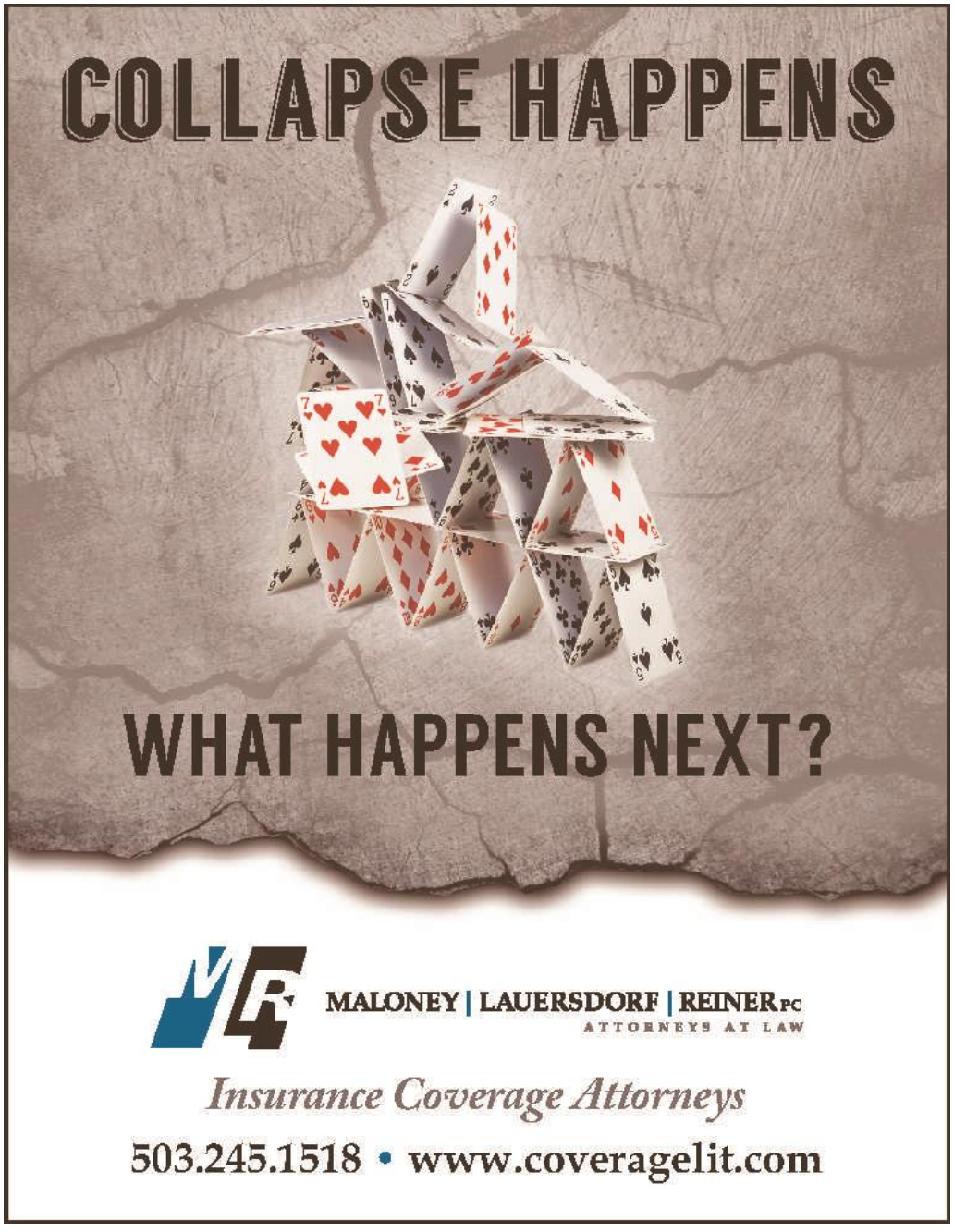
Insurance Coverage Law:

MLR's Second Annual Year in Review



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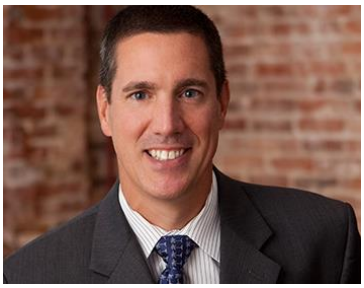
MALONEY | LAUERSDORF | REINER PC
ATTORNEYS AT LAW

ABOUT MALONEY LAUERSDORF REINER PC ("MLR")

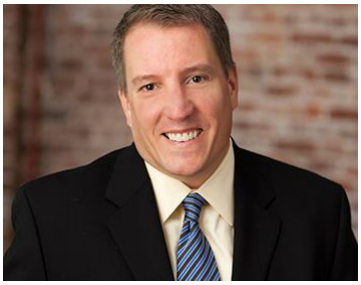
The attorneys at MLR have experience in all aspects of the insurance claims and litigation process. We have successfully litigated scores of insurance disputes through trial and appeal. Collectively, we have tried approximately 200 trials. Our lawyers have also analyzed numerous complex insurance coverage questions. MLR is knowledgeable and experienced handling insurance disputes on property, commercial, auto, and other specialty insurance policies. Although we primarily practice in Oregon and Washington, our attorneys have represented clients insurance disputes throughout the country.

Francis "FJ" Maloney, Shareholder



F.J. Maloney is recognized as the "go-to" attorney in large first-party extra-contractual and "bad faith" litigation. F.J. started his legal career as a Deputy District Attorney for Deschutes County, Oregon, where he gained valuable trial experience prosecuting criminal cases ranging from juvenile delinquencies and dependencies to minor misdemeanors and major felonies including capital murder. Since moving to civil practice, he has focused on a wide range of first-party cases involving SIU and fraud, tort defense, "Bad Faith" and extra contractual trial work. F.J. is panel counsel for several national insurance companies and has litigated cases in both the state and federal courts of Oregon, Washington, South Dakota, Tennessee, Oklahoma, Idaho, Nevada, New Mexico and Arizona. FJ has also argued appeals in Washington, Oregon, South Dakota, the Eight Circuit and the Sixth Circuit. His published articles have appeared in the Tort Trial & Insurance Practice Law Journal and Mealey's Litigation Report, and he is a frequent speaker at events such as the Tort Trial & Insurance Law Section of the American Bar Association and the Large Loss PLRB.

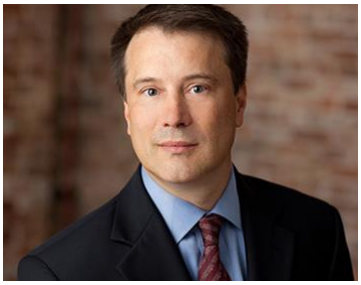
Andrew Lauersdorf, Shareholder



Andy is an accomplished trial lawyer with a demonstrated record of success. Andy has tried over 75 cases to verdict in state and federal courts throughout Oregon and Washington, and has been recognized for his ability to present complicated or technical issues to judges and juries in ways that are clear and easily understood. Much of Andy's success comes from his diligence in building strong trial teams and years of working closely with experts and other witnesses, including accountants, engineers and other forensic experts, physicians, private investigators, and law enforcement.

Andy has focused for more than a decade on resolving complex property and casualty insurance coverage disputes for both insurers and policyholders, and clients routinely seek his advice on insurance disputes throughout the United States. Andy's experience with insurance coverage disputes extends to all types of insurance coverage and claims, including commercial liability claims and property claims arising out of large fire, wind, water, collapse and contamination losses, business income and extra expense losses, and code enforcement coverage disputes. Andy has also been recognized for his unique skill in advising insurers, homeowners, and business professionals in the investigation and litigation of suspected or alleged fraud, including arson, intentional or fabricated losses, and questionable foreign deaths, and is frequently asked to speak on these topics. Andy is actively involved in the Defense Research Institute (DRI) and the International Association of Arson Investigators (IAAI), and is a frequent lecturer on topics related to trial strategy, expert witness qualification issues, and expert witness preparation.

Tony Reiner, Shareholder



Tony's extensive litigation and insurance experience has made him a recognized leader in insurance fraud and "bad faith" litigation. He is a former criminal prosecutor where he gained extensive trial experience prosecuting felony crimes for Klamath and Clatsop County, Oregon. As a prosecutor, Tony recognized the need for stronger domestic violence laws and helped draft legislation which was passed into law and criminalized interfering with a 911 emergency call. In private practice, Tony developed the unique skills required to investigate and litigate suspected insurance fraud including arson, auto and PIP claims, material misrepresentations, staged losses, and large-scaled fraud activity. His practice includes complex coverage analysis, allegations of bad-faith, and first-party property litigation. Tony has litigated claims in federal and state court ranging from fake burglaries to racketeering and class-actions. He is a speaker for local and national organizations including International Association of Special Investigation Units (IASIU), Western States Auto Theft Investigators, International Association of Arson Investigators, and the National Business Institute.

Janis Puracal, Of Counsel

Janis C. Puracal is an experienced appellate attorney who handles appeals in federal and state courts in Oregon and Washington. Janis brings a unique perspective to any appeal given her trial experience. She supports trial teams by identifying and preserving appellate issues during trial, before handling briefing and oral argument on appeal. She argues in Oregon and Washington state courts, as well as the Ninth Circuit.

Janis' *pro bono* work is also well-known in the appellate courts in Oregon and Washington. Janis is a co-founder of the Oregon Innocence Project, where she serves as co-chair and leads the Project's *amicus* work. The Project is dedicated to securing the release of wrongfully convicted inmates in Oregon and will be the only program of its kind in the state.

Scott MacLaren, Associate

Scott A. MacLaren is a first-party insurance coverage attorney focusing on the investigation and litigation of Special Investigation Unit (SIU) claims and first party property damage claims, including arson, fraud and coverage claims. He advises clients on a wide variety of matters, including extra-contractual "bad faith" litigation, first-party property and automobile insurance litigation, and suspicious insurance claims and SIU matters. Scott has advised clients regarding insurance coverage issues throughout the west coast, including in Oregon and Washington.

Prior to joining Maloney Lauersdorf Reiner, PC, Scott worked in Portland at a large insurance defense firm where he gained valuable experience advising clients on first-party insurance disputes and SIU matters.

Index of Cases

OREGON

- *Brownstone Homes Condo. Ass'n v. Brownstone Forest Heights, LLC*, No. CA A145740, 2015 WL 7299027 (Or. Nov. 19, 2015)
  - **ISSUES:** "Stubblefield Rule," Covenant not to Execute
- *Kiryuta v. Country Preferred Ins. Co.*, 273 Or App 469, —P.3d— (2015)
  - **ISSUES:** Attorney Fees, UM/UIM Safe Harbor Letters
- *West Hills Development Co v. Chartis Claims*, 273 Or App 155 (2015).
  - **ISSUES:** Duty to Defend
- *Portland Gen. Electric Co. v. Liberty Mut. Ins. Co.*, No. 3:15-cv-00217-HZ, 2015 WL 3892593, — F.Supp.3d — (D. Or. 2015)
  - **ISSUES:** Duty to Defend, Indemnity
- *Thoens v. Safeco Ins. Co. of Oregon*, 272 Or App 512, — P3d — (2015)
  - **ISSUES:** Policy Limits, UIM
- *Norgren v Mut. of Enumclaw Ins. Co.*, No. 14-cv-01591-SB, 2015 WL 3948145 (D. Or. June 29, 2015)
  - **ISSUES:** Intentional Acts, Duty to Defend
- *Navigators Ins. Co. v Hamlin*, No. 14-cv-196-MC, 2015 WL 1084825 (D.Or. Mar. 10, 2015)
  - **ISSUES:** Duty to Defend
- *De Zafra v. Farmers Ins. Co.*, 270 Or App 77, — P3d — (2015)
  - **ISSUES:** UM/UIM Coverage
- Senate Bill 411
  - **ISSUES:** PIP, UM/UIM Stacking, Suit Limitations
- *Chartis Specialty Ins. Co. v. American Contractors Ins. Co.*, No. 3:13-CV-01669-KI, 2015 WL 364315 (D. Or. Jan. 27, 2015)
  - ***ISSUES:*** Attorney Fees on Excess Insurer
- *5 Star, Inc. v. Atlantic Cas. Ins. Co.*, 269 Or App 51, ___ P3d ___ (2015)
  - **ISSUES:** Reformation
- *Deardorff v. Farnsworth*, 268 Or App 844, — P3d — (2015)
  - **ISSUES:** Estoppel, Scope of Coverage
- *Dowell v Oregon Mut. Ins. Co.*, 268 Or App 672, — P3d — (2015)
  - **ISSUES:** PIP, Recovery of Transportation Costs
- *Semeryanov v. Country Mut. Ins. Co.*, 2014 WL 6998097, No. 14-cv-313-SI (D. Or. Dec. 9, 2014)
  - **ISSUES:** Equitable Estoppel, Suit Limitation Provision
- *State v. Ramos*, 267 Or App 164, ___ P3d ___ (2014)
  - **ISSUES:** Restitution on Insurance Fraud Claim
- *Hall v. Speer*, 267 Or App 639, ___ P3d ___ (2014)
  - **ISSUES:** Proof of Loss, UIM
- *Triangle Holdings, II, LLC v. Stewart Title Guaranty Co.*, 266 Or App —, — P3d —, 2014 WL 5365977 (2014)
  - ***ISSUES:*** Attorney fee recovery under ORS 742.061

WASHINGTON/OTHER JURISDICTIONS

- *Kinsale Ins. Co. v. Georgia-Pacific LLC, No. 14-60770, 2015 WL 4529290, — F.3d — (5th Cir. 2015).*
  - **ISSUES:** Insured vs. Insured Exclusion
- *Kaady v. Mid-Continent Cas. Co.*, No. 13-35036, — F.3d — (9th Cir. 2015)
  - **ISSUES:** Known Loss Doctrine
- *Queen Anne Park Homeowners Ass'n v. State Farm Fire & Cas. Ins. Co.*, No. 90651-3, —Wn.2d —, — P.3d —, 2015 WL 3795796 (2015)
  - **ISSUES:** Collapse Coverage
- *Hampton v. Safeco Ins. Co. of Am.*, Case No. 14-6064, 2015 WL 3555866, — Fed. Appx. — (6th Cir. 2014)
  - **ISSUES:** Replacement Cost Provision
- *Mumm v. State Farm Mut. Auto. Ins. Co.*, Case 32323-4-III, 2015 WL 3381215
  - **ISSUES:** Phantom Vehicle
- *Langley v. GEICO Gen. Ins. Co.*, No. 14-cv-3069-SMJ, 2015 WL 778619 (E.D. Wash. Feb. 24, 2015)
  - **ISSUES:** IFCA/Bad Faith Damages
- *Lui v. Essex Ins. Co.*, No. 72835-1-I
  - **ISSUES:** Vacancy Exclusion
- *Patriot Gen. Ins. Co. v. Gutierrez*, No. 32109-6-III, 2015 WL 773571 (Wash. Ct. App. Feb. 24, 2015)
  - **ISSUES:** UIM Coverage
- *Strauss v. Chubb Indem. Ins. Co.*, — F.3d —, 2014 WL 6435314 (7th Cir. 2014)
  - **ISSUES:** Continuous Loss
- *State Farm Mut. Auto. Ins .Co. v. Jacobs*, No. C14-5512 RBL, 2014 WL 5470623 (W.D.Wash. Oct. 28, 2014)
  - **ISSUES:** Corporate Practice of Medicine Doctrine

OREGON CASE SUMMARIES

Oregon Supreme Court Overrules *Stubblefield* Rule (*Brownstone Homes Condo. Ass'n v. Brownstone Forest Heights, LLC*, No. CA A145740, 2015 WL 7299027 (Or. Nov. 19, 2015)

The Oregon Supreme Court recently issued an opinion overruling long established case precedent known as the "Stubblefield Rule" in *Stubblefield v. St. Paul Fire & Marine*, 267 Or 397 (1973). The 'Stubblefield Rule' states that a covenant not to execute in exchange for an assignment of rights, by itself, constitutes a release that extinguishes further liability of the insured, and therefore also extinguishes the rights of the insurer because the insured is no longer "legally obligated to pay" those sums.

In this construction defect case, *Brownstone Homes Condo. Ass'n v. Brownstone Forest Heights*, LLC, No. CA A145740, 2015 WL 7299027 (Or. Nov. 19, 2015), a condominium association (the "Association") sued a subcontractor (the "Contractor") for negligence as a result of various defects in the construction of its condominium complex. When the Contractor tendered the claim to its insurer (the "Insurer"), the Insurer refused to defend and indemnify, claiming its policy did not cover the damage the Association sought recovery. The Contractor's policy with the insurer provided coverage for "those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage.'" The Contractor and the Association entered into a stipulated judgment against the Contractor that included a covenant by the Association not execute the judgment against the Contractor and an assignment of the claims against the Insurer. The judgment was entered in the Circuit Court, and Association attempted to garnish the Insurer for the unpaid portion of the judgment pursuant to ORS 18.352. The Insurer rejected the writ of garnishment, arguing the Association's covenant not to execute against the Contractor released the Contractor from any legal obligation, effectively eliminating the Insurer's obligation of coverage. The Insurer moved for summary judgment on the issue, and the Circuit Court found Stubblefield controlled and granted the Insurer's motion for summary judgment and the Court of Appeals affirmed.

On this appeal, the Association argued Stubblefield was distinguishable in that it did not apply to garnishment actions under ORS 18.352, was abrogated under ORS 31.825, and that Stubblefield was wrongly decided. First, the Court held that Stubblefield is applicable to the present garnishment action under ORS 18.352. The statute sets out only two requirements for recovery from a judgment debtor's insurance policy: (1) that a judgment has been rendered against the judgment debtor for injury or damage to person or property; and (2) that the judgment debtor has a covered liability for any injury or damage to person or property. The

Court agreed with the Insurer's argument that "the amount covered" is affected by the fact that the covenant not to execute eliminated the Contractor's liability to the Association and, and under Stubblefield, eliminated any amount covered as well. The Court noted that the Association, in bringing the garnishment action against the Insurer, stands in the shoes of the insured, the Contractor, and is subject to any defenses that the Insurer could assert against the Contractor, including the Insurer's defense that Stubblefield applies to eliminate the Insurer's obligation to pay. In short, the Court found that the argument that Stubblefield is inapplicable in the garnishment proceeding under ORS 18.352 as not well taken.

Secondly, the Court held that the Stubblefield decision was not abrogated under ORS 31.825. The Insurer argued that, by its terms, the statute applies only to a settlement by a "defendant in a tort action against whom a judgment has been rendered." As argued by the Insurer, the tense of the emphasized phrase made it clear that the statute applies only to a particular sequence of events: First, a judgment is rendered, and then, once that has occurred, an assignment and covenant not to execute are given. That was not what happened in this case. Rather, the parties first negotiated the assignment and covenant and only later obtained a judgment. After specifically analyzing the legislative history of this statute and its plain meaning, the Court agreed with the Insurer.

Finally, the Court found that the Stubblefield decision was, in fact, wrongfully decided. The Court agreed with the Association's argument that the Stubblefield decision failed to apply the usual framework for interpreting policies of insurance and failed to offer any reasoned explanation for its conclusion about the effects of the settlement agreement. Specifically, the Stubblefield decision engaged in no examination of the wording of the policy, no consideration of its context, no determination whether the policy was ambiguous, and no discussion of what considerations weighed in favor of resolving any ambiguity one way or the other. Additionally, the Court noted that the Stubblefield decision paid inadequate attention to the court's own prior case law, and that there is the doctrinal question whether a covenant not to execute constitutes a release that, of its own force, extinguishes any further liability. Ultimately, the Court found that the phrase "legally obligated to pay"—at least as it is commonly used in liability insurance policies—is ambiguous, thus triggering the well-worn rule that such ambiguities in insurance policies are to be construed against the insurer, therefor overturning the Stubblefield decision.

Insurer Voids UM/UIM Attorney Fee Safe Harbor in Pleading (Kiryuta v. Country Preferred Ins. Co., 273 Or App 469, 359 P.3d 480 (2015).

On September 2, 2015, the Oregon Court of Appeals issued an opinion addressing Oregon's ORS 742.061(3) attorney fee "safe-harbor" letter in uninsured/underinsured (UM/UIM) motorist claims in *Kiryuta v. Country Preferred Ins. Co.,* 273 Or App 469, 359 P.3d 480 (2015). The court held that because the

insurer made allegations in its responsive pleadings that raised issues other than the liability of the driver and "the damages due the insured," the insurer was not eligible for the attorney fee safe-harbor provided in ORS 742.061(3).

By way of background, ORS 742.061(1) provides that an insured is entitled to an award of attorney fees if a settlement of an insurance claim "is not made within six months from the date [when] proof of loss is filed with an insurer" and the insured recovers more than any amount that the insurer has tendered. However, under ORS 742.061(3), the insured is not entitled to an award of attorney fees if, within six months of the filing of the proof of loss, "the insurer states in writing that it accepts coverage, that the only remaining issues are the liability of the [uninsured or the] underinsured motorist and the amount of damages due the insured, and that it consents to binding arbitration." This is known as the UM/UIM attorney fee "safe-harbor" letter and can effectively cut off attorney fee exposure to an insurer.

In this case, the insured was injured in an automobile accident and made a claim for underinsured motorist (UIM) benefits. The insurer denied the claim and subsequently issued a letter that complied with the requirements of ORS 742.061(3). The insured filed a lawsuit against the insurer alleging that its failure to pay UIM benefits breached the insurance policy. In its answer, the insurer set out affirmative defenses entitled "Contractual Compliance" and "Offset." The insured prevailed in the arbitration and filed an attorney fee petition under ORS 742.061(1), arguing that the insurer's answer and its response to certain requests for admissions raised issues for arbitration other than liability of the driver and the damages due to the insured. The arbitrator awarded the insured its attorney fees, and the insurer filed exceptions to the attorney fee award in the trial court, contending that its safe-harbor letter precluded an award of fees. The circuit court reversed the arbitrator's award of attorney fees and the insured appealed the decision.

On appeal, the insured contended that the insurer raised issues in the lawsuit other than the liability of the uninsured or underinsured motorist and the damages due to the insured that preclude eligibility for the safe-harbor protection under ORS 742.061(3). The insurer argued that that the affirmative defenses labeled "Contractual Compliance" and "Offset" were not intended to assert that some term in the policy prevented the insured from recovering any damages and that no issues other than the damages due to the insured were litigated in the arbitration.

The Court of Appeals agreed with the insured, stating that the insurer's pleadings provided a foundation for the insurer to litigate an issue other than the amount of the insureds damages or liability of the underinsured driver. In other words, through its answer, the insurer pursued a litigation strategy that was broader than that contemplated by the legislature in ORS 742.061(3). The fact that the insurer

may not have followed through with that litigation strategy at the arbitration proceeding makes no difference. The Court noted that the insurer was in control of its own pleadings and was in a position to conform those pleadings to the limitations of the safe-harbor provision, by alleging only ultimate facts that pertained to the liability of the uninsured or underinsured motorist and the damages due to the insured. The Court noted that the insurer nonetheless opted to include issues in its pleadings other than those issues permitted by the safe-harbor provision, and it did not amend those pleadings before the arbitration hearing to limit the issues at the hearing to those allowed by the safe-harbor provision. As a result, the insured had to be prepared at the arbitration hearing to meet any proof that the insurer might offer consistent with its pleadings.

Oregon Court Finds Duty to Defend Additional Insured (*West Hills Development Co v. Chartis Claims*, 273 Or App 155, 359 P.3d 339 (2015).

The Oregon Court of Appeals recently issued a decision regarding an insurance company's duty to defend an additional insured in the construction defect case *West Hills Development Co v. Chartis Claims,* 273 Or App 155, 359 P.3d 339 (2015). In this case, the Court of Appeals rejects a rigid application of the "four-corner" rule (i.e. only looking at the policy and complaint) in determining the duty to defend. Previously, in *Fred Shearer & Son s, Inc. v. Gemini Ins. Co.*, 237 Or App 468, 476, 240 P3d 67 (2010), rev den, 349 Or 602 (2011), the Court of Appeals held that extrinsic evidence could be used to address "the preliminary question: whether the party seeking coverage was actually an insured within the meaning of the policy." In *West Hills*, the Court of Appeals relied on extrinsic evidence to conclude that the duty to defend was triggered for an additional insured.

In this case, a homeowners association sued a general contractor for alleged construction defects that, when the homeowners bought their units, the alleged deficiencies "existed and had already started to cause property damage." The insurer of a subcontractor on the project rejected the tender of defense by the general contractor on the grounds that the association's complaint did not identify the subcontractor, allege any improper work by the subcontractor, or specify that damages occurred during the subcontractor's ongoing operations for the general contractor. The general contractor sued the insurer for breach of contract based on the insurer's failure to defend, and the trial court granted the general contractor's motion for summary judgment on the breach of contract claim. The insurer appealed the trial court's decision.

The Court of Appeals held that if an injured claimant can recover under the allegations made in the complaint upon any basis for which the insurer affords coverage, that insurer is obligated to defend the insured. On the facts presented, the Court of Appeals concluded that the complaint alleged that the

general contractor negligently supervised its subcontractors, and the alleged defects resulted from the negligent supervision. Thus, the complaint alleged facts which, if proved, could subject the general contractor to liability for work by a subcontractor. Although the complaint did not identify the subcontractor, the Court of Appeals held that extrinsic evidence could be considered in order to identify the subcontractor and put the insurer on notice that its duty to defend the general contractor (additional insured) had been triggered.

Specifically, the homeowners' suit did not allege when the property damage occurred, but it did indicate that, when the homeowners bought their units, the alleged deficiencies "existed and had already started to cause property damage." Given the ambiguity of that statement, and given that any ambiguity in the complaint relating to coverage must be resolved in favor of the insured, and the Court concluded that the complaint contains allegations that could allow for proof at trial that the damages occurred during the subcontractor's ongoing operations. The decision of the trial court was affirmed.

Insurer Has Duty to Defend Despite Indemnity Agreement Per Oregon Court
(Portland Gen. Electric Co. v. Liberty Mut. Ins. Co., No. 3:15-cv-00217-HZ, 2015 WL 3892593, — F.Supp.3d — (D. Or. 2015))

The Oregon federal district court recently addressed the enforceability of an indemnification agreement under ORS 31.140 and its impact on an insurer's duty to defend and duty to indemnify an insured. In Portland Gen. Electric Co. v. Liberty Mut. Ins. Co., No. 3:15-cv-00217-HZ, 2015 WL 3892593, — F.Supp.3d — (D. Or. 2015), the district court concluded that the indemnification agreement was partially enforceable under a recent Oregon Supreme Court opinion. The court further concluded that the allegations in the underlying complaint triggered the insurer's duty to defend.

In the case, PGE had been sued by Joel Belgarde, who alleged that he was injured at one of PGE's plants. At the time of the accident, Belgarde was working as a boilermaker for NAES Corp. He alleged that at all relevant times, PGE controlled, directed, and monitored his work at the plant. Several years prior to Belgarde's accident, PGE and NAES entered into a contract that required NAES to procure commercial liability insurance covering all of its operations at PGE's plant against bodily injury and property damage and name PGE as an additional insured by endorsement or otherwise. A certificate of insurance was issued on May 16, 2012, listing NAES as the insured under a commercial general liability policy.

The subject policy obligated the insurer to "pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage' to which this insurance applies" and "to defend the insured against 'suit'

seeking those damages." The insurer did not dispute that Belgarde suffered a bodily injury or that the litigation he filed qualified as a suit. The issue was whether PGE qualified as an insured under the policy and, specifically, whether ORS 31.140 operated to bar the agreement between PGE and NAES.

The insurer argued that ORS 31.140 voided the agreement by NAES to insure PGE against liability for any injury arising out of NAES's work for PGE. ORS 31.140 precludes agreements in which a party's insurer would be required to indemnify another party for damages arising from the latter party's negligence. In the case, the insurer argued that the NAES/PGE agreement was void because it required NAES to procure insurance for PGE's own negligence. The insurer acknowledged that the contract encompassed the fault of NAES in addition to that of PGE. Despite that, the insurer contended that the contract was void because it was not limited specifically to the negligence of NAES.

The district court rejected the insurer's argument, citing the Oregon Supreme Court's recent decision in *Montara Owners Ass'n v. La Noue Dev., LLC*, No. SC S062120, 2015 WL 3791636 (Or. June 18, 2015). There, the Court held that ORS 31.140 operated to void only that portion of the indemnification agreement that violated the statute, but that the remaining agreement was enforceable. Accordingly, the district court rejected the insurer's position, and concluded that the NAES/PGE agreement was "partially enforceable."

The insurer nevertheless argued that it did not have a duty to defend PGE in the Belgarde action because the indemnification agreement was enforceable only to the extent it asserts liability by NAES. According to the insurer, the underlying complaint did not assert that NAES acted negligently and, instead, that it solely asserted liability against PGE which would not be covered under the policy. The district court again rejected the insurer's position. Belgarde did not mention NAES in his complaint, but affirmatively asserted that PGE controlled, directed, and monitored his work at the PGE plant. The district court concluded that these allegations were attributable to the exclusivity of Oregon's workers compensation law which prohibited Belgarde from asserting a direct claim against his employer. Despite that, the court found that the allegations implied fault against NAES and thus triggered coverage.

The district court did, however, reject PGE's argument that it was entitled to summary judgment on the insurer's duty to indemnify. It concluded that the duty to indemnify could not be decided because it was premature.

Policy Limits Admissible in UIM Dispute Per Oregon Court (*Thoens v. Safeco Ins. Co. of Oregon*, 272 Or App 512, 356 P.3d 91 (2015))

On July 22, 2015, the Oregon Court of Appeals released an opinion in *Thoens v. Safeco Ins. Co. of Oregon*, 272 Or App 512, 356 P.3d 91 (2015), addressing the admissibility of (1) an insured's underinsured motorist (UIM) coverage limits and the at-fault driver's liability policy limits in a UIM coverage dispute, and (2) the testimony of a biomechanical engineering expert regarding the forces experienced by a person during an automobile accident. The Court of Appeals found that the two coverage limits were admissible in the case based upon the manner in which the case was presented to the jury. It also found that the biomechanical engineer was properly permitted to testify in the case.

The case involved an insured that was injured when she was rear-ended while stopped behind a school bus. Following the accident, the insured received medical treatment for injuries that she attributed to the accident. The insurance company paid personal injury protection (PIP) benefits, but eventually cut them off based on the results of an independent medical examination. The insured settled with the at-fault driver's insurer for the full liability policy limits, and sought additional payments from her insurance company under her UIM coverage. The insured filed suit when the insurance company refused to pay any additional benefits. The suit included separate claims seeking payment of additional PIP benefits and for failure to pay UIM benefits. The jury found for the insured on the PIP claim, but ruled in favor of the insurance company on the UIM claim. The insured appealed, arguing that the trial court improperly excluded evidence of her UIM policy limits and the liability limits of the at-fault driver and improperly allowed a biomechanical engineer to testify.

At trial, the insurance company moved to exclude any evidence of the amount of the insured's UIM coverage limits. The basis of the insurance company's position was (1) the evidence was irrelevant because the jury needed only to determine the damages and the trial court could apply an offset, and (2) disclosure of the coverage amounts would unnecessarily inject insurance into the matter—beyond the insurance company being named in the lawsuit—and would produce an "anchoring" effect that would tend to increase the jury award. The insurance company also moved to exclude any evidence of the adverse driver's liability limits or that the limits were paid to the insured on the ground that the evidence was irrelevant and unfairly prejudicial. The trial court granted the insurance company's motions and precluded any such evidence at trial.

The Court of Appeals began its analysis of the issue by assessing how the case was presented to the jury. In particular, the court noted that the case was presented to the jury in a "hybrid contract-tort fashion" in that the jurors were asked to determine both whether the at-fault driver was underinsured for purposes of triggering UIM coverage and the damages the insured sustained. The court noted

that had the insurance company stipulated to the fact that the at-fault driver was underinsured, the trial court's rulings would have been correct. Given the manner in which the case was presented, however, the court concluded the trial court's rulings were in error because there was no evidence to permit the jury to accurately determine whether the at-fault driver was, in fact, underinsured.

The insured also appealed the trial court's ruling permitting the insurance company to present the testimony of a biomechanical engineering expert regarding the forces experienced by an occupant of a vehicle in a collision. At trial, the insured argued that the biomechanical expert should not be permitted to testify because his conclusions were based on "junk science." The trial court conducted an OEC 104 hearing to assess the expert's qualifications and concluded that the expert should be permitted to testify. The Court of Appeals affirmed the trial court's conclusion, holding that the record supported the conclusion that the biomechanical engineer established adequate "knowledge, skill, experience, training, and education" to qualify him to testify as to the impact speed of the collision, the forces transmitted to the insured in the subject accident, the forces the insured experienced in her daily activities prior to the accident, and the forces generally tolerated by human joints and tissues without injury.

Oregon District Court Finds Duty to Defend NIED Claim (*Norgren v Mut. of Enumclaw Ins. Co.*, No. 14-cv-01591-SB, 2015 WL 3948145 (D. Or. June 29, 2015))

The U.S. District Court in Oregon recently found that an insurance company had a duty to defend its insured in a lawsuit alleging that their minor child intentionally assaulted another minor. In the case, captioned *Norgren v Mut. of Enumclaw Ins. Co.*, No. 14-cv-01591-SB, 2015 WL 3948145 (D. Or. June 29, 2015), the insureds had a homeowners policy that provided that the insurance company had a duty to defend the insureds against claims for bodily injury or property damage, but not for any claims arising from intentional acts. The insureds' minor child attended school with another minor child, referred to in the case as J.H. The insureds were sued in a lawsuit alleging that their child had, over a period of time, physically assaulted J.H. with the intent to harm her. The insureds sued seeking a declaration that the insurance company had a duty to defend them in the underlying lawsuit.

The underlying lawsuit alleged claims for, among other things, battery and negligent infliction of emotional distress ("NIED"). The court initially noted that the NIED claim is not based on intentional conduct and is therefore covered under the policy. The insurance company responded that NIED is not a cognizable claim under Oregon law and thus could not trigger the insurance company's duty to defend. The court rejected the insurance company's position, noting that under Oregon law a party can recover for NIED, but only if he or she is also "physically injured, threatened with physical injury, or physically impacted by the tortious

conduct." In the underlying suit, J.H. alleged that she was physically injured or impacted by the allegedly tortious conduct. Based on those allegations, the court concluded that J.H. appeared to have asserted a claim based in negligence.

The insurance company responded that although the underlying suit may have included a negligence claim, the allegations underlying the claim include only intentional conduct. Under Oregon law, when subjective intent to harm is the only reasonable inference to be drawn from the allegations, the court may make that inference and hold that the duty to defend is not triggered. The court also rejected this argument, finding that J.H.'s allegations of negligent conduct in the underlying lawsuit precluded the court from drawing an inference that the insureds' child had a subjective intent to harm that was sufficient to find there was no duty to defend.

Finally, the court rejected the argument that the exception in the policy for damages "arising out of, or resulting from, actual, alleged, or threatened … physical or mental abuse" applied to bar coverage. The applicable policy did not define abuse, but the court concluded that the term required a showing of willful conduct. Again, the court found that the allegations of negligence precluded application of the exception.

Oregon Court Finds No Duty to Defend or Indemnify for Alleged Professional Services (*Navigators Ins. Co. v Hamlin*, No. 14-cv-196-MC, 2015 WL 1084825 (D.Or. Mar. 10, 2015)

An Oregon federal district court judge recently issued an opinion and order in *Navigators Ins. Co. v Hamlin*, No. 14-cv-196-MC, 2015 WL 1084825 (D.Or. Mar. 10, 2015) addressing an insurance company's duty to defend and indemnify its insured for claims relating to alleged professional services rendered by the insured. The district court concluded that the facts and allegations did not trigger either the duty to defend or duty to indemnify the insured because they did not satisfy the definition of "professional services" in the policy. The court also determined that the claim was barred by the "personal profit" exclusion in the policy.

The case involved a plaintiff that retained the services of an accountant to assist in a divorce proceeding. After the divorce the plaintiff and accountant continued a working relationship. In 2009, the plaintiff contacted the accountant to determine whether the accountant could obtain higher returns on investments. Between 2009 and 2011, the plaintiff loaned the accountant $660,000 that were secured by six separate promissory notes with progressively higher interest rates. The plaintiff understood that the accountant would invest the money with local businesses, but later learned that did not occur. The accountant defaulted on the loans, and the plaintiff

filed suit for breach of contract and breach of fiduciary duty. Shortly after being deposed, the accountant committed suicide.

The accountant's insurance company filed a declaratory judgment action seeking a declaration that it did not have a duty to defend or indemnify the accountant in the action. The plaintiff filed a cross-motion for summary judgment seeking a declaration that the professional liability insurance policy issued to the accountant provided coverage.

The subject policy provided that the insurance company "will pay on behalf of the [accountant] all sums in excess of the deductible that the [accountant] shall become legally obligated to pay … by reason of an act or omission, including personal injury, in the performance of professional services by the [accountant]." The term "professional services" was defined by the policy to include accounting services, including acting the capacity of an "accountant or accounting consultant" and "investment advisor." The court concluded that the facts and allegations did not trigger either the duty to defend or duty to indemnify because they did not establish that the accountant was providing professional services, but was personally involved in the sale of the investments which was not covered. In finding there was no coverage, the court rejected the plaintiff's emphasis on the fiduciary relationship established with the accountant, holding that "the proper inquiry to determine what conduct falls under 'professional services' is the nature of the act itself, not the status of the party performing the act or the status of the party harmed."

Additionally, the court concluded that there was no duty to defend or duty to indemnify because the claim was barred by the "personal profit" exclusion. The policy provided that the insurance company would not defend or indemnify any claim "[b]ased upon or arising out of the [accountant] gaining, in fact, any personal profit or advantage to which the [accountant] is not legally entitled." The court found that the personal profit exclusion applied in the case because the accountant gained the profit or advantage of $660,000 that, upon default, he was no longer legally entitled to retain.

Oregon Court Construes Scope of UM/UIM Coverage Grant, *De Zafra v. Farmers Ins. Co.*, 270 Or App 77, 346 P.3d 652 (2015)

On March 25, 2015, the Oregon Court of Appeals issued its decision in *De Zafra v. Farmers Ins. Co.*, 270 Or App 77, 346 P.3d 652 (2015), addressing the scope of coverage available under the uninsured/underinsured motorist (UM/UIM) statute. The specific issue before the court was the meaning of the phrase "arise out of" use of an uninsured vehicle. The court rejected prior case

law that incorporated a requirement that there be a "direct cause" between the injury and use of the vehicle.

The case concerned an insured that was passenger in a vehicle. Another vehicle drove alongside the insured's vehicle and fired several gunshots, causing her serious injuries. The liability insurer covering the individual that fired the gunshots denied the insured's claim. The insured filed a claim under the UM/UIM insurance policy covering the vehicle she was occupying at the time of the incident. The UM/UIM insurance company denied the insured's claim. As a result, the insured filed a lawsuit alleging breach of contract.

At the trial court, the parties filed cross-motions for summary judgment on whether there was coverage under the policy. The primary issue for consideration was whether the insured's injuries fell within the requirement under ORS 742.504(1)(a) and the policy that injuries "arise out of the * * * use of [an] uninsured motor vehicle." The insurance company relied on the decision in *Worldwide Underwriters Ins. Co. v. Jackson*, 121 Or App 292, 855 P2d 166, *rev den*, 318 Or 26 (1993). In *Jackson*, the Court of Appeals construed the same phrase in a UM policy and determined a gunshot, not a vehicle, to be the "direct cause" of the injury and upheld the denial of a claim. The insured, on the other hand, relied on the more recent Oregon Supreme Court decision in *Carrigan v. State Farm Mut. Auto. Ins. Co.*, 326 Or 97, 949 P2d 705 (1997). In *Carrigan*, the court construed similar language in the context of the personal injury protection (PIP) statute and rejected the "direct cause" interpretation. The trial court agreed with the insurance company and granted its motion, finding that *Carrigan* was distinguishable and *Jackson* to be on point. The insured appealed.

The parties reiterated their arguments before the Court of Appeals. The court began its opinion with a thorough analysis of the *Jackson* and *Carrigan* decisions, including outlining the basis for each decision. Citing other Oregon authorities interpreting the phrase, the court concluded that the term "arising out of" is broader than "caused by." The court also concluded that it was unable to draw any meaningful distinction between the Supreme Court's interpretation of the phrase in the context of the PIP statute, finding that although PIP and UM provide distinct insurance benefits, the causal link in the statutes between an injury and vehicle is the same. The court rejected the insurance company's invocation of the doctrine of *stare decisis*, holding that the UM/UIM statute requires coverage "when the injury arises out of the use of an uninsured motor vehicle and that coverage cannot be denied based on an interpretation that the gunshots were the 'direct cause' of the injury."

Oregon Legislature Passes Significant Changes to PIP and UM/UIM Laws

On March 12, 2015, Governor Kate Brown signed into law Senate Bill 411 which makes substantial changes Oregon's personal injury protection (PIP) and uninsured/underinsured motorist (UM/UIM) statutes. The new law becomes effective on January 1, 2016.

The new law amends the PIP statute to enables a policyholder to apply PIP benefits to any damages-not just economic damages-before the insurer is able to recover expenses. This change ensures that the policyholder is fully compensated before the insurer is able to assert any subrogation or lien rights. Another major amendment to the PIP law is that coverage must be made available for two years from the date of the underlying accident, as opposed to one year as the prior law required. The amended UM/UIM law permits policyholders to "stack" UM/UIM policy benefits on top of the at-fault driver's liability policy limits. Under the prior law, insurers were permitted to include "anti-stacking" provisions that limited an insured's recovery to the policy's UM/UIM limits.

Insurer Not Entitled to Attorney Fees from Excess Insurer (*Chartis Specialty Ins. Co. v. American Contractors Ins. Co.,* No. 3:13-CV-01669-KI, 2015 WL 364315 (D. Or. Jan. 27, 2015))

The Oregon federal district court recently issued an opinion in *Chartis Specialty Ins. Co. v. American Contractors Ins. Co.,* No. 3:13-CV-01669-KI, 2015 WL 364315 (D. Or. Jan. 27, 2015), addressing whether an insurance carrier is entitled to direct recovery of its attorney fees against another insurer when it is forced to litigate the number of "occurrences" for purposes of determining insurance coverage. In this case, the Oregon federal district court determined that there was no basis under ORS 742.061 for recovery of attorney fees.

The case involved insurance coverage dispute between Chartis Specialty Insurance Company ("Chartis") and American Contractors Insurance Company Risk Retention Group ("ACIG"), both of which provided insurance policies covering the development of a condominium complex built by the same insured contractor. The Chartis policy provided excess coverage of $2 million per "occurrence" with a $4 million aggregate limit. The ACIG Commercial General Liability policy was primary, with a limit of $2 million per "occurrence" and an aggregate limit of $4 million.

In 2011, the condominium complex discovered a structural problem, prompting a lawsuit against the insured. ACIG and Chartis together paid $3.6 million to settle that lawsuit in February 2013. ACIG paid $2 million and Chartis paid $1.6 million with a reservation of rights to seek reimbursement from ACIG. Chartis then sought a declaratory judgment that the property

damage alleged in the lawsuit was caused by more than one "occurrence." If correct, Chartis should have been reimbursed the $1.6 million it paid to help settle the lawsuit. ACIG filed a cross claim for declaratory judgment on the number of occurrences and a claim to statutory attorney fees under ORS 742.061.

As an initial matter, the Oregon federal district court ruled that, as a matter of law, there was a single "occurrence" under the ACIG policy. This ruling eliminated Chartis' reimbursement claim against ACIG. However, ACIG still maintained it was entitled to declaratory relief and attorney fees against Chartis. The Oregon federal district court ruled that ACIG's claim for declaratory judgment was moot because the Court had already found in its favor regarding the number of "occurrences" under the policy. The court then went on to rule that regardless of whether ACIG is entitled to judgment on its claim for declaratory judgment, as an insurer, it is not entitled to recover attorney fees from Chartis as a matter of law. The court reasoned that ACIG could not recover its fees because it was not standing in the shoes of the insured, had not received an assignment from the insured, and was not a judgment creditor. As such, ACIG had no direct cause of action for attorney fees against the excess carrier Chartis under ORS 742.061 and summary judgment was appropriate.

Oregon Insured Not Entitled to Reformation of Policy (*5 Star, Inc. v. Atlantic Cas. Ins. Co.*, 269 Or App 51, 344 P.3d 467 (2015))

The Oregon Court of Appeals analyzed two commonly litigated issues that arise when a policyholder has inadequate insurance coverage and suffers a loss. First, the court considered whether reformation of the insurance policy was appropriate. Second, it assessed whether there was a viable claim for negligent procurement of insurance. In *5 Star, Inc. v. Atlantic Cas. Ins. Co.*, 269 Or App 51, 344 P.3d 467 (2015), the court determined that the insured was not entitled to statutory or common law reformation of the insurance policy, and that the insured's claim against the insurance company for "negligent procurement of insurance" failed as a matter of law.

The case concerned an insured that was a general contractor and, as such, was required by Oregon law to meet mandatory minimum insurance requirements. In 2002, the insured contracted with an insurance agent to obtain the mandatory insurance coverage, which was ultimately purchased from an insurer. The policy issued to the insured contained multiple exclusions, including an exclusion for claims arising out of the actions of subcontractors.

While the policy was in effect, an individual was injured while working as a subcontractor for Plaintiff. The injured person sued the insured, who submitted the lawsuit to insurance company and requested a defense. The insurance company denied coverage for the damages alleged in the lawsuit. It also denied that it had any duty to defend the insured, based upon the exclusion for subcontractors. The insured failed to answer or defend the lawsuit on its own, which resulted in the trial court entering a default judgment against the insured and awarding the injured party approximately $18 million dollars in damages.

The insured filed suit against the insurance company alleging (1) the insured was entitled reform the policy to include coverage for subcontractors, and (2) the insurance company was vicariously liable for the insurance agent's negligent failure to procure adequate insurance. The trial court granted summary judgment in favor of the insurance company, dismissing with prejudice all of the claims against the insurance company. (Note: Additional claims against the insurance agent survived the motion for summary judgment.)

On appeal, the insured argued it was entitled to reformation of the policy because it did not satisfy the requirements of *former* ORS 701.105 (now ORS 701.073), which requires contractors to have at least $500,000 in insurance coverage. The Court of Appeals noted that there was no dispute that the policy at issue provided $500,000 in coverage to the insured as the general contractor, but emphasized the issue was whether the exclusion for subcontractors violated the intent of the statute and the mandatory minimum insurance requirement. On this issue, the Court of Appeals noted that the statute does not impose a legal obligation onto insurers, but onto contractors. The insurance company did not violate the statute by including the subcontractor exclusion in the policy. Accordingly, the statute did not provide a basis for reformation.

The court further held that the insured's reformation claim failed for lack of evidence of any antecedent agreement. A party seeking common law reformation of a contract must prove three elements: (1) there was an antecedent agreement to which the contract can be reformed; (2) there was a mutual mistake by both parties to the contract, or a unilateral mistake by the party seeking reformation plus inequitable conduct by the other party; and (3) the mistake by the party seeking reformation was not the result of gross negligence. The court held there was no evidence of an antecedent agreement or that insurance company agreed to provide coverage that would cover the actions of subcontractors.

The insured's negligent failure to procure insurance claim was premised on the theory that the insurance company was vicariously liable for the acts and omissions of the insurance agent pursuant to ORS 744.078(4). The insured argued that under the statute, *any* person who solicits or procures an application for insurance as an agent for an insured is the agent of the insurer in all matters relating to that application for insurance. The Court of Appeals rejected the insured's argument, holding that ORS 744.078(4) unambiguously applies only in those cases where (1) the insurance producer is an appointed agent for the insurer; or (2) the insurance producer transacts insurance on behalf of another insurance producer who is an appointed agent of the insurer. The Court of Appeals noted that there was no evidence of either circumstance in this case, and summary judgment was appropriate.

Estoppel Cannot Expand Coverage Per Oregon Court (*Deardorff v. Farnsworth*, 268 Or App 844, 343 P.3d 687 (2015)

On February 4, 2015, the Oregon Court of Appeals issued an opinion in *Deardorff v. Farnsworth*, 268 Or App 844, 343 P.3d 687 (2015), addressing the circumstances in which estoppel applies to prevent an insurance company from relying on a provision in a policy to deny coverage. In the case, the insurance company denied a claim for defense of a lawsuit based on the application of an exclusion contained in a business insurance policy. During the process of procuring the policy, the agent inquired whether the insurance company offered care, custody or control (CCC) insurance. A representative of the insurance company responded that "[l]iability exposure for property of others in the insured's CCC, that is covered in liab[ility] form." The agent later contacted the insurance company to bind coverage, and the policy was issued.

When the policy was issued, the insured's agent represented to the insured that the policy included property and liability care, custody, or control (CCC) coverage. Despite the agent's representation, the policy did not include CCC *liability* coverage; specifically, the policy excluded, "'Property damage' to * * * [p]ersonal property in the care, custody or control of the 'insured'." The policy did, however, include CCC *property* coverage that was excess to "other insurance." After the policy was issued, the insureds were transporting horses in California that were owned by others when the trailer they were in caught fire, killing the horses. The insurers for the horse owners paid for the loss, but then filed suit against the insured in California alleging they had negligently caused the death of the horses. The insureds tendered defense of the matter to the insurance company, who denied coverage pursuant to the CCC liability exclusion in the policy. The insureds defended the California action themselves and incurred costs doing so.

The insureds filed an action against the insurance company seeking to recover their defense costs from the California action. The trial court granted summary judgment in favor of the insureds, finding that the insurance company was estopped from denying liability coverage for the loss of the horses and that the insurance company had breached the insurance contract. The trial court's application of estoppel relied on the insurance company's communication to the agent that CCC liability coverage was "covered" under the liability form. The insurance company appealed.

On appeal, the insurance company argued that the trial court incorrectly granted summary judgment on the ground that it was estopped from relying on provisions in the insurance policy to deny liability coverage for the loss of the horses. The Court of Appeals began its analysis by drawing a distinction between policy provisions that are considered "conditions of forfeiture" and those provisions that relate to the "scope of coverage." Under Oregon law, conditions of forfeiture—which exists where, initially, there is coverage, but some action of the insured nullify coverage—are subject to estoppel; whereas, provisions relating to the scope of coverage—which define the parameters of coverage available under the policy—are not. *See ABCD … Vision v. Fireman's Fund Ins. Cos.*, 304 Or 301, 744 P2d 998 (1987) and *DeJonge v. Mut. of Enumclaw*, 315 Or 237, 843 P2d 914 (1992). The court concluded that provision at issue was an express exclusion that relates to the scope of coverage and, therefore, is not subject to estoppel.

The court analyzed two cases (*Farley v. United Pac. Inc. Co.*, 269 Or 549, 525 P2d 1003 (1974) and *Allstate Ins. v. State Farm Ins.*, 67 Or App 623, 679 P2d 879 (1984)) that presumably provided exceptions to the general rule that estoppel cannot be applied to express exclusions. However, the court determined that the exception did not apply here. It summarized the legal principals in concluding that the "pertinent case law establishes that—in the absence of an insurance agent's interpretation of an ambiguous policy provision—estoppel cannot be used to negate an express exclusion in an insurance policy." In this case, the agent did not make such an interpretation.

Oregon PIP Statute Does Not Cover Transportation Costs (*Dowell v Oregon Mut. Ins. Co.*, 268 Or App 672, 343 P.3d 283 (2015))

In *Dowell v Oregon Mut. Ins. Co.*, 268 Or App 672, 343 P.3d 283 (2015), the Oregon Court of Appeals analyzed Oregon's Personal Injury Protection ("PIP") statute and addressed whether "expenses of medical … services" in ORS 742.524(1)(a) includes transportation expenses incurred while seeking covered medical services. The court determined that the legislature did not contemplate that transportation expenses would be covered under the PIP statute. Accordingly, the insured was entitled to payment for transportation expenses incurred while seeking medical treatment that was otherwise covered under the policy.

The insured was injured in a motor vehicle accident. Following the accident, the insured applied for PIP benefits. In addition to the medical costs incurred, the insured also made a claim for $430.67 in transportation expenses incurred to attend medical appointments and to obtain medication. The insurance company denied this portion of her claim. The insured then filed suit individually, and on behalf of those similarly situated individuals. The insured's suit was limited to a claim for breach of contract relating to the transportation expenses. The insurance company moved for summary judgment on the insured's claim, arguing that ORS 742.524(1)(a) did not require it to pay plaintiff's transportation expenses because they were not incurred by a medical provider. The trial court granted the insurance company's motion for summary judgment. Plaintiff appealed.

The Court of Appeals analyzed the entire context of ORS 742.524(1)(a), including the dictionary definitions of the disputed terms, "expenses of medical … services." It also consulted how the disputed terms were used in other sections of the PIP statute. Based on the definitions and use throughout the remaining provisions of the PIP statute, the court concluded that the legislature did not intend the phrase "expenses of medical … services" to include the expense of transportation to obtain those services. The Court went on to state that ORS 742.524(1)(a) not only lists the services that an insurer is required to cover, but also contemplates that those services will be provided by a "provider." The Court held that the term "provider," as used in ORS 742.524(1)(a) can only mean a person who is licensed, certified, or otherwise authorized to administer medical or mental health services—in other words, an authorized medical or mental health services provider. See ORS 742.518(10); ORS 743.801(13). Based on that limitation, the Court held that there is no PIP coverage for expenses of services provided by cab drivers, bus drivers, or other persons who are not authorized medical or mental health services providers who transport an insured to attend medical appointments or to obtain medication.

Court Considers Application of Equitable Estoppel to Suit Limitation Provision (*Semeryanov v. Country Mut. Ins. Co.*, 2014 WL 6998097, No. 14-cv-313-SI (D. Or. Dec. 9, 2014))

Last year, the Oregon federal district court, applying Washington law, addressed whether equitable estoppel barred an insurance company from relying on a one-year suit limitation provision. *Semeryanov v. Country Mut. Ins. Co.*, 2014 WL 6998097, No. 14-cv-313-SI (D. Or. Dec. 9, 2014), concerned an insured whose residence, which sat in Washington, was damaged by fire on January 11, 2012. The applicable insurance policy contained a clause requiring that all claims under the policy must be brought within one year of the date of loss and that the insured must comply with all duties under the policy within the same period. Before the expiration of the one year period, the insurer wrote a number of letters to the insured citing to the clauses.

On January 15, 2013, after the one year period expired, the insurer sent the insured a letter indicating that the investigation of the claim was continuing. The letter also informed the insured that the insurer was requesting a sworn statement of loss and may also seek an examination under oath. On November 18, 2013, nearly two years after the fire, the insurer denied coverage for the remainder of the insured's claim.

The insured filed suit against the insurer on February 25, 2014. The insurer filed a motion for summary judgment, arguing that the insured's claims were barred by the applicable suit limitation period. The insured responded that the insurer should be equitably estopped from relying on the suit limitation period based on its correspondence with the insured.

Applying Washington law, the court denied the insurer's motion for summary judgment. It determined that "there is at least an issue of fact whether equitable estoppel applies." In support, the court cited to prior Washington case law and the facts concerning the insurer's continuing investigation and several communications after expiration of the suit limitation provision. The court reasoned that the circumstances of the case reasonably led the insured to believe that the insurer would continue to investigate the claim and work toward settlement, without necessarily requiring initiation of litigation, and that the insurance claim was "open for further consideration."

Oregon Court Allows Criminal Restitution on Fraudulent Claim *State v. Ramos*, 267 Or App 164, 340 P.3d 703 (2014))

In *State v. Ramos*, 267 Or App 164, 340 P.3d 703 (2014), the Oregon Court of Appeals recently addressed an insurance company's right to restitution from an insured that submitted a fraudulent insurance claim. The court determined that an insurance company is entitled to restitution for various expenses associated with investigating and processing a fraudulent insurance claim, including attorney fees, investigative expenses, and other related costs.

The insured set fire to her restaurant business and made an insurance claim for the resulting damage to the restaurant and equipment. The insured was later convicted of arson, in connection with setting the fires, and attempted aggravated theft, in connection with submitting the fraudulent insurance claim. The State sought approximately $28,000 in restitution for the insured's insurance company. In support, the State presented evidence that the insurance company paid those amounts to a law firm, a forensics company, two investigators, and a court reporting company in connection with its investigation.

The insured appealed the trial court's order granting restitution to her insurance company. In particular, the insured objected to two categories: (1) attorney fees paid in connection with the investigation of the insured's claim, and (2) the fees

paid to investigators' for time spent providing grand jury and trial testimony. Alternatively, the insured contended no restitution should be ordered for expenses incurred after the claim was denied. The State responded that the insurance company was a victim of the insured's attempted theft by deception and was, therefore, entitled to restitution for economic damages it sustained as a result of the insured's commission of the crime. The Court of Appeals agreed with the State and upheld the trial court's restitution award.

The court began its analysis by citing the requirements for criminal restitution: (1) criminal activity, (2) economic damages, and (3) a causal relationship between the two. The court also reiterated Oregon law that the defendant's criminal activities must be the "but for" cause of the damages, but that the damages need not be the direct result of the defendant's criminal activities. The court concluded that the evidence satisfied these requirements: the insured, with intent to defraud, made a false insurance claim; the insurance company undertook an investigation solely because the insured filed the claim; and the insurance company's investigation addressed the harm posed by the insured's actions. Based on the facts presented by the State, the Court of Appeals found that all of damages that were part of the restitution order satisfied these requirements and upheld the restitution award.

Oregon Court Analyzes "Proof of Loss" on UIM Claim (*Hall v. Speer,* 267 Or App 639, 343 P.3d 640 (2014))

On December 24, 2014, the Oregon Court of Appeals issued a published opinion in *Hall v. Speer*, 267 Or App 639, 343 P.3d 640 (2014), concerning what constitutes a "proof of loss" for triggering an insurance company's obligation to investigate a potential underinsured motorist (UIM) claim and, thus, an insured's right to attorney fees under ORS 742.061. The case had been remanded to the Court of Appeals for consideration of the case in light of the Oregon Supreme Court decision in *Zimmerman v Allstate Prop. and Cas. Ins. Co.*, 354 Or 271, 311 P3d 497 (2013). In applying the factors announced in Zimmerman, the Court of Appeals determined that the information provided by the insured in Hall failed to trigger an obligation to investigate the UIM claim and, thus, meant the insured was not entitled to attorney fees under ORS 742.061.

The Court of Appeals summarized the relevant timeline of facts as follows:

- Sept. 16, 2006: The insured is injured in an automobile accident.
- Sept. 18, 2006: The insured notifies the insurance company that she was injured in the accident.
- Sept. 27, 2006: The insured submits to the insurer her application for PIP benefits, in which she described the accident and her injuries. With the exception of the heading, the PIP application is identical to the UIM application in all material respects.

- Fall 2006: The insurer opens a PIP claim and notes that the allegedly at-fault driver carried liability insurance, but did not notify the UIM adjuster of the insured's claim.
- Feb. 5, 2007: At the insurer's request, the insured was examined by a surgeon, who reported that the insured sustained significant injuries as a result of the accident.
- May 24, 2007: The insured's attorney wrote letters informing the insurer's PIP adjuster and general liability adjuster that he represented the insured and requesting certain documentation.
- Jan. 29, 2009: The UIM adjuster writes to the insured's attorney indicating that the insurer accepted coverage of the UIM claim, that the remaining issues between the parties were liability and damages, and that if they were not able to reach a settlement, the insurer would be willing to submit to binding arbitration.

The insured declined arbitration and later obtained a jury verdict in excess of the insurance company's settlement offer. The insured then petitioned the trial court for attorney fees under ORS 742.061. The insured argued to the trial court that the application for PIP benefits, together with the surgeon's report and counsel's letters to the insurance adjusters, constituted "proof of loss" for purposes of triggering the insurer's obligation to investigate the UIM claim and right to attorney fees. The insurer argued that in a UIM case, the insurer does not have proof of loss until it knows the underinsured motorist's liability limit and the nature of the insured's injuries, which did not occur until approximately two months before the insurer's acknowledgement of coverage and offer to arbitrate in January 2009.

The trial court ruled in favor of the insurer, finding that the information available to the insurer did not trigger the insurer's obligation to investigate until shortly before the January 2009 offer. The Court of Appeals initially overruled the trial court's decision, but the case was remanded for reconsideration in light of the Zimmerman decision. On reconsideration, the Court of Appeals affirmed the trial court.

Applying the Oregon Supreme Court's holding in *Zimmerman*, the Court of Appeals concluded that the circumstances on which the insured relied to constitute her proof of loss were insufficient to trigger the insurer's obligation to investigate, because the circumstances did not even suggest to the insurer the possibility of a UIM claim. The court pointed to the fact that the letters from insured's attorney indicated only that he represented the insured, requested that future correspondence be directed through him, and requested certain information pertaining to the claim. Those letters—which did not suggest a UIM claim was possible—were distinguishable from the correspondence received by the insurer in *Zimmerman* and did not constitute proof of loss under ORS 742.061.

Oregon Court Holds No Attorney Fees Without Judgment (*Triangle Holdings, II, LLC v. Stewart Title Guaranty Co.*, 266 Or App 531, 337 P.3d 1013 (2014)

On October 22, 2014, the Oregon Court of Appeals issued an opinion in *Triangle Holdings, II, LLC v. Stewart Title Guaranty Co.*, 266 Or App 531, 337 P.3d 1013 (2014), analyzing an insured's right to attorney fees under ORS 742.061. In the opinion, the Court of Appeals addressed what constitutes a "recovery" for purposes of determining whether an insured is entitled to attorney fees. The court concluded that, under the facts of the case, the insured did not obtain a "recovery" and, thus, was not entitled to recover its attorney fees.

In the case, the insured sued its title insurance company seeking reimbursement for construction liens the insured had paid. During the litigation, the title insurer paid, and the insured accepted, the amount the insured sought for the liens, plus interest. The insurer then moved for summary judgment. The trial court granted summary judgment, finding that the insured's claims were moot because the insurer paid the amount sought by the insured.

After summary judgment was entered, the insured sought to recover its attorney fees under ORS 742.061. The trial court denied the insured's request for attorney fees on the ground that the insured had not obtained a "recovery" under ORS 742.061(1) because the insured had not obtained a money judgment against the insurance company. The insured appealed the trial court ruling, arguing that it did recover the amount it sought—even though it did not obtain a judgment against the insurance company—because the insurance company's payment of the liens constituted a "recovery" within the meaning of the Oregon attorney fee statute. The Court of Appeals affirmed the trial court ruling, finding that the insured was not entitled to attorney fees.

The court began it opinion by articulating the three requirements for recovery of attorney fees under ORS 742.061: first, there must be no settlement within six months of the insured filing its proof of loss; second, a party must bring an action on the policy; and third, the insured's "recovery" under the policy must exceed the amount tendered by the insurance company during the six-month period after the insured files its proof of loss. The term "recovery" is not defined in the statute. The insured argued it satisfied the recovery requirement because the insurance company did not pay the amount of the claim within six months and it recovered the full amount of its claim when the insurance company paid the claim during litigation. The insurance company, on the other hand, argued that the term "recovery" is a money judgment.

The Court of Appeals agreed with the insurance company. Citing its ruling in *Becker v. DeLeone*, 78 Or App 530, 717 P2d 1185 (1986), the court held that the term "recovery," as used in ORS 742.061, requires a judgment. The court further explained that another type of entitlement to money, including a jury verdict, does

not satisfy the requirements of the statute. The court found that insured in the Triangle Holdings case was not entitled to recovery of attorney fees because it did not satisfy the "recovery" requirement.

WASHINGTON CASE SUMMARIES

Insured-Versus-Insured Exclusion Does Not Bar Coverage Per Fifth Circuit
(*Kinsale Ins. Co. v. Georgia-Pac., L.L.C.*, 795 F.3d 452 (5th Cir. 2015)

On July 27, 2015, the U.S. Court of Appeals for the Fifth Circuit issued an opinion addressing the "insured-versus-insured" exclusion in a case captioned (*Kinsale Ins. Co. v. Georgia-Pac., L.L.C.*, 795 F.3d 452 (5th Cir. 2015). The court concluded that the exclusion did not apply to an indemnity claim brought by one insured against another in the circumstances presented because the suit was not one for property damage as the term was defined in the policy.

The case arose when Georgia-Pacific hired Advanced Services, Inc. to perform work on a plant. Advanced was covered under a commercial general liability policy issued by Kinsale. Georgia-Pacific was named as an additional insured on the policy. A fire occurred at the plant, damaging equipment Advanced had leased from H&E Equipment Services in order to perform work on the plant. Following the fire, H&E filed suit against Advanced who then filed a third-party demand for indemnification against Georgia-Pacific for any damages Advanced was required to pay to H&E. Based on the third-party claim, Georgia-Pacific filed a claim for coverage under the Kinsale policy. Kinsale denied coverage, citing the policy exclusion that applies to suits brought by one insured against another.

Kinsale then filed suit in federal district court seeking a declaration that it did not owe indemnification to Georgia-Pacific. Georgia-Pacific counterclaimed for a declaration that the insured-versus-insured exclusion did not apply. The district court found in favor of the insurance company, concluding that the claim was barred because the exclusion was unambiguous and the third-party demand arose from property damage. Georgia-Pacific appealed.

The insured-versus-insured exclusion in the relevant policy provided: "This insurance does not apply to claims or 'suits' for 'bodily injury,' 'property damage' or 'personal and advertising injury' brought by one insured against any other insured." Georgia-Pacific argued that the exclusion did not apply because Advanced's suit was not for property damage brought by one insured against another; instead, the original claim was brought by H&E, who was not a party to the policy. The Fifth Circuit agreed.

The court found that while the suit was one in which an insured was seeking reimbursement from another insured, it did not make the claim one for property

damage brought by one insured against another. The court pointed to the fact Advanced's third-party demand alleged that Georgia-Pacific was liable because it had exclusive control of the premises when the fire occurred. It reasoned that the insured-versus-insured exclusion did not apply because, although there was a claim by one insured against another, it was not a claim for property damage—it was an indemnity claim—and the plain language of the exclusion makes it inapplicable to an indemnity claim in the context presented.

Ninth Circuit Rules on "Known-Loss" Provision (*Kaady v. Mid-Continent Cas. Co.*, 790 F.3d 995 (9th Cir. 2015))

The Ninth Circuit Court of Appeals recently issued an opinion addressing the applicability of the "known-loss" provision in an Oregon commercial liability insurance policy. In *Kaady v. Mid-Continent Cas. Co.*, 790 F.3d 995 (9th Cir. 2015), the court concluded that the known-loss provision did not operate to bar coverage where an insured knew of property damage to one component of a structure before the policy was effective, but was not aware of damage to a distinct component of the same structure. The court also concluded that the insurance company failed to satisfy its burden on summary judgment to establish that unknown property damage was barred because it constituted a continuation, change or resumption of the same damage known to the insured.

The case concerned a mason that installed manufactured stone at a multi-unit residential project. The mason installed the stone to the wall sheathing, wrapped deck posts with the stone and installed masonry caps on top of the stone that was wrapped around the deck posts. The construction work was completed in May 2006. In September 2006, the mason was called back to the project to inspect cracks in the stone and masonry work he installed. The mason told the general contractor that the cracks "had something to do with settling, being struck, or the substrate contracting or expanding." Three months later, in December 2006, the mason purchased a CGL from the insurance company.

In June 2007, the homeowners' association sued the developer, who sued the general contractor, who then sued all of the subcontractors including the mason. The claims against the mason in the underlying lawsuit relating to deterioration of the deck posts and wall sheathing behind the stone he installed. The mason settled his portion of the lawsuit, then he tendered it to the insurance company under the CGL policy. The insured company denied the claim and the mason brought lawsuit. The mason alleged that the damage to the structures for which he was sued was "property damage" under the CGL policy. The Oregon federal district court judge granted the insurance company's summary judgment motion, finding the claim was barred by the policy's known-loss provision. In particular, the district court found that there was relevant property damage prior to the mason obtaining the policy and that the damage was known to the mason prior to obtaining the policy. The mason appealed.

At the Ninth Circuit, the parties agreed that the damage to the deck posts and sheathing constituted covered "property damage" under the policy. The insurer argued that the claim was nevertheless barred pursuant to the policy's known-loss provision, which provides that the policy only covers property damage if no insured knew that the damage had occurred, in whole or in part. The mason admitted that he knew of the cracks in the masonry, but stated that he did not have any knowledge of the damage to the posts and sheathing behind the masonry. The insurance company did not proffer any evidence contradicting the mason's account, but argued that the mason's knowledge of the cracks sufficed to bar coverage. The Court of Appeals rejected the insurer's position.

First, the insurer argued that the known-loss provision applied to bar coverage so long as the insured knew of any damage to the structure. In support, the insurance company argued that the stone and underlying structural components all constitute the same property and, thus, the mason's knowledge of the masonry cracks sufficed to bar coverage for all property damage. The court disagreed with the insurer's position, concluding that components installed by the insured should be distinguished from those installed by others. Additionally, the court concluded that the known-loss provision could not bar coverage where the property damage known to the insured (cracks in the masonry) is distinct from the property damage asserted against the insured (deterioration of the posts and sheathing). Finally, the court determined that the insurer's interpretation would eviscerate the "continuing property damage" language in the known-loss provision because if knowledge of any damage barred coverage, it would not matter whether the damage was a continuation, change or resumption of the known damage.

Second, the insurance company asserted that the damage for which coverage was sought constituted a continuation, change or resumption of earlier cracks in the masonry, which were barred by the known-loss provision. The court also rejected this position, finding that the insurance company failed to satisfy its burden of proof on the issue. While the mason admitted that the damage to the posts and sheathing arose from his defective workmanship, it did not constitute an admission that the damage was caused by the cracks in the masonry. The court conceded that the claimed damage may very well be barred, but determined that the insurer failed to satisfy its burden of proof on summary judgment.

Washington Supreme Court Interprets "Collapse" (*Queen Anne Park Homeowners Ass'n v. State Farm Fire & Cas. Co.*, 183 Wash. 2d 485, 352 P.3d 790 (2015))

On June 18, 2015, the Washington Supreme Court issued an opinion in *Queen Anne Park Homeowners Ass'n v. State Farm Fire & Cas. Co.*, 183 Wash. 2d 485, 352 P.3d 790 (2015), addressing the meaning of the term "collapse" in an insurance policy. We previously wrote on this case in an entry dated August 21,

2014. The Supreme Court found that the term "collapse" means "substantial impairment of structural integrity" which, defined further, means substantial impairment of the structural integrity of a building or part of a building that renders the building unfit for its function or unsafe and must be more than mere settling, cracking, shrinking, bulging or expansion. The Supreme Court decided the issue solely on the definition of "collapse" contained in the policy at issue in the case, noting that it was not adopting a fixed definition for all insurance contracts. The case, which was on certified question from the U.S. Court of Appeals for the Ninth Circuit, concerned a condominium building that was insured under a policy providing coverage for "accidental direct physical loss" to property, unless the loss was otherwise excluded or limited. The policy further provided coverage for damaged property involving collapse of a building or a part of a building caused by hidden decay, but excluded coverage for settling, cracking, shrinking, bulging or expansion. The term "collapse" was not defined in the policy.

The insured filed a claim asserting that during the policy period its building collapsed as a result of hidden decay. Specifically, the insured contended that the building suffered substantial impairment of structural integrity based on an engineer's finding of hidden decay in walls which impaired the walls' ability to resist lateral loads. The insurance company investigated the claim and determined that a collapse had not occurred during the policy term and that various exclusions from coverage applied. The insured filed suit in federal district court, which granted the insurance company's motion for summary judgment. The insured appealed to the Ninth Circuit, which certified the question to the Washington Supreme Court.

The court began its opinion by finding that the term "collapse," as used in the policy was ambiguous, because it was susceptible to more than one reasonable interpretation. As a basis for its finding, the court cited its opinion in *Sprague v Safeco Ins. Co. of Am.*, 174 Wn.2d 524, 276 P.3d 1270 (2012), in which the court was asked to define the term collapse in insurance policies. Although the *Sprague* matter was ultimately decided on alternate grounds, the court offered competing definitions of collapse. The court also cited a number of cases across the country offering distinct meanings of the term. Following the standard rules of policy interpretation, the court adopted the insured's interpretation of collapse to mean "substantial impairment of structural integrity." The court did caution, however, that collapse means something more than settling, cracking, shrinking, bulging or expansion based on the terms of the policy. Additionally, it found that "substantial impairment of structural integrity" means an impairment so severe as to materially impair a building's ability to remain upright.

Replacement Cost Provision Construed by Sixth Circuit (*Hampton v. Safeco Ins. Co. of Am.*, 614 F. App'x 321 (6th Cir. 2015))

The U.S. Sixth Circuit Court of Appeals recently addressed an insured's entitlement to replacement cost benefits following a fire loss. In *Hampton v. Safeco Ins. Co. of Am.*, 614 F. App'x 321 (6th Cir. 2015), the court addressed whether an insured could recover the estimated cost to replace a damaged structure or was limited to the amount actually spent to replace it. The court ruled in favor of the insurance company, holding that it was required to pay the amount the insured actually and necessarily incurred to repair or replace the damaged structure.

The case concerned an insured's home that was damaged by fire. The insurance policy covering the home provided for replacement cost benefits. The parties agreed the actual cash value of the home was $62,500, which the insurance company paid. A few months later, the insured informed the insurance company that she planned to replace the home with a mobile home quoted at $66,729.12. The insured provided a receipt showing her $500 deposit on the new home as evidence of her "intent" to purchase it. The insurance company indicated that it would pay the difference between the actual cash value of the damaged home and the proposed replacement mobile home which totaled $3,229.12. The insured countered that she was actually owed $45,245, which constituted the difference between the actual cash value and the estimated $108,745 cost to replace the home. The insured filed suit seeking the greater amount. The federal district court ruled in favor of the insurance company, and the insured appealed.

The Court of Appeals first interpreted the "replacement cost" provision in the policy, which provided that the insurance company would pay "the full amount actually and necessarily incurred to repair or replace the damaged building as determined shortly following the loss." The insured argued that she reasonably expected that replacement cost coverage would be available to restore a normal life following the fire. The court rejected the insured's argument, finding that the plain and ordinary meaning of the replacement cost provision provided that the insurance company would pay for the actual costs that were reasonably incurred by the insured. It concluded that the insured was not permitted to purchase a less expensive structure and keep the difference between that amount and the estimated rebuilding cost in cash.

Additionally, the court addressed whether actually purchasing the new home was a prerequisite to recovering replacement cost benefits and whether the insurance company's refusal to pay the price of the replacement mobile home constituted an anticipatory breach. The insured argued she was entitled to the

payment although she had yet to purchase the replacement mobile home. Again, the court sided with the insurance company, holding that the policy language unambiguously required the insured to actually incur the cost of purchasing the replacement home before she could recover the replacement cost holdback.

Washington Addresses UIM Coverage for Phantom Vehicle (*Mumm v. State Farm Mut. Auto. Ins. Co.*, 187 Wash. App. 1035 (2015))

In a May 26, 2015, opinion, the Washington Court of Appeals addressed an insured's entitlement to uninsured/underinsured motorist (UIM) benefits in the context of a "phantom vehicle" accident. In *Mumm v. State Farm Mut. Auto. Ins. Co.*, 187 Wash. App. 1035 (2015), Division 3 of the Court of Appeals concluded that the insured failed to provide independent corroboration of the incident and, thus, was not entitled to UIM coverage under the terms of the policy.

The case concerned an insured that was riding a bicycle to work. According to the insured, a car passed on the left and abruptly turned to the right in front of her to enter a parking lot. The insured braked quickly to avoid colliding with the vehicle, which caused her to fall off of her bicycle and injure her right hand and thumb. The driver of the vehicle did not stop and the insured was not able to locate any witnesses at the scene. About an hour after the incident, the insured was taken to a medical clinic to have her injuries examined. The chart notes from the insured's visit to the clinic detail her account of the incident.

At the time of the incident, the insured had an UIM policy that provided coverage for "phantom vehicle" accidents. The phantom vehicle provision stated that in order to be entitled to coverage, "the facts of the accident must be corroborated by competent evidence other than testimony of the insured or any other person who has a claim." During the insurance company's investigation of the incident, the insured reported that several people likely witnessed it but that she did not speak with any of them. The insurance company denied the insured's claim for failure to provide corroborating information from an independent source. The insured sued.

The insurance company moved for summary judgment, arguing that the absence of independent corroborating evidence precluded coverage for the phantom vehicle accident. The insured responded with a declarations stating: (1) the insured was crying, shaking, and in shock and pain when she reported the incident to a medical provider; (2) the insured was crying and upset and appeared to be in shock when she told her husband of the incident; and (3) the medical provider's treatment detailing the account of the incident. The insurance company moved to strike the declarations because they constituted inadmissible hearsay evidence. The trial court granted the insurance company's motion, finding that there was no coverage for the phantom vehicle claim because there was not

sufficient corroborating evidence because the declarations constituted inadmissible hearsay. The insured appealed.

The Court of Appeals upheld the trial court's ruling. It first found that the independent corroboration requirement in the policy was proper under Washington law. The court then concluded that the trial court correctly disregarded the declarations submitted by the insured because they were hearsay. Specifically, it found that the statements to the medical provider did not meet the requirements for an "excited utterance" under Washington law. The court found that the insured was not entitled to coverage because she was not able to provide independent corroboration as required by the UIM policy.

Washington Fed. Courts Split on IFCA *Langley v. GEICO Gen. Ins. Co.*, No. 14-cv-3069-SMJ, 2015 WL 778619 (E.D. Wash. Feb. 24, 2015)

A judge in the Eastern District of Washington, expressly rejecting the holdings in a series of cases from the Western District of Washington, recently found that an insured could establish a claim under the Insurance Fair Conduct Act (IFCA) by showing the insurance company violated one of the Washington Administrative Code (WAC) provisions set forth in RCW 48.30.015(5). The case, captioned *Langley v. GEICO Gen. Ins. Co.*, No. 14-cv-3069-SMJ, 2015 WL 778619 (E.D. Wash. Feb. 24, 2015), relied on a series of recent cases from the Eastern District and its conclusion that the IFCA created an implied cause of action under Washington law.

The litigation involved an insurance claim for a recreational vehicle (RV). A dealer had purchased the RV with a salvaged title for $50,500, allegedly restored the vehicle, and sold it to the insured for $270,000. After the insured purchased it, in June 2013, the RV was completely destroyed by fire. The insurance company offered to pay the original purchase price for the salvage title RV of $50,500. The insured filed suit against the insurance company in May 2014 alleging, among other things, a claim for violation of the IFCA.

The insurance company moved for summary judgment on the insured's IFCA claim. The basis of the insurance company's motion was that the IFCA claim was not viable because there was no denial of coverage or benefits. The parties conceded that Washington case law makes clear that under RCW 48.30.015(1) a party can maintain an IFCA claim by establishing that there was an unreasonable denial of coverage or payment of benefits. The insured argued, however, that a third cause of action exists under the IFCA. Specifically, the insured asserted that RCW 48.30.015(5)—which sets forth a number of Washington Administrative Code (WAC) provisions—provides an independent

basis for maintaining a claim under the IFCA, regardless of coverage or benefits. The insurance company responded with a series of federal district court decisions from the Western District of Washington rejecting the argument.

The court first analyzed the authorities from the Western District. It then pointed to the line of recent authority from the Eastern District of Washington that "has begun to reject the precedent set by the Western District." Citing to the opinions issued by the Eastern District in *Merrill v. Crown Life Ins. Co.*, No. 13-cv-110-TOR, 2014 WL 2159266 (E.D.Wash. May 23, 2014); *Hell Yeah Cycles v. Ohio Sec. Ins. Co.*, 16 F.Supp.3d 1224, 1235-36 (E.D. Wash. 2014); and *Hover v. State Farm Mut. Auto. Ins. Co.*, No. cv-13-5113-SMJ, 2104 WL 4239665 (E.D. Wash. Aug. 26, 2014), the court concluded that it was "not persuaded that an IFCA cause of action requires a denial of coverage or benefit."

The court further reasoned that its conclusion was supported by its conclusion that the IFCA created an implied cause of action under Washington law. In particular, it determined that RCW 48.30.015(5) satisfied the requirements of Washington case law to create such a cause of action. The court concluded: (1) the insured was with the "protected class" of the IFCA, (2) the legislative intent behind the statute supported creating such a claim; and (3) that the implied remedy was consistent with the purpose of IFCA. Based on those findings, the court found that "at a minimum, an independent implied cause of action exists under the IFCA for a first party claimant to bring suit of violation of the enumerated WAC provisions in RCW 48.30.015(5)" and expressly rejected the line of cases from the Western District of Washington reaching another conclusion.

Washington Court Holds Vacancy Exclusion Unambiguous (*Lui v. Essex Ins. Co.*, No. 72835-1-I)

On April 6, 2015, the Washington Court of Appeals issued an opinion in *Lui v. Essex Ins. Co.*, No. 72835-1-I, addressing the meaning of a vacancy provision in an insurance contract. The court concluded that the vacancy provision in the commercial policy was clear and unambiguous, and operated to bar coverage for the insureds' claim.

The case concerned two insureds that owned a commercial building containing tenant space. On or about January 1, 2011, a water pipe froze and burst, causing significant damage to the insured building. There were no tenants in the building at the time. The prior tenant was evicted on December 7, 2010. The insurance company investigated the claim and paid almost

$300,000 for property damage. The insurance company later learned that the building was vacant, as the term was defined in the policy, at the time of the loss and denied coverage for the claim, although it would not seek reimbursement of the amount already paid.

The insureds sued for the remainder of the claim amount. The parties filed cross-motions for summary judgment. The insureds argued the policy's vacancy provision did not restrict coverage until after 60 consecutive days of vacancy occurred. Additionally, the insureds argued that the insurance company waived its right to deny coverage, was estopped from claiming the vacancy provision applied, and denied coverage in bad faith. The insurance company responded that the vacancy provision was triggered at the inception of the vacancy period and, thus, operated to bar coverage. The trial court denied the insurance company's motion and partially granted the insureds' motion, finding the vacancy endorsement was ambiguous and construing the provision in favor of the insureds. The trial court denied the insureds' motion with respect to their claims for waiver, estoppel, and bad faith due to unresolved factual issues. The insurance company sought, and was granted, interlocutory appeal on the sole issue of whether the vacancy provision was ambiguous.

The Court of Appeals reversed the trial court, holding that the insurance company proposed the only reasonable construction of the vacancy provision. It determined that, absent written permission to the contrary, the vacancy provision restricted coverage in two ways: (1) to specified causes of loss when use of the building was less than 31% of total square footage, and (2) after 60 days of vacancy, coverage is suspended altogether. Under the first limitation, coverage was limited to specified causes of loss that did not include the cause of the insureds' water damage. The Court of Appeals determined that these limitations were clear and unambiguous as used in the policy. Pursuant to this interpretation of the vacancy provision, the insureds were not entitled to coverage.

Undisclosed Adult Child Entitled to UIM Coverage (*Patriot Gen. Ins. Co. v. Gutierrez*, No. 32109-6-III, 2015 WL 773571 (Wash. Ct. App. Feb. 24, 2015)

The Washington Court of Appeals recently issued an opinion in *Patriot Gen. Ins. Co. v. Gutierrez*, No. 32109-6-III, 2015 WL 773571 (Wash. Ct. App. Feb. 24, 2015), addressing whether an insured's adult child was covered under an auto policy. The insured failed to disclose the adult child on the insurance application, although the application required the child to be disclosed. The court determined the adult child was covered because the insurance policy did not expressly exclude the undisclosed relative.

The insured submitted an application for an auto insurance policy requesting underinsured motorist (UIM) coverage. In the application, the insured listed himself as the insured, and he and his wife as the authorized drivers. This insured did not list his child, then 18 years old, as part of his household even though the insured certified on his application that he had listed all of the members of his household over the age of 14.

During the coverage period, the insured's child was a passenger in an underinsured vehicle that was involved in a rollover accident. The child sustained serious injuries. The child, who was still living with the insured at the time, tendered a UIM claim under his parents' policy. The insurance company denied the claim because the son was not an "insured" under the policy. The insurer cited the fact that the child was an undisclosed relative over the age of 14. The insurance company filed a declaratory judgment action asserting it that the child was not covered under the policy. The child counterclaimed for breach of contract, bad faith, and violation of the Washington Consumer Protection Act (CPA). The trial court, applying the statutory definition of "insured," for purposes of personal injury protection (PIP) coverage, determined that the child was covered under the policy. The insurance company appealed.

The Washington Court of Appeals first dismissed the trial court's application of the PIP definition of "insured" because the policy contained a generally applicable definition of the term. The court found the child met the general definition of an insured. It then analyzed whether the insured's failure to list the child resulted in an exclusion for coverage. The policy did not contain an express exclusion from UIM coverage for undisclosed adult household members. Noting that the insurer controlled the language of the policy, the court found that the child was a covered insured because the insurer failed to include such an exclusion in the terms of the policy. The court concluded that it cannot assist the insurer in rewriting the policy and granted the child's request for UIM coverage.

Seventh Circuit Analyzes Continuous Loss Triggering Language (*Strauss v. Chubb Indem. Ins. Co.*, 771 F.3d 1026, 2014 WL 6435314 (7th Cir. 2014)

On November 18, 2014, the United States Court of Appeals for the Seventh Circuit issued an opinion in *Strauss v. Chubb Indem. Ins. Co.*, 771 F.3d 1026, 2014 WL 6435314 (7th Cir. 2014), addressing coverage for a continuous loss under a first-party property insurance policy. In October 2010, the insureds discovered that water infiltration had been damaging their home. It was determined that the water damage was ongoing and progressive, beginning around the time of construction and continuously occurring with each rainfall. The insureds built their home in 1994 and insured it continuously with the insurance company through 2005, when they began insuring the home with another company. Upon learning of the

continuing nature of the loss, the insureds submitted a claim for the discovered damage.

The applicable insurance policies that covered the home from 1994 through 2005 provided that coverage was limited "only to occurrences that take place while the policy is in effect." The term "occurrence" was defined in the policy as "a loss or accident to which this insurance applies occurring within the policy period. Continuous or repeated exposure to substantially the same general conditions unless excluded is considered one occurrence." The insurance company denied the claim on the grounds that (1) the damage was not discovered during the applicable policy periods, and (2) any legal action was time barred under the Wisconsin statute of limitations and the "suit against us" provision in the policies.

The insureds filed suit in October 2011, within one year of discovering the loss, alleging the insurance company incorrectly denied coverage. The parties filed cross-motions for summary judgment on the coverage issue. The court concluded that the insured was entitled to coverage, finding that the "continuous" trigger theory applied to the "occurrence-based" policy because it covered ongoing losses. In addition, the court found that the insureds' claim was not time-barred because the "continuous" trigger theory applied. The insurance company appealed to the U.S. Seventh Circuit Court of Appeals.

The court of appeals began its coverage analysis by describing the various coverage theories advanced by the parties. The insurance company argued that the "manifestation" trigger theory applied. It holds that only the insurer that bears the risk at the time the loss manifests or can be discerned is liable. The insureds relied on the "continuous" trigger theories, which states that, in the context of a progressive loss, all policies in effect from the time the loss begins until it manifests owe coverage. The insurance company urged the court to adopt a bright-line rule that the continuous trigger theory be limited to third-party liability policies, and require that the manifestation trigger theory apply in all first-party insurance coverage disputes. The court of appeals rejected the insurance company's invitation to adopt the rule. Rather, it held that the policy language—which controlled the analysis under Wisconsin law—dictated that the continuous trigger theory applied to the loss, and that the insured was entitled to coverage. In addition, the court found that the insureds' claim was not time barred because the policy language deviated from the applicable statute (permitting an insurer to limit claims within one year of "inception" of the loss) and, instead, allowed the insured to bring action within one year of the time the loss occurs (which the court determined was ambiguous when applied to progressive losses).

Washington Court Holds Insurer Not Entitled to Invoke Corporate Practice of Medicine Doctrine (*State Farm Mut. Auto. Ins .Co. v. Jacobs*, No. C14-5512 RBL, 2014 WL 5470623 (W.D.Wash. Oct. 28, 2014)

A federal court judge from the Western District of Washington recently issued an order in *State Farm Mut. Auto. Ins .Co. v. Jacobs*, No. C14-5512 RBL, 2014 WL 5470623 (W.D.Wash. Oct. 28, 2014) addressing whether an insurance company has a private cause of action under the Washington corporate practice of medicine doctrine and Professional Service Corporate Act (PSCA), RCW 18.100.010 et seq. After analyzing the purpose of the statute, the court concluded that an insurer did not have such a right and dismissed all of the insurer's claims against a clinic that were based on application of it.

The case concerned an insurance company's attempt to recoup approximately $800,000 it paid on behalf of its insureds—and individuals injured by its insureds—a clinic for physical therapy and massage services. The insurance company's claim was predicated on application of Washington's corporate practice of medicine doctrine and the PSCA because the owners were not licensed to practice the medical services the clinic was providing. The clinic and its owners sought to dismiss the insurance company's claims on the ground that, even if the practice was improper, Washington law does not permit a private cause of action for an insurance company to collect a refund on that basis.

The court began its analysis by summarizing the corporate practice of medicine doctrine and PDCA as follows:

> "Washington's corporate practice of medicine doctrine prohibits corporations from employing medical professionals to practice their licensed professions. In other words, medical professionals generally cannot form or work for limited liability companies. The PSCA is a statutory exception to this prohibition. It allows medical professionals to form (and to be employed by) professional (limited liability) services corporations, if and only if, all of the corporation's shareholders are themselves licensed to provide the offered medical services."

Id. at *1 (internal citations omitted). For purposes of the motion, the clinic conceded that none of its stakeholders was licensed to practice the services the clinic provided and that the exception provided in the PSCA did not apply.

Washington appellate courts had not squarely addressed the arguments presented in the case. Accordingly, the court undertook an analysis to determine whether an insurance company was intended to have a cause of action based on the prohibition. The court ultimately agreed with the clinic and its owners, concluding that the insurance company was not within the class of persons the prohibition was designed to protect—nor did it align with the legislative intent in adopting the

PSCA. Instead, the court determined the prohibition was intended to protect patients treated by the provider and, perhaps, the public at large. The court also rejected the insurance company's citation to authority from other jurisdictions, finding those cases unpersuasive under the circumstances. Finally, the court concluded that "permitting an insurance company to seek a refund for fees already paid on behalf of a presumably satisfied patient does nothing to advance purpose of this statute, and is not consistent with it." Id. at *4.