WILLIAMS KASTNER

# NORTHWEST INSURANCE LAW

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## TABLE OF CONTENTS

# WASHINGTON COURT OF APPEALS REVERSES $1.7 MILLION COVENANT JUDGMENT SETTLEMENT IN CONSTRUCTION LAWSUIT AFTER FINDING "SIGNIFICANT DISCREPANCY" IN SETTLEMENT AMOUNT

Under Washington law, an insured may enter into a settlement agreement with the claimant that includes an assignment of claims against the insured's liability insurer along with a covenant judgment against the insured and an agreement by the claimant to not execute on the judgment, but instead seek recovery against the liability insurer for bad faith damages. The basis for how and when such agreements are permitted has been hotly disputed and litigated for years. Recently, a Washington Court of Appeals addressed a separate issue: the standard applied by a trial court during a reasonableness hearing after the parties enter into a covenant judgment settlement agreement.

In *Wood v. Milionis Construction, Inc.*, 2020 WL 2042964 (Wash. Ct. App., April 29, 2020), plaintiffs, Jeffrey and Anna Wood, hired Milionis Construction, Inc. ("MCI") as a general contractor to build a residential house. After numerous defects were discovered and the Woods stopped making payments, the Woods filed suit against MCI. MCI's insurer agreed to defend the suit under a reservation of rights. After a series of failed mediations, the Woods and MCI eventually stipulated to a $1.7 million covenant judgment. At the time, MCI's expert estimated the damages to be $1.2 million, but had previously found damages to be approximately $224,000. The expert also allocated only 65% liability to MCI, and 35% to the architect and structural engineer. The insurer moved to intervene at the reasonableness hearing and sought an opportunity to conduct discovery. The trial court granted the motion to intervene, but denied the request for discovery, and found that the $1.7 million settlement was reasonable.

The Court of Appeals reversed due to a "significant discrepancy" between the damage estimates and the settlement amount. The Court noted that MCI's expert had "substantially increased" his contract damages opinion after mediation, However, the Court noted that the record "emphatically shows" that nothing occurred to justify this change in opinion that resulted in such a dramatically higher evaluation of the claim. The Court observed that the 35% fault allocated to the architect by MCI's expert and structural engineer was not factored by the trial judge when determining the reasonableness of the settlement agreement. Thus, the Court held that the trial court's ruling that the $1.7 million was "reasonable" under the circumstances was not supported by substantial evidence. In remanding for a second reasonableness hearing, the Court remarked that the record did not show that MCI valued the Woods' contractual damages at $1.7 million, but at less than $350,000, including the $200,000 the Woods claimed they previously paid for home repairs.

This case is important because it reiterates the general notion that the purpose of the "Chaussee factors," when determining whether a settlement amount is reasonable is to determine a fair settlement figure. *Chaussee v. Maryland Cas. Co.*, 60 Wn. App. 504, 512, 803 P.2d 1339 (1991). If a trial court merely looks at numbers in a vacuum without context, it is unlikely that a court will reach a fair settlement amount in such covenant judgment settings. This case also underscores the importance of conducting a through reasonableness hearing, with the opportunity to present witnesses and evidence, in order for the court to make a reasonableness determination with all pertinent information.

# WASHINGTON SUPREME COURT FINDS THAT LETTER ANNOUNCING PROPERTY RIGHTS UNDER 1854 TREATY CONSTITUTES A "DEMAND" UNDER TITLE INSURANCE POLICY TO TRIGGER DUTY TO DEFEND

In recent years, the Washington Supreme Court has expanded the duty to defend into areas that were previously believed to be beyond the normal scope of this duty. Such is the case in the most recent duty to defend decision in *Robbins v. Mason County Title Insurance Company,* 2020 WL 2212437 (May 7, 2020), where the Court interpreted the existence of a duty to defend in a title insurance policy that provided coverage for "all demands and legal proceedings" against an insured.

In this case, the insureds, Leslie and Harlene Robbins, purchased property that included tidelands with manila clam beds. They purchased a standard title insurance policy from Mason County Title Insurance Company ("MCTI"). The policy provided that MCTI would defend the insureds from all demands and legal proceedings founded upon a claim of title, encumbrance or defect which existed or is claimed to have existed as of that date, subject to certain exceptions. The policy did not define "demand."

For years, the Robbinses had contracted with a commercial shellfish harvester to enter the property to harvest shellfish. However, they later received a letter from the Squaxin Island Native American Tribe ("Tribe") that it had a legal right to harvest shellfish from the insureds' property. The Tribe claimed its right from the 1854 Treaty of Medicine Creek, under which the Tribe relinquished the right to the land (upon which the property was later built), but retained the right of "taking fish at all usual and accustomed grounds and stations…" The Tribe issued a letter to the harvester, disagreeing with the harvester's assertion that the clam beds were not part of the Treaty. After the Robbinses learned of the letter from the Tribe, they tendered a claim to MCTI to defend against the Tribe's demand to enter the Property to harvest clams. MCTI denied the Robbinses' request for a defense because it did not believe the claim fell within the scope of the policy because the treaty between the federal government and a Native American Indian tribe is not a record that imparts constructive notice pursuant to Washington law.

The Robbinses filed suit against MCTI for the breach of the duty to defend. The trial court granted MCTI's motion for summary judgment, but the Robbinses appealed. They argued that MCTI breached the duty to defend because the Tribe's letter was a "demand" under the policy. MCTI countered that there was no duty to defend as the Tribe did not initiate legal proceedings. The Court of Appeals reversed and held that the Tribe's letter was a "demand" under the policy, triggering the duty to defend. Finding the breach of the duty to defend "unreasonable," the Court of Appeals held that, as a matter of law, MCTI acted in bad faith. MCTI petitioned the Supreme Court for review.

The Washington Supreme Court began by defining the term "demand" by referring to a dictionary, which defined this term as "the asking or seeking for what is due or claimed as due" and "[t]he assertion of a legal or procedural right." The Court remarked that the Tribe asserted its legal right to harvest shellfish on the property by sending the Robbinses a letter stating that the Tribe was seeking the shellfish to which it was entitled. Thus, the Court held that the letter was a demand under the plain meaning of the policy. The Court went on to discuss how a duty to defend can be triggered without a legal proceeding when the policy contains language that does not necessarily require such a proceeding. It held that the present case was distinguishable based on the policy language that provided coverage for a "demand," which did not require the filing of the lawsuit.

This case underscores the importance of reading the insuring agreement carefully when determining whether a duty to defend arises. In certain situations, the language of the policy may provide coverage for actions short of a lawsuit, such as a demand letter or even a notice of violation that could lead to a lawsuit. Insurers should make sure to thoroughly analyze the pertinent language of the policy when making this determination given the potential consequences for breaching the duty to defend under Washington law.

# WASHINGTON FEDERAL DISTRICT COURT FINDS NO COVERAGE FOR CLAIM AT APARTMENT BUILDING UNDER DESIGNATED PREMISES ENDORSEMENT

Most property insurance policies designate the specific property that is covered for first-party coverage. However, when the named insured is sued for a claim arising from events at other property, a dispute can arise about whether third-party liability coverage is available to the named insured for events at non-designated locations.

This was the situation presented in *Mid-Century Insurance Company v. Vernice Zanco,* 2020 WL 1988255 (E.D. Wash.. April 27, 2020), where the insured owned and operated an apartment complex in Spokane, Washington. Mid-Century Insurance Company ("MCIC") issued a policy for the apartment complex that included liability coverage and a Designated Premises Endorsement, which provided that the policy "applies only to 'bodily injury' ... arising out of the ownership, maintenance, or use of the premises shown in the Schedule and operations necessary or incidental to those premises." The policy defined the covered "premises" as the apartment complex.

A visitor to the apartment complex filed a personal injury lawsuit against the insured, alleging that she was an invited social guest at the insured's home (not the apartment complex), that she was injured when she dove off a defective dock at the insured's residence, and that the insured had failed to warn her of the defect. Safeco Insurance Company, which issued a homeowners' policy to the insured, agreed to defend the insured against the liability action. Safeco tendered the complaint to MCIC, alleging that the insured maintained a home office that implicated coverage under MCIC apartment policy. MCIC agreed to defend under a reservation of rights, and then filed a declaratory judgment action that its policy did not provide coverage for the claim.

MCIC moved for summary judgment and argued that there was no coverage because there were no allegations of personal injury arising from the ownership, maintenance or use of the apartment complex. In response, the insured countered that the party where the claim arose had a dual business-pleasure purpose, thus giving rise to coverage. She also argued that the apartment policy was implicated because she kept a home office where she operated the apartment complex.

The Court agreed with MCIC that the claim was unrelated to the business of running the insured's apartment complex. The complaint in the liability action alleged that the insured was liable due to a failure to warn of a condition in her home's dock. There were no allegations on the face of the complaint that the dock's condition was related to any business purpose or the apartment complex; indeed, the complaint did not even mention the apartment complex or the insured's business endeavors. Rather, it alleged that the insured was liable as a homeowner – not a business owner.

In an interesting decision, the Court found that the extrinsic facts offered by the insured, e.g. that she managed the apartment complex from her residence, were immaterial under the eight corners rule because they did not make it more likely than not that the insured would succeed on the claims. The Court observed that the complaint in the lawsuit appeared to be a "run of the mill personal injury action against [the insured] in her capacity as a homeowner."

This case presents a situation where the plaintiff likely could have crafted the complaint to plead herself into coverage had she alleged that the social event had a dual business-personal purposes. However, there may have been a good reason for what that was not done: the Safeco homeowners' policy may have contained an exclusion for claims arising out of business ventures. Thus, the insured could have pled herself out of coverage under the Safeco policy by trying to plead into coverage under the MCIC apartment policy. This case highlights the importance of having policy language similar to MCIC policy in this case as there may have been coverage under the MCIC policy without such an endorsement despite the injury occurring at a separate location.

# OREGON FEDERAL DISTRICT COURT FINDS INSURER ACTED IN BAD FAITH BY FAILING TO SETTLE UIM CLAIM PRIOR TO TRIAL

The bad faith standard in Oregon for insurers is whether they acted as a reasonably prudent insurer under the circumstances, and is not predicated on whether its intent indicated "bad faith" or an attempt to injure the insured. Notwithstanding, Oregon's Unfair Claim Settlement Practices law—codified in ORS §746.230—lists a number of acts committed by insurers which may comprise "unfair claim settlement practices." For example, if an insurer compels its insured to initiate litigation to recover amounts due by offering significantly than the amount ultimately recovered, such actions can be prima facie evidence of an unfair claim settlement practice.

This was the scenario addressed by the *Court in Foraker v. USAA Cas. Ins. Co*., No. 3:14-CV-87-SI, 2020 WL 1914935, at *1 (D. Or. Apr. 20, 2020). In 2012, Peggy Foraker suffered serious injuries in an automobile collision caused by an uninsured motorist. Foraker reported the accident to her insurer, USAA, and later made a demand against USAA for $1 million, the limit of her policy's uninsured motorist ("UM") coverage. Foraker and USAA then agreed to an "open extension" of time for USAA to respond to Foraker's demand. In July 2013, USAA set its reserves at $1 million and retained Dr. John Glass—a board-certified neurologist—to conduct a peer review of Foraker's medical records. In his August 11, 2013 report, Dr. Glass concluded (in part) that although Foraker had hydrocephalus, there was "no evidence" it was caused by the accident.

In November 2013, USAA offered Foraker $250,000 to resolve her UM claim. Foraker rejected USAA's offer and did not counteroffer. Instead, she sued USAA in Oregon state court. USAA removed the lawsuit to federal court. At trial, the Court found that Foraker suffered $1,172,338 in economic damages and $750,000 in noneconomic damages. Shortly thereafter, USAA paid $1 million, the policy's UM limit, to Foraker for her claim.

Foraker also asserted claims against USAA for breach of the implied covenant of good faith and fair dealing under the insurance contract. Foraker contended that USAA breached its implied covenant of good faith and fair dealing by failing to conduct a reasonable investigation of her UM claim. Had USAA done so, Foraker argued, USAA would have paid Foraker the policy limits of $1 million well before trial. Foraker further asserted that had USAA conducted a reasonable investigation based on all available information, then: (1) Foraker would have had the use of that $1 million well before February 2016; (2) she would not have needed to sue USAA and thus would not have incurred litigation costs; and (3) she would not have suffered additional personal injuries that she alleged were caused by USAA's delay in paying its UM policy limit. Foraker also sought an award of attorney fees, under ORS § 746.061, in pursuit of the bad faith claims.

The Court determined the threshold question to be whether USAA breached its implied covenant of good faith and fair dealing by offering only $250,000 to settle and forcing Foraker to sue, when the facts showed that USAA was liable for the full UM policy limits of $1 million. Foraker cited ORS §746.230, which states that an insurer commits an unfair claim settlement practice by "[c]ompelling claimants to initiate litigation to recover amounts due by offering substantially less than amounts ultimately recovered in actions brought by such claimants."

The Court found that USAA compelled Foraker to initiate litigation to recover amounts due by offering her well less ($250,000) than the amount that she ultimately recovered ($1 million), describing such actions as prima facie evidence of an unfair claim settlement practice. The Court held further that it is "beyond reasonable dispute" that when an insurer engages in an unfair claim settlement practice that is precisely the sort of "improper behavior in the performance" of a contract that "would have the effect of destroying or injuring the right of the other party to receive the fruits of the contract," and thus, it would be a breach of the implied covenant of good faith and fair dealing.

In making its ruling, the Court observed that Dr. Glass unequivocally stated that based only on his review of the file there was "no evidence" that the accident caused Foraker's hydrocephalus. However, the court noted, there was evidence of that in USAA's possession, in the form of several other doctors' medical opinions, which were not reviewed by Dr. Glass, who, the Court held, was acting as USAA's agent. Further, the Court noted that although USAA set its reserves at $1 million, consistent with the adjuster's valuation, USAA never offered more than $250,000, and by failing to treat Foraker's interests with as much consideration as its own, breached its implied obligation of good faith and fair dealing. The Court held that Foraker was entitled to judgment in her favor in the total amount of $322,882.78, and that she could seek attorney fees and costs under ORS §742.061.

This case serves as a reminder to insurers operating in Oregon that a full and complete investigation must be undertaken with every claim. Overlooking key medical evidence, and offering settlement in amounts well below a reasonable assessment of the case can lead to a finding of unfair claim settlement practices, which can expose the insurer to bad faith liability and attorney's fees.

# INSURANCE TEAM

For over 90 years Williams Kastner attorneys have represented clients in the insurance industry, including primary and excess insurers, reinsurers, self-insurers, agents, brokers, and insurance pools. Our attorneys have advised clients on regulatory and claim handling issues, and have assisted insurers in countless claims from the claim investigation through trial on cases involving coverage and bad faith claims. Please feel free to contact us if you have any questions regarding insurance law in Washington and Oregon.

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