies than the representative because the class representative's policy contained a diminished value exclusion and the proposed class definition included potential class members whose policies did not contain this exclusion. The Court noted that courts in other jurisdictions have found that recovery of diminished value is not permitted where the policy limits liability to the "lesser" of the vehicle's repair or cash value. Given this, the Court found that certain class members would need to make different legal arguments than the class representative to state a breach of contract claim. In addition, the insurer presented evidence that it had changed its claim handling practices and procedures during the period of time covering the policies at issue. Therefore, the Court found that the class representative's CPA claims were not typical with certain other members of the potential class.

The Court also found that the class representative had failed to show common issues over individual issues regarding the claims. The Court specifically noted that in the UIM context, an insured must prove that he or she could recover the diminished value from the other driver. Such an analysis would give rise to individualized factual assessments of the underlying claim including the fault of the insured driver. Another factor that weighed against finding punitive class action was the presence of prior accidents. In this case, it was undisputed that some of the potential class members had prior accidents while others did not. While the policyholder argued this was simply a damages issue, the Court rejected this argument and found it also pertained to liability.

Lastly, the Court found that the class representative failed to show that a class action was the superior method for adjudicating this matter. Given the individual issues that predominate over the common issues, the Court found that there were potential class members that would likely have an interest in individually controlling the prosecution of their own action rather than being bound by a class action.

Despite the recent number of cases seeking class certification for diminished value claims, this ruling provides support for insurers seeking to fight class certification for diminished value claims under UIM policies. The Court's ruling should also provide authority for insurers in other diminished value claims fighting class certification as some of the same issues raised by the Court in this case may be present in other diminished value cases.

CD CLAIMS FROM THE PERSPECTIVES OF THE INSURER AND THE POLICYHOLDER

by Thomas A. Ped—Williams Kastner & Gibbs PLLC

and Seth H. Row—Miller Nash Graham & Dunn LLP

This article aims to provide a brief overview of common insurance-coverage issues in construction-defect disputes, from both the policyholder and insurer perspectives. By combining both a primer on Oregon law and where needed the different perspectives of the two sides we hope to provide some guidance to the general practitioner in this complex area. We have not provided case citations in the interest of readability—citations for some of the propositions below can be found in the various OSB insurance law Bar Books.

Hypothetical

Imagine the following: You represent a general contractor involved in both residential and commercial construction. Your client received a statutory "701 notice" from a law firm representing a homeowners' association for a large projects that your client worked on about five years ago. *See* ORS 701.565. The 701 notice alleges that the client is responsible for numerous construction defects at the project. What do you do? One thing that should be done, of course, is to advise the client to look into what insurance may be available to respond to the 701 notice. So let's assume that your client confirms that they have maintained the required Commercial General Liability (CGL) coverage for the last five years. What do you advise the client to do?

The Initial Notice

There are seldom any downsides to tendering a claim right away - and plenty of potential upsides. A 701 notice will usually include an allegation that the construction defects have resulted in damage to physical property. That is, of course, within the coverage grant of any CGL coverage. The client, you, or the client's insurance broker should therefore tender the 701 notice to the CGL carriers. [NB: If your client is a design professional with "claims-made" coverage, failure to tender any kind of notice of claim may result in coverage problems later on.] Which insurers should receive notice? Usually the simple answer is: all of them. A CGL policy covers liability resulting from property damage that occurs during the policy year. So, if the alleged property damage is the result of rainwater intrusion, then every policy in effect from when the project was completed to the present is at least theoretically on the "risk," and should be notified. But, your client asks you, the policy says that the carrier only owes a defense against a "suit"—why would the carrier be interested in a mere letter notice? From the policyholder perspective, a 701 notice is a "suit." To put it simply, because most CGL policies define "suit" to include ADR, and a 701 notice is a statutorily required form of pre-suit dispute resolution, which is a form of ADR, each insurance carrier has an obligation to immediately provide a defense, even to a 701 notice. From the insurer perspective a 701 notice is not actually a proceeding of any kind where a defense is even necessary. For that reason, some insurers will accept a tender of a 701 notice, and some will not.

Insurer's Initial Response to Claim—Determining the Duty to Defend

Each insurer will analyze the notice in light of its two primary duties—to defend and

indemnify. The duty to defend usually involves hiring legal counsel to defend the suit. The duty to indemnify involves paying the amount for which the insured becomes liable for the claim, subject to the conditions and exclusions of the policy.

The duty to defend is broader than the duty to indemnify. An insurer must defend an action against its insured if the claim stated in the notice or complaint could impose liability for conduct covered by the policy: that is, if there is a possibility that the insurer will have a duty to indemnify. In Oregon, the duty-to-defend inquiry is limited to the "4 corners" of the complaint and the insurance policy. That is to say, in Oregon the insurer cannot look beyond the pleadings and the policy and consider extrinsic evidence to assess the duty to defend. (This approach contrasts with Washington law, for example, where an insurer has a duty to examine extrinsic evidence to determine whether a duty to defend exists, although an insurer cannot use extrinsic evidence to decline a defense.)

Insurer Response: Requesting Documents

Generally speaking, a CGL insurer general must indemnify its insured only for liability for damage to other property (that is, to property other than the insured's) caused by the insured's work. The damage must occur during the policy period.

From the insurer perspective, therefore, it is appropriate to respond to a notice and request for defense by requesting documents and information regarding the scope of the insured's work and the dates of construction. The insurer will request copies of the contracts and invoices, and any notices of completion or certificates of occupancy. From the policyholder's perspective, because the duty to defend is determined only by comparing the four corners of the policy with the four corners of the notice/complaint, these documents are not relevant to the threshold issue of the duty to defend, although they may be relevant to the insurer's indemnity obligations.

Insurer Response: Examining Language of 701 Notice/Complaint

If the insured's allegedly faulty work was performed before the policy incepted, the insurer will most likely conclude that there is a duty to defend. If the work at issue was performed after the policy expired, the insurer will most likely conclude that there is no basis to defend or indemnify. From the policyholder perspective, unless these facts are pled in the 701 notice (or the complaint), the insurer cannot deny a defense based on "extrinsic" facts about when the work was performed.

In recent years, plaintiff's attorneys have gotten wise to the impacts of these exclusions on insurers' decisions on the duty of defend. The more dates that are mentioned in a pleading, the better chance an insurer will determine there is no duty to defend, because there could be no duty to indemnify. Because it is in an owner's interest for there to be insurance coverage for the costs of construction repairs, savvy owner's attorneys include few, if any, dates in their pleadings.

Many commercial general liability policies also include "known loss" and "prior loss" exclusions. The known loss exclusion applies where the insured knew of the loss when applying for the policy but failed to disclose it. The prior loss exclusion applies if the damage began to occur before the policy period. If the pleadings disclose a basis for either exclusion to apply, the claim will likely be denied. If the pleadings do not disclosure facts to support the exclusion, from the policyholder perspective the insurer is not entitled to documentation on the issue before accepting the duty to defend.

Insurer Response—Deny Defense

From the insurer's perspective, denying defense exposes the insurer to certain risks. On the one hand, if the insurer guesses wrong, the insured's remedy is in contract only because Oregon courts have generally refused to recognize a tort of bad faith failure to defend. In other words, even if the insurer is wrong, the insurer's liability will be limited to any sums owed for defense costs, and indemnification for the underlying liability. (This is in contrast to other states, where in some instances the insurer can be exposed to treble damages, punitive damages and liability for a judgment that is in excess of the policy limits.)

On the other hand, an insurer that refuses to defend loses the right to control the handling of the case against the insured. The insured's choice of counsel may or may not have expertise in the subject matter, or may have to take "short cuts" in the defense such as not hiring experts. In the event that the complaint is amended such that the duty to defense is triggered later, the insurer may have to take over a defense that has been incomplete, increasing the insurer's eventual liability.

Of more potential concern to an insurer is that the insured could enter into a stipulated judgment and covenant not to sue with the claimant. Under this scenario, the insured would agree to a money award against it for a stipulated sum, which could be far in excess of an amount the insurer might believe to be an appropriate exposure. The insured would then assign to the claimant the insured's rights against its insurer, in exchange for a covenant by the claimant to limit any recovery from the insurance proceeds and a promise not to seek recovery from the insured's assets.

Such settlements can lead to a host of problems for the insurer. Under a stipulated judgment, a $100,000 battle could lead, for example, to a $1 million dollar problem, if the insured so stipulates. Left unsettled under Oregon law are issues such as whether an insurer is entitled to object to such a settlement under a provision in the policy requiring the insured to obtain

an insurer's consent to a settlement. Also unsettled as of this time is whether an insurer has a right to contest the liability issues in the underlying case, and whether any exposure is limited to the policy limits, or in excess of the limits.

From the policyholder's perspective, a denial of defense can be devastating because of the costs of self-funding a defense. It may be prudent to contest the denial in writing and/or enter into discussions with the plaintiff about either filing suit (if the case is just at the 701 notice stage), amending the complaint to allege additional true facts that may trigger coverage, or stipulating to a covenant judgment as laid out above. Policyholder counsel must of course be careful about collateral effects from having an unsatisfied judgment against the client on the books, and about making sure that the covenant truly protects the client in the event that the plaintiff is unable to recover from the insurer.

Insurer Response — Defend Under a Reservation of Rights

Let's suppose that the insurer instead agrees to defend, but only under a reservation of rights to deny indemnity. Typically, the insurer will then appoint counsel. What should the client's lawyer do then?

In Oregon, a reservation-of-rights defense creates a "tripartite" relationship where the defense counsel has two clients, but because of the inherent conflict of interest, the insured is the "main" client, and defense counsel may not jeopardize the insured's coverage interests. Thus, there is a role for personal counsel, in helping defense counsel avoid coverage pitfalls.

As the case progresses the role of personal counsel may involve dealing with "bad" coverage facts. It may be the case that extrinsic evidence (e.g., the insured's invoices) will show that the insured's work was performed after the policy expired. But if the pleading does not mention any dates, the insurer may have a duty to continue to defend, although there may not ultimately be any duty to indemnify. Therefore, personal counsel may be able to convince the carrier to make settlement money available at mediation based on the insurer's anticipated cost of defense going forward.

Mediation – Issues for Insured and Insurer

From the policyholder's perspective an insurer that is defending, whether or not under a reservation of rights, has a fiduciary duty to settle the claim to avoid exposing the insured to liability. This is particularly true where the demand exceeds policy limits or where there are coverage problems. As a practical matter, however, personal counsel's job is to make it easier for the insurer to make the "right" decision about funding a settlement. This requires understanding what the typical insurer needs, and when they need it, to come to mediation equipped with sufficient authority to make that "right" decision.

From the insurer's perspective mediation is (hopefully) the final stage in a rather long process of getting an understanding of the potential liability and any coverage issues, obtaining settlement authority from upper-level supervisors at the insurer, and working out in advance (if possible) any disputes with the insure. The bottom line is that the insurer needs time to prepare for mediation, and needs not to face surprises at mediation. If the insurer is diligent the adjuster will request information well in advance, and will follow up with the insured or its counsel before the mediation to do as much "advance" work as possible.

Insurance coverage is a common, practically omnipresent issue in construction litigation. It adds another set of players to the mix, and a player whose decision-making process can sometimes be challenging for the contractor to understand and contend with. The duty-to-defend and mediation stages of a case are where insurance are often at the fore. Fortunately, Oregon law is fairly well-developed on most issues that come up in construction coverage disputes. We hope that this outline provides some help in understanding the considerations of insurers and policyholders.

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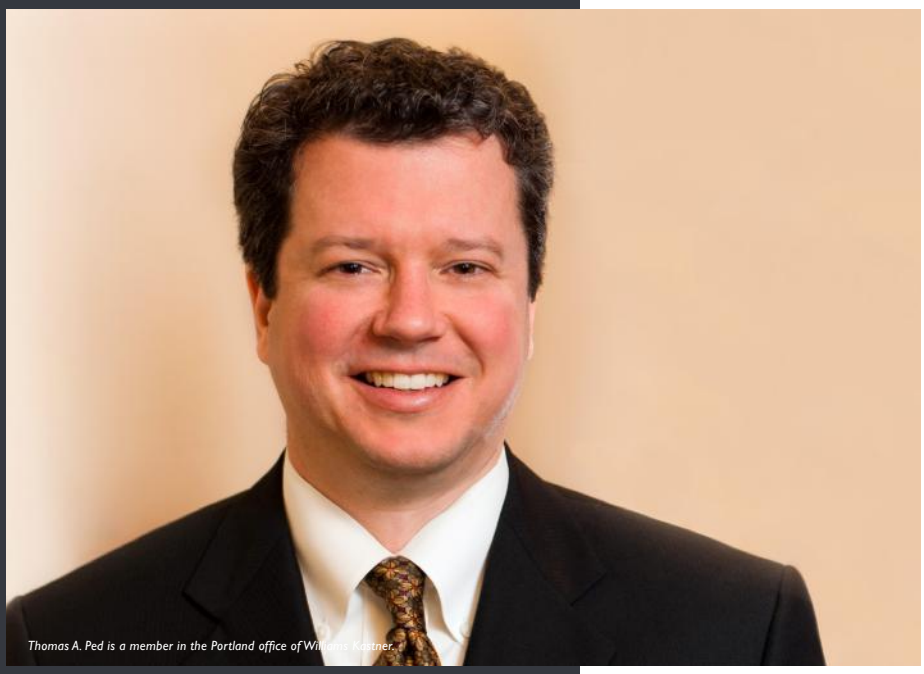
Eliot's practice focuses on commercial litigation with an emphasis on insurance coverage, including general liability coverage, trademark and intellectual property coverage, construction defect coverage, and professional liability coverage. He has successfully represented insurers in Washington, Oregon, California, and Arizona courts. He has tried multiple cases to verdict, including cases involving bad faith and punitive damages against insurers. Eliot also has experience defending lawsuits involving catastrophic personal injuries, environmental toxic tort, intellectual property and product liability.

Mr. Harris was named a "Rising Star" for 2010-2012 and 2014-2016 by Washington Law and Politics Magazine. He has tried multiple cases to verdict, including cases involving insurance coverage issues and bad faith. He has taken countless depositions and obtained dismissals of claims for clients in both State and Federal courts.



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Tom Ped is a member in Williams Kastner's Portland office. His practice specializes in civil litigation matters, including construction, business torts, real estate and insurance coverage matters. Tom regularly assists insurers with coverage analysis and actions for declaratory relief. Tom also represents owners, general contractors, subcontractors and suppliers in contract performance and payment claims. His work in real estate includes litigating and resolving a wide range of disputes concerning the ownership and use of land. He also advises individuals and businesses in real estate transactions, including acquisitions and sales, leasing and finance. Tom has conducted numerous trials in state and federal courts as well as private mediations and arbitrations.

Tom is also committed to improving diversity in the workplace. As a member of the firm's Diversity Committee, he is proud be involved with the Oregon State Bar's Opportunities for Law in Oregon program. Tom has also helped coach mock trial teams at Roosevelt High School in Portland.

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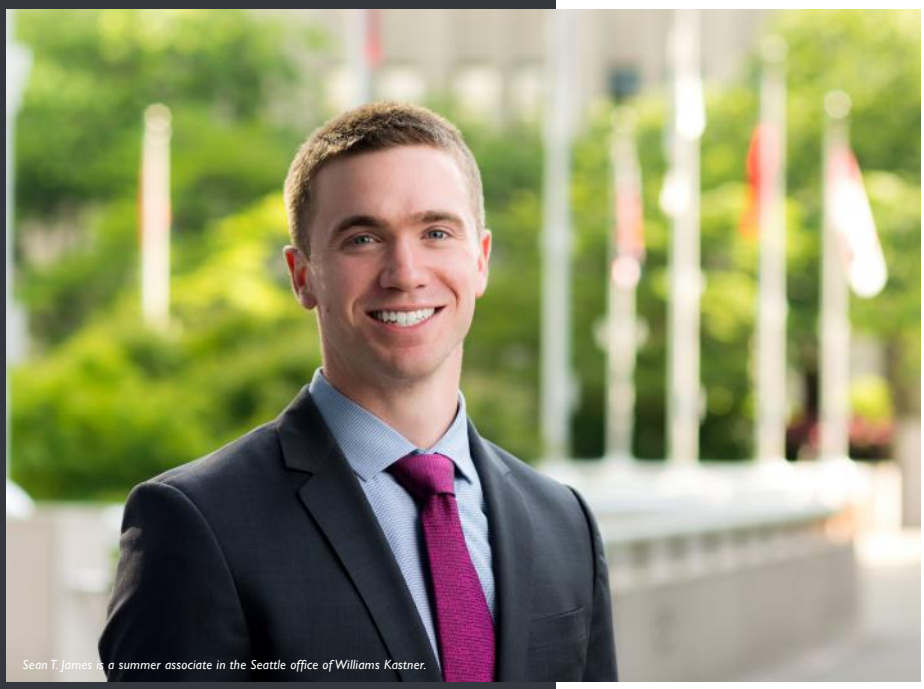
Margaret is a member of the Business Litigation practice group. Her practice is focused on general litigation, insurance, and bankruptcy. Margaret has worked on a variety of cases defending corporations and businesses in employment and breach of contract claims. She has also worked on an array of cases representing insurance companies in commercial general liability coverage disputes.

Prior to joining Williams Kastner, Margaret worked as a paralegal for a Chapter 13 Trustee in Denver, Colorado. While working for the trustee, she reviewed and prepared to implement Chapter 13 bankruptcy plans for individual debtors, as well as analyzed bankruptcy plans to accurately disburse funds received from the debtor to each creditor.

During law school, Margaret received CALI Awards in Civil Procedure, Legal Writing I, and Elder Law. She also acted as an Executive Editor for the Seattle Journal for Social Justice and was one of five graduating students nominated for the National Order of Scribes. Margaret is a particularly skilled legal writer and is experienced in drafting motions and briefs.

Margaret is currently a volunteer attorney with the Northwest Immigrant Rights Project and the H.E.L.P. Project.



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