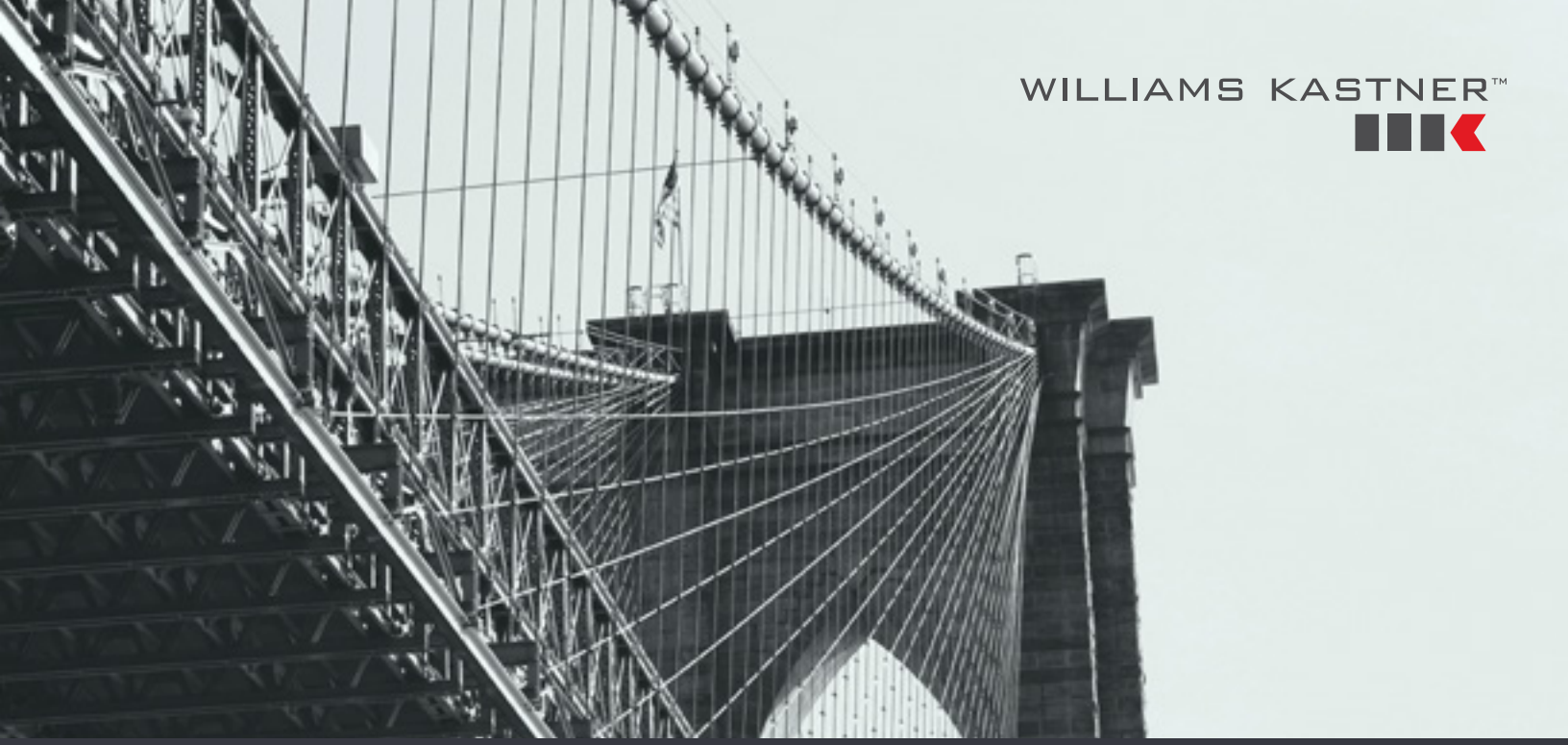

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NORTHWEST INSURANCE LAW

QUARTERLY NEWSLETTER WINTER 2017

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WASHINGTON COURT LIMITS DISCOVERY OF INSURER'S CLAIMS-HANDLING MANUALS AND GUIDELINES FOR UNRELATED LINES OF COVERAGE

by Eliot M. Harris

Insurers faced with a bad faith lawsuit are often asked in discovery to produce copies of claim handling manuals and guidelines. Oftentimes such discovery requests are broad and request any manuals or guidelines used by the insurer regardless of whether it specifically applies to the policy at issue. Courts in various jurisdictions have allowed such broad discovery under a variety of circumstances. However, recent changes to the Federal Rules of Civil Procedure may make it more difficult for policyholders to obtain such materials absent a showing that the claim handling guidelines and manuals specifically relate to the policy at issue.

In Ro v. Everest Indem. Ins. Co., 2017 U.S. Dist. LEXIS 11106, a Washington federal judge found that a request for production for "all manuals, books, pamphlets, memorandum, best practice manuals, guidelines" that are used by an insurer when receiving, investigating and/or adjusting claims for insurance benefits under any insurance policy was overbroad and not proportional to the needs of the case. The court cited to Fed. R. Civ. Pro. 26(b)(1), which was recently amended to limit the scope of discovery based on the proportional needs of the case.

In Ro, the court noted that the third-party adjuster that handled the plaintiff's claim produced its claim handling guidelines related to the type of insurance policy and claim at issue in the case. However, the insurer, which had retained the third-party adjuster to handle the claim on its behalf, refused to produce its own manual and guidelines regarding professional liability claims, which were the claims at issue. The court held that the insurer must produce it claim handling guidelines regarding professional liability claims regardless of whether the claim service reviewed or was required to comply with these guidelines as the guidelines would be relevant to a determination of whether the insurer and its agent behaved reasonably and/or or in bad faith. The court held that while the insurers internal guidelines do not set the standard of reasonable care, they may inform the analysis by showing an industries participants, custom and practice or by providing a benchmark by which to compare the agent's conduct and policies.

However, the court ordered that the insurer need not produce claim handling guidelines and manuals regarding investigation and adjustment of other claims, such as worker's compensation, uninsured motorists, or first party property claims, as this information would have little, if any relevance to the evaluation of the plaintiff's claim.

This ruling is significant because the court utilized the proportionality approach set forth in the recently amended FRCP 26(b)(1) in allowing discovery of certain claims handling manuals and guidelines, while also precluding broad discovery of any such manuals and guidelines kept by the insurer for any claims. It is also significant that the court allowed discovery of the insurer's guidelines and manuals despite the fact that it hired a third party claims service to investigate and evaluate the claim. Since these types of discovery issues arise in many bad faith claims in Washington, both insurers and policyholders should take note of the court's decision and the scope of discovery allowed for claim handling guidelines and manuals.

NEW WASHINGTON LAWSUIT SEEKS JUDGMENT OF NO COVERAGE FOR E-CIGARETTE RETAILER

by Naazaneen Hodjat

In recent years, millions of Americans have turned to electronic cigarettes ("e-cigarettes") as a safe alternative to traditional smoking products. In 2015, the United States had an estimated 10.8 million e-cigarette users—generating about $3.5 billion in sales. Recently, however, e-cigarettes have found themselves in hot water for exploding and causing serious bodily injury to their users. The Federal Drug Administration ("FDA") identified about 66 explosions in 2015 and early 2016. The e-cigarette industry, however, maintains that e-cigarettes are safe if used properly. After increased pressure, the FDA began regulating e-cigarettes in May 2016.

The FDA claims that e-cigarette explosions are due to faulty batteries. E-cigarettes contain lithium-ion batteries that are commonly used in many consumer products and generally are safe. However, lithium-ion batteries have also been known to cause fires in hoverboards and smart phones. E-cigarette explosions are believed to be caused by an overheating of the devices' lithium-ion batteries. Further, there are concerns that the batteries are "unregulated and manufactured haphazardly with poor warnings that never get down to the consumer." Recently, U.S. Senator Charles Schumer urged the federal government to consider recalling e-cigarettes because they are "ticking time bombs" that explode and injure users.

There has been a rise in products liability lawsuits as e-cigarette users sue over explosive devices. In 2015, a California jury awarded nearly $1.9 million in damages in a product liability lawsuit to the plaintiff who suffered second degree burns and permanent scarring after her e-cigarette exploded while it was charging in her vehicle. The product liability action was brought against the e-cigarette's retailer, distributor, and wholesaler. Similar lawsuits have already been filed in Washington, Florida, New York, Illinois, and Texas.

A new insurance case in Washington State suggests that insurance companies may inadvertently face liability. Over four years, Marlene Rupertt purchased e-cigarette products at Lilac City Vapor, a smoke shop located in Spokane, Washington. On January 30, 2016, while Rupertt was taking a drag, her e-cigarette device "suddenly exploded in her mouth and face." Rupertt brought a lawsuit under Washington's Product Liability Act against the retailer and the manufacturers of the device and battery, alleging that the lithium-ion batteries used in her e-cigarette device were faulty. Lilac City Vapor is insured by Atlantic Casualty Insurance Company ("Atlantic"). On December 1, 2016, Atlantic filed a complaint for declaratory relief seeking a judgment that Lilac City Vapor is not entitled to coverage under its policies.

Atlantic contends that it is not obligated to defend or indemnify Lilac City Vapor because the products-completed operations hazard exclusion bars coverage. Under the exclusion, the policy "does not apply to 'bodily injury' or 'property damage' included within the policy's 'products-completed operations hazard.'" The products-completed operations hazard is defined as all bodily injury that occurs away from premises the insured owns or rents and arises out of the insured's product. The insured's "product" includes all goods and products sold or distributed by the insured. Atlantic alleges that because Ms. Rupertt's injury arose from an e-cigarette product purchased at the insured's business, and because the injury occurred away from the insured's premises, coverage is barred by the products-completed operations hazard exclusion. Atlantic also alleges that medical expenses included within the products-completed operations hazard are also excluded from the policy agreement. Atlantic also argues that Lilac City Vapor is not a named insured on the policy, as the named insured is "Brad Bellinger dba Lilac City Vapor," "an individual." Because Ms. Rupertt named Lilac City Vapor as the defendant, and not Brad Bellinger, Atlantic claims it does not owe coverage. The case is still pending.

We are not aware of other e-cigarette product liability cases involving insurance companies. However, many e-cigarette and battery manufacturers are Chinese companies—making product liability claims against them difficult to pursue. As a result, victims are left without many feasible avenues of recovery, and therefore, plaintiffs will likely need to name an e-cigarette's entire supply chain in lawsuits. We expect to see more cases involving insurance companies to follow. E-cigarette coverage currently presents a unique risk for insurance companies. Until this case is resolved, insurance companies should assess the risk and write their coverage accordingly.

WASHINGTON COURT LOOKS BEYOND POLICY DEFINITION TO INTERPRET A TERM PARTIALLY DEFINED IN FIRST-PARTY PROPERTY POLICY

by Reshvin Sidhu

Oftentimes, the meaning of a term in an insurance policy is critical to a coverage determination. When the exact term at issue is defined by the policy, the Court will usually adopt that definition. However, when the policy does not contain a definition of the exact term at issue, Washington Courts may still look beyond the policy, and utilize a dictionary, when defining the exact term used in the policy. A good example of this practice was presented recently in Herzog v. Property & Cas. Ins. Co., 2016 LEXIS 166177, where a Washington Court held that a dock connected to the shore was not a "building" under a homeowner's property policy. In making this determination, the Court looked not only at the policy's definition of "fully enclosed building," but also the dictionary definition of "building."

In Herzog, the insured purchased a policy that provided coverage for the replacement cost value (RCV) for dwelling coverage, but only actual cash value (ACV) for other structures. In April 2015, a windstorm damaged the insured's dock and the insurer offered to pay the ACV under the other structures coverage, which provided coverage for "structures that are not buildings." The insured believed that the dock should have been covered under the dwelling coverage, entitling him to the RCV of the dock, not the ACV. On cross-motions for partial summary judgment regarding coverage, the Court held that the dock was not a "building" under the policy.

As noted above, the policy at issue did not define the term "building," but defined the term "fully enclosed building" as one "with continuous walls on all sides extending from the ground level to the roof, with windows and doors...." Nonetheless, the Court looked beyond the policy definition to a dictionary definition of "building," which defined this term as "a thing built: a constructed edifice designed to stand more or less permanently, covering a space of land, usu. covered by a roof and more or less completely enclosed by walls, and serving as a dwelling...shelter...."

The insured argued that these definitions conflicted, and thus, the Court should adopt the broader dictionary definition of "building." However, the Court disagreed and held that, while the dictionary definition was broader than the policy definition, it was not inconsistent. The Court concluded that the context in which "building" was used in the policy as a whole suggested that the narrower definition provided by the policy was the most plausible definition as opposed to the selective part of the dictionary definition since, otherwise, it would render other terms in the policy pointless such as distinguishing between "buildings" and "other structures."

This decision is important for two reasons. First, it supports the proposition that a Court can look beyond a policy definition when that definition is not the same as the term used in the policy. Second, it shows that, when interpreting the Policy, the Court should be mindful of the context that a term is used when interpreting coverage to determine the scope of the coverage provided.

WASHINGTON COURT FINDS NO BAD FAITH DESPITE INCORRECT ASSESSMENT BY INSURER ON COVERAGE ISSUES

by William Hansen

Insurers and policyholders are often faced with a situation of whether depreciation may be recovered when the insured sustains a covered loss but does not use "new construction materials" to rebuild their house. In a recent opinion, a Washington Court rejected an insurer's position that the term "new," in the replacement cost clause of a Homeowners Policy ("Policy") required the insurer to only repay the withheld depreciation if the insureds built or purchased a new home. However, the Court also held that, despite being incorrect on the scope of coverage, the insurer could not be held liable for bad faith, or violation of the Consumer Protection Act ("CPA") and Insurance Fair Conduct Act ("IFCA").

In Baskett v. Country Mut. Ins. Co., 2016 U.S. Dist. LEXIS 160449, the insureds sustained an accidental fire that damaged their home. The insurer hired a restoration contractor that estimated that the full cost of repairs would be approximately $269,000. Under the Policy, the insurer was required to pay the "actual cash value," defined as "the cost actually and necessarily incurred to repair or replace the damaged property using standard new construction materials of like kind and quality and standard new construction techniques, less depreciation" or "[f]air market value." Once the homeowner incurred the cost of repairing or replacing the damaged property, Defendant was then required to pay the "replacement cost," defined as "the cost actually and necessarily incurred to repair or replace the damaged property using standard new construction materials of the kind and quality and standard new construction techniques." Here, the insurer paid approximately $199,000 for the actual cash value, but because the cost of repair exceeded the alleged Policy limit, the insureds felt that they "had no choice but to purchase a replacement house that was not brand new." When they sought to recover the deprecation, the insurer took the position that it was not owed under the Policy because the insureds had not used "new construction materials" and "new construction techniques" in repair or replacing their house. The insureds filed suit.

The Court held that the term "new," which was not defined by the Policy, was ambiguous. By looking at the common definition of "new," the Court concluded that both the insureds' interpretation that "new" meant a recently bought home and the insurer's interpretation that "new" meant a recently built home were both reasonable. As such, the Court construed the ambiguity against the insurer, as is required under Washington law, and granted partial summary judgment for the insureds on the breach of contract claim.

However, the Court found that the insurer could not be liable for bad faith, CPA, or IFCA claims because it found that the insurer's definition of "new" was reasonable. Thus, the Court refused to engage in an in-depth factual inquiry of the steps the insurer took before denying coverage and found that such an inquiry was unnecessary in this case.

This decision is important because it provides some clarity to the scope of coverage afforded under certain homeowner's policies for recovery of depreciation when the insured decides to buy a different house. It also shows that courts will not always engage in an in-depth inquiry into the facts of every bad faith, CPA and IFCA claim.

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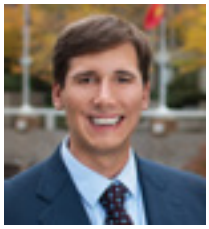

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