

65322-9

65322-9

NO. 65322-9-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

FARMERS INSURANCE COMPANY OF WASHINGTON

Appellant,

vs.

TARYN BARQUEST, on behalf of herself and all others similarly
situated,

Respondent.

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COURT OF APPEALS
DIVISION I
STATE OF WASHINGTON

APPEAL FROM KING COUNTY SUPERIOR COURT
NO. 06-2-36909-2 KNT

REDACTED BRIEF OF RESPONDENT

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 ORIGINAL

TABLE OF CONTENTS

I. INTRODUCTION.....1

II. STATEMENT OF THE CASE.....11

 A. Procedural history before summary judgment.....11

 B. Evidence before the trial court at summary judgment.....11

 C. Procedural history after summary judgment.....18

III. ARGUMENT.....19

 A. Standard of Review.....19

 B. Farmers’ practice is bad faith both because Farmers refuses to pay claims before completing a reasonable investigaiton, and because Farmers fails to timely communicate the true basis for its refusal until after the IME.....20

 1. It is bad faith to refuse to pay claims before completing a reasonable investigation.....21

 2. It is bad faith for an insurer to fail to communicate the basis for its decisions.....28

 3. Claims investigation practices are judged at the time of the investigation, not retrospectively in light of the investigation’s ultimate results. The duty of good faith is owed and judged at each moment.30

 4. Farmers’ practices erode the very protection purchased by the insured.....31

 C. Farmers’ arguments that its practices are not bad faith rely on misinterpretations of law and of the trial court’s ruling.34

 1. Decisions allowing insurers to require insureds to attend IMEs, and to deny benefits for noncooperation do not establish that insurers

can refuse to pay claims before completing a reasonable investigation.....34

2. The evidence Farmers presented at summary judgment was insufficient to demonstrate that its pre-IME claims denial practices did not violate its duties to proceed in good faith.....37

3. Farmers’ argument regarding WAC 284-30-395 misinterprets the court’s ruling and ignores the fact that Farmers argued below that WAC 284-30-395 should be applied.41

 a. Farmers misinterprets the trial court’s use of WAC 284-30-395. 41

 b. Under the invited error doctrine, Farmers may not advance below the theory that WAC 284-30-395 controls this case, yet assert on appeal that the regulation does not apply.42

4. The trial court’s ruling neither creates coverage by estoppel nor conflicts with WAC 284-30-370 and -380.44

5. The duties Farmers violated are not debatable.48

IV. CONCLUSION49

TABLE OF AUTHORITIES

| <u>Authority</u> | <u>Page No.</u> |
|---|-----------------|
| <u>Washington Cases</u> | |
| <i>Albee v. Farmers Ins. Co. of Washington</i> , 92 Wn. App. 866, 869, 967 P.2d 1 (1998)..... | 34, 35 |
| <i>City of Bellevue v. Kravik</i> , 69 Wn. App. 735, 850 P.2d 559 (1993) | 42 |
| <i>Coventry Associates v. American States Insurance Company</i> , 1 36 Wn.2d 269, 961 P.2d 933 (1998)..... | Passim |
| <i>Federal Way Sch. Dist. No. 210 v. State</i> , 167 Wn.2d 514, 523, 219 P.3d 941 (2009)..... | 20 |
| <i>In re Estate of Stevens</i> , 94 Wn. App. 20, 971 P.2d 58 (1999) | 42 |
| <i>Indus. Indem. Co. v. Kallevig</i> , 114 Wn.2d 907, 917, 792 P.2d 250 (1990)..... | Passim |
| <i>Kim v. Allstate Ins. Co.</i> , 153 Wn. App. 339, 223 P.3d 1180, 1184-86 (2010)..... | 34, 35 36 |
| <i>McGreevy v. Or. Mut. Ins. Co.</i> , 128 Wn.2d 26, 36-37, 904 P.2d 731 (1995)..... | 21 |
| <i>Murray v. Mossman</i> , 56 Wn.2d 909, 355 P.2d 985 (1960)... | 20 |
| <i>Safeco Ins. Co. v. Butler</i> , 118 Wn.2d 383, 823 P.2d 499 (1992). | 20 |
| <i>Safeco Ins. Co. of Am. v. JMG Rest. Inc.</i> , 37 Wn. App. 1, 15, 680 P.2d 409 (1984)..... | 24 |
| <i>State v. Carter</i> , 74 Wn. App. 320, 324 n. 2, 875 P.2d 1 (1994)... | 20 |

| | |
|--|-------------------------|
| <i>State v. Grundy</i> , 25 Wn. App. 411, 415-16, 607 P.2d 1235 (1980)..... | 20 |
| <i>St. Paul Fire and Marine Ins. Co. v. Onvia, Inc.</i> , 165 Wn.2d 122, 196 P.3d 664 (2008)..... | 2, 4, 21 |
| <i>Tank v. State Farm</i> , 105 Wn.2d 381, 385-86, 715 P.2d 1133 (1986)..... | 21 |
| <i>Van Noy v. State Farm Mutual Ins. Co.</i> , 142 Wn.2d 784, 16 P.3d 574 (2001)..... | Passim |
| <i>Van Noy v. State Farm</i> , 98 Wn. App. 487, 983 P.2d 1129 (1999) | 4, 21, 28, 30, 47 |
| <i>Weden v. San Juan County</i> , 135 Wn.2d 678, 689, 958 P.2d 273 (1998)..... | 20 |
| <u>Washington Federal Cases:</u> | |
| <i>Sadler v. State Farm Mut. Auto. Ins. Co.</i> , 2008 U.S. Dist. LEXIS 71665 (W.D. Wash. 2008)..... | 36-37 |
| <i>Aecon Bldgs., Inc. v. Zurich North America</i> , 572 F. Supp. 2d 1227, 1239 (W.D. Wash. 2008)..... | 23 |
| <u>Other Jurisdictions:</u> | |
| <i>Bonenberger v. Nationwide Mut. Ins. Co.</i> , 791 A.2d 378, 379 (Penn. 2002)..... | 26 |
| <i>Etten v. U.S. Food Service Inc.</i> , 446 F. Supp. 2d 968 (N.D. Iowa 2006)..... | 26 |
| <i>Ivanov v. Farmers Ins. Co. of Oregon</i> , 344 Or. 421, 430, 185 P.3d 417 (2008) | 23 |

| | |
|---|-------|
| <i>McIlravy v. North River Ins. Co.</i> , 653 N.W.2d 323, 329 (Iowa 2002)..... | 27 |
| <i>Krajicek v. Auto. Club Inter-Ins. Exch. Inc.</i> , 2009 WL 3254904, slip op. at *8 (N.D. Okla. 2009)..... | 27 |
| <i>Paul Revere Life Ins. Co. v. DiBari</i> , 2010 WL 918084 (D. Conn. 2010) | 24 |
| <i>Rawlings v. Apodaca</i> , 151 Ariz. 149, 157, 726 P.2d 565 (1986).. | 3, 32 |
| <i>Revelation Industries, Inc. v. St. Paul Fire & Marine Ins. Co.</i> , 350 Mont. 184, 206 P.3d 919 (Mont. 2009) | 24 |
| <i>Storrer v. Paul Revere Life Ins. Co.</i> , 2009 WL 1916714, slip op. at *3 (N.D. Cal. 2009)..... | 27 |
| <i>Strawn v. Farmers Ins. Co. of Oregon</i> , 228 Or. App. 454, 209 P.3d 357 (2009) | 27 |
| <i>Wilson v. 21st Cent. Ins. Co.</i> , 42 Cal 4th 713, 721-22, 171 P.3d 1082 (Cal. 2007)..... | 27 |
| <i>Uberti v. Lincoln Nat'l Life Ins. Co.</i> , 144 F. Supp. 2d 90, 104-05 (D. Conn. 2001)..... | 26 |
| <u>Revised Code of Washington</u> | |
| RCW 18.130.180..... | 26 |
| RCW 48.01.030..... | 2, 28 |
| RCW 48.30.010..... | 2, 29 |
| RCW 48.30.040..... | 2 |
| RCW 48.22.005..... | 1 |
| RCW 48.22.085..... | 1 |

| | |
|--------------------|---|
| RCW 48.22.095..... | 1 |
| RCW 48.22.100..... | 1 |

Washington Administrative Code:

| | |
|---------------------|-----------------------------------|
| WAC 284-30..... | Passim |
| WAC 284-30-300..... | 2 |
| WAC 284-30-310..... | 2 |
| WAC 284-30-330..... | Passim |
| WAC 284-30-370..... | 44-46 |
| WAC 284-30-380..... | 16, 29, 45, 47 |
| WAC 284-30-395..... | 3, 19, 22, 28 29, 41- 44 |

Rules:

| | |
|--------------|----|
| RAP 2.5..... | 20 |
|--------------|----|

Other Resources:

| | |
|---|----|
| 1 Allan D. Windt, Insurance Claims & Disputes: Representation of Insurance Companies and Insureds § 2.0, at 38 (3d ed. 1995)..... | 23 |
|---|----|

I. INTRODUCTION

This case is a class action regarding Farmers Insurance Companies of Washington's (Farmers) claims management practices for Personal Injury Protection (PIP) auto coverage. PIP coverage, governed by RCW 48.22.085 through .100, provides first-party no-fault coverage to individuals injured in auto accidents. PIP covers only medical expenses, funeral expenses, lost wages, and lost services, and coverage is limited by statute to the actual amount of expenses incurred, and to reasonable and necessary medical treatment. RCW 48.22.095, 48.22.005. The purpose of PIP is to provide prompt coverage.

Insurance, for good reason, is a highly-regulated industry. The fundamental bargain of insurance is that the insured pays now for coverage later, and trusts, often for years, that the insurer will meet its end of the bargain if and when the time comes. First-party insureds' interests are, financially speaking, diametrically opposed to their insurers'—every dollar paid toward a claim is a dollar the insurer does not get to keep. The first-party insured is exquisitely vulnerable. To prevent the insurer from toeing the line of the law while undermining the interests of the insured, Washington's laws and regulations impose a duty of good faith on insurers.

Washington protects individuals purchasing insurance by imposing

statutory, regulatory, and common-law duties of good faith on insurers. An insurer may act in bad faith either by violating statutes or regulations defining unfair claims practices, or by violating its quasi-fiduciary duties to the insured under Washington's common law of bad faith. *See, e.g. St. Paul Fire and Marine Ins. Co. v. Onvia, Inc.*, 165 Wn.2d 122, 196 P.3d 664 (2008) (regulations); *Van Noy v. State Farm Mutual Ins. Co.*, 142 Wn.2d 784, 16 P.3d 574 (2001) (common law).

RCW 48.01.030 provides that “[t]he business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters.” RCW 48.30.010(1) broadly prohibits unfair or deceptive acts in the business of insurance. RCW 48.30.010(2) empowers the Insurance Commissioner to promulgate regulations defining unfair or deceptive practices. RCW 48.30.040 again prohibits false or deceptive representations in the business of insurance. WAC 284-30 was promulgated by the Insurance Commissioner under RCW 48.30.010, and “define[s] certain minimum standards which, if violated with such frequency as to indicate a general business practice, will be deemed to constitute unfair claims settlement practices.” WAC 284-30-300. The regulations at WAC 284-30 “appl[y] to all insurers and to all insurance policies and insurance contracts.” WAC 284-30-310.

WAC 284-30-330 defines specific unfair claims settlement practices, among them “(1) Misrepresenting pertinent facts or policy provisions,” “(4) Refusing to pay claims without conducting a reasonable investigation,” and “(13) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim.” WAC 284-30-395 provides supplementary regulations specific to PIP insurance, and sets forth a finding by the Commissioner that “some insurers limit, terminate, or deny coverage for personal injury protection insurance without adequate disclosure to insureds of their bases for such actions.” As a corrective measure, WAC 284.30.395(2) specifically requires that the insurer provide the insured with a “written explanation that describes the reason for its action” whenever the insurer denies, limits, or terminates PIP benefits.

At common law, the covenant of good faith and fair dealing is breached when the insurer’s conduct “damages the very protection or security which the insured sought to gain by buying insurance.” *Coventry Assocs. v. American States Ins. Co.*, 136 Wn.2d 269, 278-79, 961 P.2d 933 (1998) (quoting *Rawlings v. Apodaca*, 151 Ariz. 149, 157, 726 P.2d 565 (1986)) At common law, every insurer owes its insureds “(1) the duty to disclose all facts that would aid its insureds in protecting their interests; (2) the duty of equal consideration; and (3) the duty not to mislead its

insureds.” *Van Noy*, 142 Wn.2d at 791 (quoting *Van Noy v. State Farm*, 98 Wn. App. 487, 492, 983 P.2d 1129 (1999)).

These duties, the duty not to refuse to pay claims without first conducting a reasonable investigation, and the duty to disclose all pertinent facts to the insured, are in effect throughout the life cycle of the claim. The Washington Supreme Court has repeatedly held that this is so even if later investigation reveals that the claim was correctly denied. *Coventry*, 136 Wn.2d 269 (upheld by *St. Paul*, 165 Wn.2d 122). The Washington Supreme Court has also held that it is bad faith to deny claims based on the adjuster’s suspicion or conjecture. *Indus. Indem. Co. v. Kallevig*, 114 Wn.2d 907, 917, 792 P.2d 250 (1990).

Barquest v. Farmers originated in October, 2005 when class representative Taryn Barquest and her treating physician received a letter from Farmers stating that Farmers was “denying payment of these bills and all future bills....awaiting the results of further investigation into this claim.” CP 165. Although Farmers now contends that Ms. Barquest’s claim was suspicious because she was receiving treatment several months after a low-impact auto accident, the letter Ms. Barquest and her providers received included no information about why payments were being denied or why Farmers had become suspicious about Ms. Barquest’s claim. While many individuals who purchase PIP insurance have medical insurance that

will pay for treatment in this situation, Ms. Barquest did not. Ms. Barquest's treating doctor was unwilling to continue treatment without a source of payment, and Ms. Barquest was unable to pay, and therefore had to discontinue treatment. CP 539-40; CP 126. When Ms. Barquest did attend her first Independent Medical Examination (IME), the IME physician concluded that treatment to date and continued treatment were both reasonable and necessary, and also concluded that Ms. Barquest's condition had worsened as a result of her break in treatment. CP 168-178. Ms. Barquest then filed suit challenging Farmers' practice of refusing to pay claims before its investigation was complete, refusing payment based on internal criteria never communicated to the insured, and sending denial letters to both the insured and the treating physicians. CP 1-20.

Pre-certification discovery in this case, conducted in parallel by Farmers and by Ms. Barquest, demonstrated that the letter Ms. Barquest received was not unique—at least 84.9% of the time, Farmers sends such denial letters to insureds and their providers when an IME is scheduled. CP 1079-1234. At summary judgment, Farmers also introduced evidence that IMEs are scheduled, and refusals to pay then issued, based on broad claims management criteria having little to do with individual medical necessity. These criteria include:

- Minor automobile accident; property damage is minor or non-existent; no demonstrated bodily injuries;
- Treatment for soft tissue injury continues for four months without improvement;
- Treatment is claimed for an injury or condition that is not usually claimed as a result of an auto accident;
- Soft tissue injury claim is accompanied by a significant and unusual wage loss or essential service claim.
- Long delay between the date of the accident and the treatment or between series of treatments;
- Pre-existing unrelated condition is present.

CP 1239-1240.

Farmers also introduced evidence that 82.8% of the time, the IME, when it is eventually conducted, concludes that all treatment prior to the IME was reasonable, necessary, and related to the accident, and thus should, in hindsight, have been promptly covered under the PIP policy. CP 1127-1129. Thus, by communicating a denial and refusing to pay at the time the IME is scheduled, Farmers is denying claims that are, in retrospect, valid 82.8% of the time, and is doing so not based on a searching examination of medical necessity in the individual claim (something that could not be conducted by the adjuster, who generally has no medical training), but upon broad criteria that do a poor job of targeting invalid claims and amount to a mere suspicion that the claim is invalid. And by sending the vague letters to providers as well as to the insured,

Farmers is interfering with the insureds' ability to get treatment, thus suppressing the costs associated with valid claims. This is an unreasonable practice that fails to communicate the real basis of denial to the insured, discourages insureds with valid claims from seeking or receiving medical treatment, and favors Farmers' interest in keeping the insured's money over the insured's interest in prompt payment for and adequate investigation of legitimate claims. See Declarations of Steve Chance (Sub No. 27); Patrick LePley (Sub No. 31), Karen Koehler (Sub No. 32), Tom Jacobs (Sub No. 33); Douglas Levinson (Sub No. 34); and Patricia Willner (Sub No. 35).¹

The practice the plaintiffs contest in this case is not the practice of sending PIP insureds to an IME, or of discontinuing benefits based on the results of an IME, or of denying a claim for non-cooperation if the insured refuses to go to an IME. All of these are lawful practices in Washington, and are, as a matter of common sense, necessary for responsible claims management. The claims management practices that Ms. Barquest and the class contest are: the practice of refusing to pay claims before the reasonable investigation is completed; the practice of communicating a denial to the insured and their physician before the IME is conducted; and the practice of failing, at that time, to communicate the true basis for the

¹ Designated on Plaintiffs' supplemental designation of clerk's papers filed 1/18/11.

denial to the insured.

As of late 2008, the class in this case consisted of an estimated 3,200 to 3,900 Washington consumers.² CP 808-833 at ¶ 15. The statistics set forth above—that Farmers sends denial letters 84.9% of the time when it schedules an IME, and that 82.8% of the time, treatment prior to the IME is found to be reasonable, necessary, and related to the accident—were generated by Farmers’ expert statistician, Sydney Firestone of Deloitte Financial Advisory Services LLP from a representative sample of claims files. CP 808-833.

The sole evidence Farmers presented in opposition to plaintiffs’ motion for summary judgment consisted of five hand-picked claims files in which the IME physician found treatment had not been reasonably necessary prior to the IME. CP 1551-1576, 1577-1637, 1638-1697, 1698-1757, 1758-1782. This evidence was insufficient to rebut Plaintiffs’ evidence at summary judgment for five reasons. First, in Washington, an insurer’s denial decision is judged by what the insurer knows at that time—not what evidence is generated later. *Coventry*, 136 Wn.2d 269. Therefore, the later-conducted IMEs cannot retroactively establish that Farmers was reasonable to deny claims before the IME. Second, with the exception of one case in which the adjuster had [REDACTED] evidence that

² Because Farmers has continued the practice disputed here, the class has continued to grow.

the claim was likely not reasonable and necessary ([REDACTED], see CP 1638-1697), and one claim in which the insured had [REDACTED] [REDACTED] ([REDACTED], see CP 1577-1637) even in these claims the adjusters were operating from hunches, suspicions, or rules of thumb rather than actual medical evidence that the claims were invalid. This is prohibited under *Kallevig*. *Kallevig*, 114 Wn.2d 901. Third, the gravamen of Plaintiffs' complaint against Farmers is that Farmers' practice of issuing claims denials based on "suspicious claim" criteria prior to the IME fails to adequately sort the valid from invalid claims, instead treating all "suspicious" claims as if they are invalid. To point to some claims in which the denial may (retroactively) have been justified does not explain why the 82.8% of claims that were valid all along were also denied, and cannot justify the general practice. What Farmers needed to bring forth was evidence showing that valid claims were denied based on criteria that were valid at the time of the denial. They did not do this. Fourth, Farmers' evidence lacks statistical validity and as a result says nothing about their general practice. The class at the time of the file review numbered at least 3,200. CP 808-833 at ¶ 15. Five claims is .15% of the class, and Farmers made no showing that these files were a representative sample, rather than cherry-picked examples of the best justifications Farmers could find for pre-IME denials. Even if those claim files demonstrated that Farmers'

practice was justified as to those claimants, they cannot demonstrate that the practice is not bad faith as a general practice. Fifth, none of the files brought forth by Farmers demonstrate that the actual basis for the denial was communicated to the insured when Farmers first refused to pay.

Farmers' conduct is a risk-shifting practice that goes to the heart of the insurance contract. PIP coverage is no-fault coverage—its primary benefit is speedier resolution of injury claims because payment is not held up while liability is determined. Insureds buying PIP coverage expect that claims will be paid promptly so that treatment can go forward—that is why they buy PIP coverage. When Farmers instead refuses to pay pending IME and communicates vague denials to the insured and their treating providers, the primary benefit of the insurance contract is, from the point of view of the insured, destroyed. The clear intent of WAC 284-30-330(4) is that the insurer bear the burden of proving the claim invalid, and that the financial risk of the claim remain with the insurer until the investigation is complete. Farmers' practice prematurely shifts financial risk to the insured.

While much of the argument below focused on the duty of equal consideration and the requirement not to refuse to pay claims without a reasonable investigation, evidence was also presented which, even viewed in the light most favorable to Farmers, establishes that at the time of the

pre-IME denials, Farmers fails to inform its insureds of the real bases for its actions, thus violating the common-law duty to disclose all facts that would aid its insureds in protecting their own interests, and violating the regulatory duty to disclose the true basis for denial of claims.

II. STATEMENT OF THE CASE

A. Procedural history before summary judgment.

This case was certified as a class action in July 2009 on claims of breach of contract, bad faith, and violations of the Consumer Protection Act. CP 697-700. Farmers sought, but did not receive, discretionary review of the class certification decision. In February, 2010, Farmers moved for summary judgment on all elements of the class's bad faith claim, and the class moved for partial summary judgment limited to the elements of duty and breach. The practice that the plaintiff class contended breached the duty of good faith was Farmers' practice of refusing to pay before completing its investigation, sending letters to PIP claimants and their doctors announcing that benefits are being withheld or denied pending the IME, and failing to specify the true reason for that decision. On April 16, 2010, the trial court granted the plaintiff class's motion. CP 1068-1070.

B. Evidence before the trial court at summary judgment.

The decision here under review is the trial court's decision to grant

summary judgment for the plaintiffs on the issue of whether Farmers' practice of denying claims pending IME breaches its duty of good faith and fair dealing under Washington law. At summary judgment, all evidence must be viewed in the light most favorable to the nonmoving party—in this appeal, Farmers.³ That being so, the trial court at summary judgment, like the jury at trial, is not free to disregard undisputed evidence in reaching its conclusions. Viewed in the light most favorable to Farmers, the evidence before the trial court at summary judgment was as follows.

Farmers has a general practice in Washington of scheduling IMEs based on criteria that, for Farmers, make the claim suspicious. The declaration of Douglas Heatherington, introduced by Farmers, stated that the IME criteria are:

- Minor automobile accident; property damage is minor or non-existent; no demonstrated bodily injuries;
- Treatment for soft tissue injury continues for four months without improvement;
- Treatment is claimed for an injury or condition that is not usually claimed as a result of an auto accident;
- Soft tissue injury claim is accompanied by a significant and unusual wage loss or essential service claim.

³ The trial court was presented with cross-motions for summary judgment on the bad faith issue, but the decision on which discretionary review was granted was the decision to grant summary judgment for the plaintiffs, not the simultaneous decision to deny summary judgment for Farmers.

- Long delay between the date of the accident and the treatment or between series of treatments;
- Pre-existing unrelated condition is present.

CP 1239-1240.

Since 2001 if not before, when an IME is scheduled, it has been Farmers' general practice to simultaneously send a letter to the insured and their health care providers stating that pending and future claims are being "denied," "withheld," or "declined" "pending IME" or "pending further investigation." The most common phrasing is that "we are withholding payment of these bills and all future bills" pending the results of the IME. Declaration of Le'a Kent, Sub No. 186⁴, Exh. 9, 15. However, letters also say that payment of the bills received and all future bills is being "declined," or "denied." *Id.* Plaintiffs submitted numerous examples of such letters. *Id.*

None of the letters reviewed by plaintiffs' attorneys stated any specific basis for the denial. No letter said, for instance, that the claims were being denied because Farmers had a policy of denying claims and calling for an IME if treatment for a soft-tissue injury continued beyond 3 months. CP 1239-1240. None said that the claims were being denied because they outstripped the dollar value of the damage to the vehicle, although that was often the reason articulated in the internal claims

⁴ Included in supplemental designation of clerks' papers 1/18/2011.

management record kept by the adjusters. Sub No. 186 Exh. 10, 13. Uniformly, the letters said only that the claims were being denied “pending IME” or “pending further investigation.” Id. Exh. 9, 15. Letters were uniformly either sent directly to the provider with the insured cc’d, or vice-versa. Sub No. 186 Exh. 15; CP 1541.

The policies and criteria underlying the denials were frequently discussed by the claims representatives and their supervisors as they made decisions about the claim, e.g. “ [REDACTED] [REDACTED] [REDACTED] ” Sub No. 186 Exh. 10. Farmers’ Unit Activities reports often noted dollar amounts that the claim should not exceed. Sub No. 186 ¶ 16, Exh. 13. Adjusters also triggered IME and refused to pay claims when the dollar value of treatment was “disproportionate” in comparison to the dollar value of the vehicle damage. *Id.* These thresholds and guidelines were never communicated to the insured. Often, these decisions were made internally long before the insured was notified that there was any potential problem with the claim. *Id.*

Plaintiffs presented uncontested evidence, received from Farmers during discovery and via depositions, that the denial letters are generated by an automated “ [REDACTED], ” that sends a letter to the

insured automatically when the IME is scheduled. CP 1510, 1512. There is no opportunity for the claims adjuster to change the content of the letter. CP 1529-1550. A Farmers claims adjuster deposed by the plaintiffs frankly admitted that the letters go out as a standard part of scheduling an IME, and that the [REDACTED] does not allow modification of the letters. CP 1543-1544. The adjuster also confirmed that there is no statutory or regulatory requirement that the denial letter go to the insured's health care providers—the decision to let the providers know Farmers isn't going to pay anymore is entirely Farmers' choice. CP 1541. Farmers' [REDACTED] [REDACTED] indicated that denial letters to the provider are a standard part of the IME process. CP 1504, 1527.

Plaintiffs also introduced Farmers [REDACTED], received from Farmers during discovery, indicating that it is standard practice to deny payment for claims pending IME, and that the IME is viewed primarily as a means of cutting off the claim.

[REDACTED]

CP 1494-1496. Farmers' [REDACTED] also contained [REDACTED] [REDACTED], stating, for example, that [REDACTED] [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] CP 1498.

This point was also emphasized in [REDACTED] on WAC 284-30-380, which [REDACTED]

[REDACTED]. CP 1523. However, other [REDACTED], evidently used prior to 2004, characterized [REDACTED]

[REDACTED]

[REDACTED]. CP 1525. Farmers' [REDACTED] also indicated that [REDACTED]

[REDACTED]. CP 1506 (stating that [REDACTED]). Other [REDACTED]

evidenced a pervasive institutional skepticism about insureds with soft tissue injuries, referring, for example, to the [REDACTED] CP 1515-1517.

Review of a statistically-valid sample of the claims files by Farmers' statistician determined that when an IME was called for, a letter communicating a denial of bills was sent to the medical provider 84.9% of the time. CP 404-522, 442-484. The same review determined that 82.8% of the time, the IME physician concluded that all treatment prior to the date of the IME was valid. CP 452-454. This evidence was introduced by

Farmers.

Other uncontroverted evidence introduced by plaintiffs included a declaration from Ms. Barquest's chiropractor's office manager, stating that as a medical provider, Coffey Chiropractic usually stops billing the insurer and insists patients make other arrangements for payment once it receives a letter denying or withholding benefits pending IME. CP 539-540.

Plaintiffs also submitted a declaration from Naomi Smith, a 10-year Farmers customer service and sales agent. CP 256-277. Ms. Smith detailed her experience with withholding and denial pending IME and later retroactive denial of her claims. *Id.* Like Taryn Barquest, and like the other claimants suffering denial pending IME, Ms. Smith was seeking care for soft-tissue injuries. *Id.* In her sales work for Farmers, Ms. Smith often focused on the "peace of mind" and security an optional PIP policy can provide. *Id.* Ms. Smith's opinion was that if she had to "honestly disclose the claims handling practices for PIP," she could "never sell another policy" because the lack of value would be apparent to the customer. *Id.*

Plaintiffs also submitted declarations from multiple other plaintiffs' attorneys who had observed the same practices, had fought on behalf of individual clients, and had sent letters explaining to Farmers that the practice appeared to be routine bad faith. Sub No. 27, 31, 32, 33, 34, 35. Those attorneys were uniformly of the opinion that, considered as a

broad claims management practice, denial pending IME had the effect of suppressing legitimate treatment by the insureds, thereby reducing costs to Farmers. Id.

In opposition to plaintiffs' evidence, Farmers submitted portions of Ms. Barquest's PIP file, in addition to five additional PIP files in which the after-conducted IME concluded that treatment had not been reasonable and necessary. CP 1758-82. None of these files demonstrated that the true basis for Farmers' actions was disclosed to the insured at that time payment was refused. One of the claims files, that of [REDACTED], did demonstrate that the adjuster relied on some opinion from one of [REDACTED] when refusing payment and scheduling her IME. CP 1698-1757. Another file, that of [REDACTED], demonstrated that Farmers would have been within its rights to deny [REDACTED] claim for [REDACTED]. CP 1577-1637.

C. Procedural history after summary judgment.

The trial court granted partial summary judgment for the plaintiff class on April 16, 2010. CP 1068-1070. The Summary Judgment Order stated only that plaintiffs' motion for partial summary judgment regarding the duty and breach elements of the bad faith claim was granted, and that Farmers' motion for summary judgment on the bad faith claim was denied. In its current briefing, Farmers mischaracterizes the basis for the

trial court's ruling as to the duty to complete an investigation before refusing to pay claims. It is clear from the oral ruling that the judge's decision was based on WAC 284-30-330(4), *Coventry*, and *Kallevig*, and that reference to WAC 284-30-395's finding that "some insurers limit, terminate, or deny coverage for personal injury protection insurance without adequate disclosure" was used primarily to interpret whether WAC 284-30-330(4)'s "refuse to pay" language should be interpreted to encompass only final denials, or to encompass other practices limiting the claim. Tr. at 70, 74.

Farmers sought discretionary review, which was granted at least in part based on a misunderstanding of what the disputed practice below was. The commissioner viewed the trial court's ruling as applying to bar any pause in payment during investigation, not to Farmers' disputed practice of sending letters to insureds and their providers affirmatively refusing to pay and telling them that their claims were "denied," "declined," or "withheld" pending IME, while failing to communicate the true basis for Farmers' decision.

III. ARGUMENT

A. Standard of Review

The Court of Appeals reviews an order granting summary judgment de novo and engages in the same inquiry as the trial court.

Weden v. San Juan County, 135 Wn.2d 678, 689, 958 P.2d 273 (1998). Summary judgment is proper “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” CR 56(c). The facts and reasonable inferences from those facts are viewed in the light most favorable to the nonmoving party, here, Farmers. *Federal Way Sch. Dist. No. 210 v. State*, 167 Wn.2d 514, 523, 219 P.3d 941 (2009). An appeals court reviewing a grant of summary judgment is not restricted to affirming on the same basis articulated by the trial court, but may affirm on any basis supported by the record. *State v. Carter*, 74 Wn. App. 320, 324 n. 2, 875 P.2d 1 (1994); *State v. Grundy*, 25 Wn. App. 411, 415-16, 607 P.2d 1235 (1980)); see also RAP 2.5(a). Like the trial court, the appeals court cannot weight the evidence, but also cannot simply ignore evidence.

B. Farmers’ practice is bad faith both because Farmers refuses to pay claims before completing a reasonable investigation, and because Farmers fails to timely communicate the true basis for its refusal until after the IME.

The action for bad faith sounds in tort. *Murray v. Mossman*, 56 Wn.2d 909, 355 P.2d 985 (1960); *Safeco Ins. Co. v. Butler*, 118 Wn.2d 383, 823 P.2d 499 (1992). An insurer may act in bad faith either by

violating regulations defining unfair claims settlement practices, or by violating its quasi-fiduciary duties to the insured and third parties under Washington's common law of bad faith. *See, e.g. St. Paul*, 165 Wn.2d 122 (bad faith for violation of insurance regulations); *Van Noy*, 142 Wn.2d 784 (bad faith for breach of quasi-fiduciary duties).

Under Washington's common law of bad faith, insurers owe a set of quasi-fiduciary duties to their insureds, including "(1) the duty to disclose all facts that would aid its insureds in protecting their interests; (2) the duty of equal consideration; and (3) the duty not to mislead its insureds." *Van Noy*, 142 Wn.2d at 791 (quoting *Van Noy*, 98 Wn. App. at 492). The duty of equal consideration requires the insurer to "deal fairly with an insured, giving equal consideration in all matters to the insured's interests as well as its own." *Van Noy*, 98 Wn. App. at 492; *see also Coventry*, 136 Wn.2d at 280; *McGreevy v. Or. Mut. Ins. Co.*, 128 Wn.2d 26, 36-37, 904 P.2d 731 (1995); *Tank v. State Farm*, 105 Wn.2d 381, 385-86, 715 P.2d 1133 (1986).

1. It is bad faith to refuse to pay claims before completing a reasonable investigation.

WAC 284-30-330 defines specific unfair claims settlement practices, stating that "The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in

the business of insurance, specifically applicable to the settlement of claims.” WAC 284-30-330. Among the enumerated unfair practices is “Refusing to pay claims without conducting a reasonable investigation.” WAC 284-30-330 (4).

This case presents three questions about how the phrase “refusing to pay claims without conducting a reasonable investigation” should be interpreted and applied to Farmers’ conduct. First, does the duty require a reasonable investigation to be completed before refusing to pay a claim? Second, what, in this context, is a “reasonable investigation?” Third, how should “refusing to pay a claim” be interpreted—does it encompass only final denial of the claim, or does it also include other, intermediate refusals to pay? The answers to all three of these questions are unfavorable to Farmers. Under Washington law, a reasonable investigation must be conducted before the claim is refused. *Coventry*, 136 Wn.2d at 280-81. Also under Washington law, “An insurer does not have a reasonable basis for denying coverage and, therefore, acts without reasonable justification when it denies coverage based on suspicion and conjecture.” *Kallevig*, 114 Wn.2d at 917. And finally, the fact that WAC 284-30-330 (4) uses the term “refuse to pay” rather than the term “deny,” combined with the concern in WAC 284-30-395 to regulate abuses in the limitation of claims as well as their denial, argues for interpreting “refuse to pay” to

encompass the kind of intermediate refusals Farmers issues.

The duty not to “refuse to pay claims without conducting a reasonable investigation” requires that a reasonable investigation must be conducted before the refusal to pay. The Washington Supreme Court and courts elsewhere have repeatedly held that the duty imposed is one to conduct a reasonable investigation before refusing to pay a claim. *Coventry*, 136 Wn.2d at 280-81 (stating “We agree” that insurers are required to “complete a reasonable investigation before denying coverage.” (quoting 1 Allan D. Windt, *Insurance Claims & Disputes: Representation of Insurance Companies and Insureds* § 2.0, at 38 (3d ed. 1995)). The Federal District Court for the Western District of Washington, in a case involving another division of Farmers’ parent company Zurich, likewise held that WAC 284-30-330(4) requires that a reasonable investigation be conducted before denying a claim. *Aecon Bldgs., Inc. v. Zurich North America*, 572 F. Supp. 2d 1227, 1239 (W.D. Wash. 2008) (citing duty from WAC 284-30-330(4) and holding that “Zurich violated the CPA when it failed to conduct a reasonable investigation before denying Aecon's tender”).

Courts in other states, interpreting near-identical statutes and regulations, have also held that the duty is to conduct a reasonable investigation before any refusal to pay. *See, e.g. Ivanov v. Farmers Ins. Co. of Oregon*, 344 Or. 421, 430, 185 P.3d 417 (2008) (holding that statute

prohibiting insurers from “Refusing to pay claims without conducting a reasonable investigation based on all available information” required reasonable investigation before denying claim); *Paul Revere Life Ins. Co. v. DiBari*, 2010 WL 918084, slip op. at *4 (D. Conn. 2010) (same); *Revelation Industries, Inc. v. St. Paul Fire & Marine Ins. Co.*, 350 Mont. 184, 200, 206 P.3d 919 (Mont. 2009) (same, stating that the statute is “designed to protect claimants against insurers who would deny a claim without first conducting a reasonable investigation”). WAC 284-30-330(4) requires insurers to conduct a reasonable investigation before denying claims.

Second, it has long been the law in Washington that “An insurer does not have a reasonable basis for denying coverage and, therefore, acts without reasonable justification when it denies coverage based on suspicion and conjecture.” *Kallevig*, 114 Wn.2d at 917. Where “a reasonable person would have recognized that the evidence did not rise above a suspicion,” it is bad faith for an insurer to deny a claim. *Safeco Ins. Co. of Am. v. JMG Rest. Inc.*, 37 Wn. App. 1, 15, 680 P.2d 409 (1984). The guidelines that Farmers uses to deny PIP claims—the mere presence of a pre-existing condition, the amount of damage to the car, the length of treatment as compared to average treatment lengths—amount to nothing more than suspicion and conjecture until they are verified by the

IME. At the time the adjuster makes the denial decision, he has nothing more than a hunch that the claim may be invalid. By Farmers' own statistics, 82.8% of the time, the adjuster is wrong and IME physician determines that the denied claims were reasonable, necessary, and related to the accident. CP 1496, 452-454. Thus, based on suspicion alone, Farmers has a routine practice of denying claims which have only a 17.2% chance of being found invalid. *Id.*

This is well within the range of behavior that Washington courts have found to be bad faith. For example, in *Kallevig*, the insurance company was found to have relied on "mere suspicion" when it relied on the investigation and theory of the local police arson investigator rather than hiring its own expert to investigate the cause of a fire. *Kallevig*, 114 Wn.2d at 917-18. In *Coventry*, the investigation was inadequate where it involved a cursory site visit by the adjuster. *Coventry*, 136 Wn.2d at 274-75. Here, Farmers' investigation is the equivalent of a cursory "site visit"—it consists of applying internal "suspicious claim" criteria before seeking any expert opinion in the form of an IME. This falls far below the bar set by *Kallevig* and *Coventry*.

Farmers' practice is unfounded because the claims adjuster simply does not have the information and expertise to deny a claim where the treating physician vouches for the reasonableness, necessity, and

relatedness of the treatment, and the claims adjuster has no IME to displace that opinion. In all PIP claims, the medical professional treating the claimant implicitly, if not explicitly, vouches that the treatment is both reasonable and necessary—otherwise, the treatment provider would violate his or her professional code by providing the treatment. See RCW 18.130.180 (prohibiting misrepresentation by all providers licensed the by the Washington State Department of Health).

In recent years, courts have frequently been asked to consider just this issue--whether a question of bad faith is presented when the adjuster substitutes his or her judgment for that of the treating physician without first getting opinion from an independent medical expert. In cases involving individual claims, state and federal courts have repeatedly held that when an adjuster denies medical claims without first getting some medical opinion questioning the validity of the claim, there is evidence of bad faith. “An insured is entitled to expect that a claim examination will include, as part of a reasonable and adequate investigation...consideration of the opinions of an independent physician from the appropriate specialty before deciding to terminate benefits on the basis of a medical conclusion.” *Uberti v. Lincoln Nat'l Life Ins. Co.*, 144 F. Supp. 2d 90, 104-05 (D. Conn. 2001); *see also, e.g. Bonenberger v. Nationwide Mut. Ins. Co.*, 791 A.2d 378, 379 (Penn. 2002); *Etten v. U.S. Food Service Inc.*, 446 F. Supp. 2d 968 (N.D.

Iowa 2006); *McIlravy v. North River Ins. Co.*, 653 N.W.2d 323, 329 (Iowa 2002); *Krajicek v. Auto. Club Inter-Ins. Exch. Inc.*, 2009 WL 3254904, slip op. at *8 (N.D. Okla. 2009); *Storrer v. Paul Revere Life Ins. Co.*, 2009 WL 1916714, slip op. at *3 (N.D. Cal. 2009); *Wilson v. 21st Cent. Ins. Co.*, 42 Cal 4th 713, 721-22, 171 P.3d 1082 (Cal. 2007).⁵

The cases cited involve individual claims where plaintiffs challenged the practice of substituting the adjuster's judgment for the treating physician's. In the class action context, where the practice is demonstrated to be a systematic policy and practice rather than an isolated episode of poor adjuster judgment, the argument for bad faith is strengthened because any contention that the denial is based on an individualized weighing of the claim is defeated. *See, e.g. Strawn v. Farmers Ins. Co. of Oregon*, 228 Or. App. 454, 209 P.3d 357 (2009) (class action jury verdict finding that use of cost-containment software to systematically reduce PIP claim amounts was not only bad faith, but fraud).

Third, "refusing to pay a claim" should be interpreted to impose a duty of reasonable investigation before any refusal to pay the claim, not just the final denial of the claim. Intermediate refusals injure and mislead customers just as surely as do final denials. The fact that WAC 284-30-330 (4) chooses to use the term "refuse to pay" rather than the term

⁵ For a more detailed discussion of these cases, see Plaintiff's Response to Farmers Motion for Partial Summary Judgment on Bad Faith Claims. CP 948-971 § F.

“deny,” indicates that the regulation should be read to encompass intermediate refusals to pay rather than only final denials. This is particularly so because the terms “deny” and “denial” are used elsewhere in the regulations at WAC 284-30-330, indicating that “refuse to pay” is an intentional choice of terms. See, e.g. WAC 284-30-330(5) (“affirm or deny coverage”). It is also apparent from WAC 284-30-395 that the insurance commissioner has seen the need to regulate abuses in the limitation of claims as well as their denial—that section addresses a range of practices that “limit, terminate, or deny” coverage. The scope of abuses covered by WAC 284-30-330 reaches beyond final denial to any communicated refusal to pay.

2. It is bad faith for an insurer to fail to communicate the basis for its decisions.

Washington’s insurance regulations and Washington’s common law both make clear that it is bad faith for an insurer to fail to communicate the true bases for its decisions. At common law, this obligation is the “duty to disclose all facts that would aid its insureds in protecting their interests,” or the “duty not to mislead its insureds.” *Van Noy*, 142 Wn.2d at 791 (quoting *Van Noy*, 98 Wn. App. at 492). The duty also permeates Washington’s insurance code and insurance regulations, appearing in RCW 48.01.030 (insurers must “practice honesty and equity

in all insurance matters”), WAC 284-30-330 (13) (“(13) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement”); WAC 284-30-380 (1) and (3) (specific grounds and basis for denial must be communicated to insured); and WAC 284-30-395 (2) (“the insurer shall provide an insured with a written explanation that describes the reasons for its action.... The insurer shall include the true and actual reason for its action...”). RCW 48.30.010(1) broadly prohibits unfair or deceptive acts in the business of insurance. RCW 48.30.04 again prohibits false or deceptive representations in the business of insurance.

Here, Farmers’ practice of failing to tell the insured the basis for the denial is bad faith under Washington insurance statutes and regulations. It is also common-law bad faith because it misleads the insured as to why Farmers is denying the claim, and more importantly, deprives the insured of the ability to timely contest the real basis for denial. For example, where the real underlying basis for denial is that the insured has a pre-existing condition, the insured is deprived of the opportunity to have his or her treating physician submit additional documentation or explanations regarding the relation between the pre-existing condition and the insured’s new or lit-up injuries. Where the real

underlying basis for denial is that the insured has been treating “too long,” the insured is deprived of the opportunity to seek or submit additional information regarding why his or her condition has not improved as quickly as Farmers thinks it should. Instead, insureds are sent to the IME with no idea of what they’re being suspected of or how to protect their claims. This kind of gamesmanship is bad faith.

Washington courts have noted that this duty of good faith is particularly important in the first party context where “the insurer’s interests might be opposed to the insured’s and the insured is particularly vulnerable and dependent on the insurer’s honesty and good faith.” *Van Noy*, 142 Wn.2d at 793 fn. 2.

3. Claims investigation practices are judged at the time of the investigation, not retrospectively in light of the investigation’s ultimate results. The duty of good faith is owed and judged at each moment.

Farmers has a duty to act in good faith toward its insured Washington consumers in its claims investigation and claims processing. Washington courts have repeatedly held that the duty of good faith claims investigation is “separate from the duty to pay for a claim when required to do so.” *Coventry*, 136 Wn.2d at 282; *see also Van Noy*, 98 Wn. App. at 489.. Yet Farmers continues to argue that because it back-pays bills when the IME recommends further treatment, the practice of denying claims before the

IME cannot be a bad faith practice. Under Washington law, this is not so: whether an insurer's investigation is done in good faith is judged at the time of the investigation, not retroactively in light of the investigation's ultimate conclusions. Essentially, Farmers repeats the insurer's losing argument from *Coventry Associates v. American States Insurance Company*. *Coventry*, 136 Wn.2d at 280.

Under *Coventry*, an insurer's bad faith investigation is judged not in hindsight, but based on the information the insurer had at the time. In *Coventry*, the insurer proposed a "no harm, no foul" interpretation of Washington's bad faith law in which there is no bad faith in investigation if there ultimately wasn't coverage for the claim. *Coventry*, 136 Wn.2d at 280. The *Coventry* court rejected that argument, stating "Under American States' proposed rule, insurers would have a duty of good faith toward their insured only when coverage was required. That reasoning begs the question and runs counter to our previous holdings." *Id.* Washington courts evaluate an insurer's investigation for bad faith at the time the decision was made, not in hindsight.

4. Farmers' practices erode the very protection purchased by the insured.

Individuals pay extra for PIP insurance because it promises prompt, simple, no-fault coverage for medical bills resulting from an auto

accident. Insureds buying PIP coverage do so on the assumption that their medical providers will be paid promptly, thus enabling the insured to continue to get necessary treatment. When Farmers instead refuses to pay claims while the IME is pending, and furthermore communicates that refusal to the treating providers, the primary benefit of the insurance contract is, from the point of view of the insured, destroyed. When the insurer's conduct "damages the very protection or security which the insured sought to gain by buying insurance," it is bad faith. *Coventry*, 136 Wn.2d at 278-79 (quoting *Rawlings*, 151 Ariz. at 157).

This aspect of Farmers' conduct is also bad faith under Farmers common-law quasi-fiduciary duty of good faith to its insureds, primarily the duty to give equal consideration to the interests of the insured. *Van Noy*, 142 Wn.2d at 791. In refusing to pay pending the IME and retroactively denying benefits after the IME, Farmers fails to give equal consideration to the interests of the insureds, giving far more consideration to its desire not to pay out claims or carry reserves than it gives to the insureds' need for timely treatment and timely payment. This disproportion is apparent from the statistics—82.8% of these claims are ultimately proved valid, 17.2% are not, yet Farmers refuses to pay the 82.8% while it searches for the 17.2%. That is not equal consideration.

The insured suffers this loss of security *regardless of the ultimate*

validity of each individual underlying PIP claim, and this loss is cognizable in bad faith. Under Washington law, an insurer is liable for bad faith investigation even where the insured is not ultimately entitled to coverage on the underlying claim. *See Coventry*, 136 Wn.2d at 279. Here, where insureds suffer delay and uncertainty in the payment of claims, where they forego or delay treatment or diagnosis because of that uncertainty, and where they find their relationships with treating providers disrupted by Farmers' practice of withholding/denying benefits pending IME, the insured loses the very security that was bargained for in the insurance contract.

Farmers discusses its "temporary suspension" of benefits pending IME as if this practice somehow benefits the insured. It does not. Under Washington law, insureds are entitled to have their claims either paid, quickly investigated, or denied. Farmers' practice does none of these, but instead places the insured in a kind of bureaucratic limbo lacking the advantages of any of the good-faith options. If the claim is paid, the insured benefits because it is paid. If the claim is denied, the insured is at that point legally entitled to a reason for the denial, and is also entitled to pursue other dispute resolution options. What Farmers' practice does is communicate to the insured and their medical providers that Farmers is presently refusing to pay the claim (and perhaps all future claims), while

failing to actually disclose why the claim is being denied. The insured is left without the coverage he or she paid for, but the insured is also without any sense of why the claim is troubling to Farmers, and is thus left without “all facts that would aid” the insured in protecting his or her interest. This is a violation of Washington’s common law of bad faith. *Van Noy*, 142 Wn.2d at 791, 16 P.3d 574 (2001).

C. Farmers’ arguments that its practices are not bad faith rely on misinterpretations of law and of the trial court’s ruling.

1. Decisions allowing insurers to require insureds to attend IMEs, and to deny benefits for noncooperation do not establish that insurers can refuse to pay claims before completing a reasonable investigation.

Farmers argues that because Washington law allows insurers to deny benefits when an insured refuses or fails to attend an IME, Farmers may therefore deny benefits pending IME. This does not follow from the Washington case law, and is a question-begging argument of the kind rejected in *Coventry*. Farmers argues that “suspension” of benefits is allowed under Washington law so long as the insurer has a reasonable basis to continue its investigation. For this proposition, Farmers cites *Albee v. Farmers Insurance Company* and *Kim v. Allstate Insurance Company*, which do not so hold. *Albee v. Farmers Ins. Co.*, 92 Wn. App. 866 (1998); *Kim v. Allstate Ins. Co.*, 153 Wn. App. 339, 223 P.3d 1180, 1184-86 (2010).

In *Albee*, Farmers scheduled an IME for an insured whose own physicians' notes indicated that they were concerned he was exploiting his injury for "secondary gain." *Albee*, 92 Wn. App. at 869. Albee refused to attend. *Id.* at 870-72. After scheduling two IMEs, which Albee again failed to attend, Farmers sent a letter stating that if Albee did not attend the second IME, "all benefits will be suspended as of the appointment date." *Id.* at 871. In *Albee*, the basis for suspension of benefits was the insured's breach of the cooperation clause of the insurance contract by refusing to attend the IME, not the insurer's desire to continue investigating. Farmers did not suspend benefits when it decided to schedule the IME, but only after the insured breached the contract and refused to attend. *Albee* does not hold that the insurer may deny, suspend, or withhold benefits whenever it wishes to investigate a claim. That situation was not even presented in *Albee*. It holds that, under the cooperation clause of the insurance contract, an insured who refuses to attend an IME is in breach, and that insured's benefits may be suspended.

Kim v. Allstate is also inapposite to the issues of this case. The only way *Kim* could be relevant is if the case held that suspicion of fraud, without evidence, justified denial of claims. *Kim* does not so hold. The pre-denial investigation in *Kim* was extensive, included videotaped evidence that the insured was claiming loss-of-work benefits for days she was

actually working, also included an IME, and most importantly, was done prior to denial. *Kim*, 153 Wn. App. 339, 223 P.3d 1180, 1184-86 (2010). The holding of *Kim* was, that fraud, if actually demonstrated, negates a bad faith claim. *Id.*

Farmers also uses *Sadler v. State Farm Mutual Automobile Insurance Company*, a 2008 Western District of Washington case, to argue that because PIP insurers are not required to pre-approve medical treatment, it may deny claims before completing its investigation. This does not follow. In *Sadler*, the insured sought pre-approval for surgery for a disk herniation. *Sadler*, 2008 WL 4371661 at *2 (W.D. Wash. 2008). State Farm's representative advised the insured that under PIP, the insurer does not pre-approve surgery, and that State Farm would be scheduling an IME. *Id.* An IME was eventually scheduled for one month later. *Id.* at *3. The IME physician's report stated that "surgery should be arranged very promptly." *Id.* State Farm's claims representative then contacted the insured and stated that, while State Farm still did not pre-approve procedures, it was the IME physician's conclusion that the surgery would be reasonable. *Id.* at *4. The insured had surgery, but claims she suffered damages from the one-month delay. *Id.* At no point did State Farm deny, suspend, or withhold Ms. Sadler's PIP benefits—State Farm simply refused to pre-approve surgery. *Id.* The plaintiff's insurance expert agreed

that there was no duty under the PIP policy to pre-approve surgery. *Id.* at *10. On these facts, the court noted that the contract and the relevant statutes and regulations, in providing that claims should be paid within 30 days *after* they were submitted, clearly contemplated that the PIP insured would receive care and later be promptly reimbursed, and that therefore it was not bad faith for State Farm to refuse to engage in a pre-approval process. *Id.* at *12-13. *Sadler* is correct on this general principle—the PIP statutes and regulations contemplate that the insured will receive care and then be promptly reimbursed. The class has never disputed this. The class is not arguing that PIP insurers must pre-approve claims. The class argues only that Farmers acts in bad faith when it, as a matter of companywide policy, refuses to pay claims before completing a reasonable investigation, communicates that refusal to the insured and to their treating providers, and fails to disclose the reasons for that refusal.

2. The evidence Farmers presented at summary judgment was insufficient to demonstrate that its pre-IME claims denial practices did not violate its duties to proceed in good faith.

Plaintiffs' argument in this case is that Farmers' practice of refusing to pay claims pending IME is bad faith at least in part because it is implemented after an investigation that is not good enough to reliably identify invalid claims. Only 17.8% of the claims identified by Farmers' criteria for suspicious claims ultimately prove invalid. Yet 100% of those

insureds suffer a premature refusal to pay, communicated to both the insured and their medical providers with little other information. In opposition to this argument, Farmers selected five claims files out of the 3200 class members, and sought from those to demonstrate that Farmers' claims denials are reasonable.

As discussed above, the evidence from the five files is not sufficient to defeat summary judgment, for five reasons. First, much of the evidence introduced is irrelevant. Under *Coventry*, an insurer's conduct during an investigation is judged by what the insurer knows at the time, not what the insurer learns after conducting the investigation. *Coventry*, 136 Wn.2d 269. Thus, all evidence that came to Farmers' attention after the IME was scheduled is irrelevant—the IME itself cannot be used to show that it was reasonable to deny the claim before the information contained in the IME was known.

Second, only two of the claims files produced by Farmers contain any pre-IME evidence that amounts to more than a suspicion or conjecture that the claim was invalid. ██████████'s file included ██████████
██████████
██████████—non-conjectural evidence that her claims might not be valid. CP 1638-1697). ██████████'s file contained evidence that
██████████

[REDACTED]

[REDACTED] CP 1577-1637. The other files simply contain evidence that the insureds had [REDACTED]. Under [REDACTED]. Under *Kallevig*, that kind of suspicion or conjecture is not a reasonable investigation. *Kallevig*, 114 Wn.2d at 917.

Third, the gravamen of Plaintiffs' complaint against Farmers is that Farmers' practice of issuing refusals to pay based on "suspicious claim" criteria fails to adequately sort the valid from invalid claims, instead treating all "suspicious" claims as if they are invalid. To point to some claims in which the denial may (retroactively) have been justified by the IME does not ratify Farmers' acts as a general practice. What Farmers needed to bring forth was evidence showing that even the claims ultimately found valid by the IME were, at the time of denial, denied based on the results of a reasonable investigation not amounting to mere suspicion or conjecture. They did not do this. In fact, they did not introduce any evidence about what specific, non-conjectural bases were used to reject ultimately valid claims.

Fourth, Farmers' evidence lacks statistical validity and as a result says nothing about their general practice. Farmers has introduced evidence that 2 out of at least 3,200 insureds were rejected for individualized

reasons rather than based on rules of thumb. That is .063% of the class. Even if those claim files demonstrated that Farmers' practice was justified as to those claimants, they cannot demonstrate that the practice is not bad faith as a general practice.

Fifth, and most clearly, none of the files brought forth by Farmers demonstrate that that the factual basis for the denial was communicated to the insured when Farmers first refused to pay. CP 1638-1697, 1698-1757, 1577-1637.

The commissioner's opinion viewed the trial court's ruling as troubling because in some portion of Farmers' decisions, the insurer does have a good faith basis to refuse to pay the claim, and the claim is ultimately found invalid. However, 82.8% of the time, the IME ultimately finds the claim was valid, and in 3 of the 5 files cherry-picked by Farmers to demonstrate a reasonable basis for denying the claim, only conjecture supports the denial. The court's choice here is this: either the court rules that having a general practice of pre-IME denial based on general "suspicious claim" criteria that do not reliably identify invalid claims is bad faith, or the insurer gets to deny claims encompassing innocent insureds. Nothing about this ruling prevents Farmers or any other insurer from denying claims based on individual criteria known at the time of the denial. The ruling only prohibits refusing to pay claims when there is no

individualized, reasonably valid basis for doing so. The issue isn't whether some claims should be denied—they should. Not every insurance claim is valid. The issue is what basis the insurer must have before denying claims. Under Farmers' interpretation, an insurer could have a general practice of denying all claims without investigation, then pointing to the small percentage of inevitably invalid claims and arguing that the practice was not bad faith as to the class of all insureds.

Farmers also argues that whether the practice is bad faith should be judged against the fact that only a small percentage of PIP insureds are subjected to IME. This is simply not a criterion for bad faith—were it so, no claimant could ever prove bad faith without proving it was a universal practice.

- 3. Farmers' argument regarding WAC 284-30-395 misinterprets the court's ruling and ignores the fact that Farmers argued below that WAC 284-30-395 should be applied.**
 - a. Farmers misinterprets the trial court's use of WAC 284-30-395.**

Farmers misinterprets the trial court's ruling when Farmers states that the court relied principally on WAC 284-30-395 in its decision to grant partial summary judgment for the plaintiff class. It is apparent from the court's oral ruling that the court primarily used WAC 284-30-395's concern with the limitation of benefits to establish that the "refuse to pay" language in WAC 284-30-330 should be interpreted broadly to encompass

interim refusals as well as any final claim denial. As discussed above, that interpretation is correct.

- b. Under the invited error doctrine, Farmers may not advance below the theory that WAC 284-30-395 controls this case, yet assert on appeal that the regulation does not apply.**

However, even if the trial court did rely on WAC 284-30-395, and even if that reliance were error, it was error invited by Farmers. Farmers may not argue for the first time on appeal that WAC 284-30-395 does not apply to the practices at issue in this case because “[t]he doctrine of invited error prevents a party from complaining on appeal about an issue it created at trial.” *City of Bellevue v. Kravik*, 69 Wn. App. 735, 739, 850 P.2d 559 (1993). None of Plaintiff’s filings for summary judgment asserted that WAC 284-30-395 controls this case. The issue arose only because Farmers raised it. *Compare* CP 1553 (Def’s opposition: “[Plaintiff] fails to cite or analyze WAC 284-30-395, the regulation that sets forth specific duties of PIP insurers”) *with* CP 1467-87 (Pl’s Mot., citing WAC 284-30-330(4) as the regulation violated by Farmers’ practices). The court should not permit Farmers to “set up an error at trial and then complain about it on appeal.” *In re Estate of Stevens*, 94 Wn. App. 20, 31, 971 P.2d 58 (1999).

The appellant in *Stevens*, like Farmers here, sought to escape the outcome dictated by her choice of legal theories. The *Stevens* appellant

was a trust beneficiary against whom the trial court had entered an order of default. *Id.* at 23, 28. She moved to vacate the order under CR 60. *Id.* at 28. The court denied her motion, and she then asserted on appeal that it had erred by applying the standard for setting aside a default judgment, under CR 60(b), rather than an order of default, under CR 55(c). *Id.* at 30. The appellate court was unimpressed. “[Appellant] never informed the trial court that it should consider vacating the order of default under CR 55, but consistently directed the trial court to the rules and case law under CR 60.” *Id.* at 31.

Farmers has done precisely the same thing with regulations instead of court rules. Throughout summary judgment, it consistently directed the trial court to WAC 284-30-395. It did so in its own motion for summary judgment. *See* CP 818, 823 (framing the issue on summary judgment in the language of WAC 284-30-395 and dismissing WAC 284-30-330(4) as “unavailing”). It did so in its reply for that motion. *See* CP 972-984 (explaining that “WAC 284-30-330(4) . . . is not relevant” and that Farmers’ duty is to “properly evaluate claims under WAC 284-30-395(1)(a)–(d)”). It did so in its opposition to plaintiff’s motion. *See* CP 1567 (“Where (as here) the insurer investigates[,] WAC 284-30-395, the regulation that sets forth ‘standards for fair, prompt, and equitable PIP settlements,’ applies.”). It did so in its sur-reply to that motion. *See* CP

1041-47 (directing the court to the “eligibility” and “controls” inherent in WAC 284-30-395(1)(a)–(d)). And finally, it did so at oral argument. *See* Tr. 26: 6–9 (“The WAC is the 395 that we’ve been focusing on, it’s very clear that a claims handler can make the decision to deny coverage without going to an IME.”). The invited error doctrine clearly prohibits Farmers’ attempt to disclaim WAC 284-30-395 as the governing law of this case.

4. The trial court’s ruling neither creates coverage by estoppel nor conflicts with WAC 284-30-370 and -380.

After holding that, regardless of whether the claim ultimately proves valid, it is bad faith for an insurer to refuse to pay a claim before completing a reasonable investigation, *Coventry* then held that the remedy for bad faith investigation of an ultimately invalid claim was not coverage by estoppel, but tort damages fairly traceable to the bad faith conduct. *Coventry*, 136 Wn.3d at 284.

Farmers argues that the trial court’s grant of summary judgment for the plaintiffs on the issues of duty and breach somehow also mandated coverage by estoppel. It is difficult, as a matter of legal fundamentals, to see how this could be so. The trial court herein made no ruling on damages, only on duty and breach. Therefore, the court cannot have run afoul of *Coventry*’s holding as to the measure of damages. Furthermore, nothing in the trial court’s order or oral ruling at summary judgment

suggests that the court intends to impose coverage by estoppel as the measure of damages in this case.

Instead, this seems to be Farmers' hyperbolic way of asserting that if it were not able to issue letters refusing to pay claims before completing its reasonable investigation, it might end up paying some greater number of invalid claims, and this would amount to "coverage by estoppel." If that were so, then *Coventry* itself would have been requiring "coverage by estoppel" by mandating a reasonable investigation be completed before denying claims. Yet the *Coventry* court was careful to distinguish between the duty to reasonably investigate, and the damages flowing from the breach of that duty.

Nothing in the trial court's ruling requires Farmers to pay any claim. As Farmers points out, WAC 284-30-370 gives all insurers 30 days to investigate claims, and WAC 284-30-380 sets forth provisions for notifying the insured of the claim's status within fifteen working days (three weeks) of proof of loss. In the PIP context, the proof of loss is the initial PIP application—not each individual medical bill. Therefore, except during that brief period when the PIP claim is first opened, WAC 284-30-380 does not apply. Here, Farmers has already accepted the proof of loss and begun paying on the claim and paying medical bills. The deadline that pertains to each individual medical bill is the 30-day deadline from WAC

284-30-370. All Farmers has to do to remain within the trial court's ruling, and within the law, is promptly schedule an IME when Farmers deems an insured's medical bills suspicious, then timely complete that IME, make a decision based on the IME, and, if justified by the IME, deny payment for any bills received within 30 days of that decision. At all points, Farmers controls the timing of its investigation. All the trial court's ruling compels Farmers to do is manage claims in a timely fashion without violating the rights of its insureds. Nothing in the trial court's ruling prohibits Farmers from working within those deadlines to schedule an IME during the standard 30-day claims investigation period, complete it, and communicate any denial after the IME is complete.

And indeed, this was the solution contemplated by the trial court:

The insurance company controls the process, they can decide how quickly to schedule the IME or whether to schedule the IME. Tr. at 72: 1 – 3.

And the case law is replete with examples of that, that they're entitled to do that [have an IME], and they can determine how to set it up. In fact, their own training manual tells them how to take care of this, and that is, it encourages and exhorts and directs adjusters to set up those IMEs promptly and not to delay and not to procrastinate. *Id.* at 72: 8 – 14 (transcript corrected).

...they certainly, based on the criteria that they've outlined as examples of why they get suspicious, they could certainly use those examples as indicia for determining which cases are going to be very early on red flagged and put in the front of the line

for an IME. *Id.* at 72: 18 – 23.

Farmers further claims that WAC 284-30-380 permits the insurer to perform additional investigation after providing notice to the insured. What Farmers fails to acknowledge is that WAC 284-30-380 only allows an insurer to take additional time if it first notifies the insured of such a need within 15 days of receiving the proof of loss. In the PIP context, Farmers requires a proof of loss form to be filled out by the PIP applicant before the claim is initiated. All members of the class before this court cleared this hurdle—proof of loss was accepted by Farmers and Farmers began to pay the claims. Farmers did not exercise its option to deny those claims. Instead, Farmers accepted the proof of loss, paid the claims for a period of time, then sent a letter to the provider stating that it was then refusing to pay any further invoices pending the results of the IME. That letter failed to comply with WAC 284-30-380 (1)'s requirement that the grounds for denial be specified.

Having failed to comply with the initial requirements of WAC 284-30-380, Farmers cannot then seek to employ other parts of the regulation that it has failed to comply with. A similar argument was made by an insurer in *Van Noy*, 98 Wn. App. at 495. There, State Farm similarly failed to comply with WAC 284-30-380. “State Farm did not follow these notice requirements.” The court held that State Farm could

not argue that the regulation applied when it had failed to meet the notice requirements of the regulation. *Id.* at 495.

Just as in *Van Noy*, an insurer that fails to comply with a regulation cannot try to use the same regulation to shield it from liability. Here, Farmers received the insureds' proofs of loss and began to pay the claims. Months later, the insurer sends letters to the insureds' providers refusing to pay, with a copy sent to the insured, and no basis given for the refusal.

5. The duties Farmers violated are not debatable.

Farmers contends that the trial court was in error by finding Farmers in bad faith for violation of "debatable duties." A duty does not become debatable merely because the insurer chooses to debate it. Here, as discussed in Section B above, the duties Farmers violated were the well-established duties not to refuse to pay claims before completing a reasonable investigation, and not to deny claims based on suspicion or conjecture. These duties were set forth clearly in *Coventry* (1998) and *Kallevig* (1990). And indeed, even at the time those cases, when the duties were substantially less clear than they are today, violation of those duties was held to be bad faith. *Coventry*, 136 Wn.2d 269; *Kallevig*, 114 Wn.2d 907.

IV. CONCLUSION

For the above reasons, Farmers' appeal should be denied.

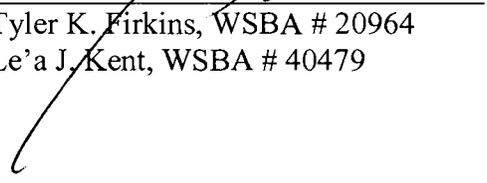
RESPECTFULLY SUBMITTED this 8th day of February, 2011.

VAN SICLEN, STOCKS & FIRKINS



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CERTIFICATE OF SERVICE

I hereby certify that the foregoing Brief of Respondent was sent out to be filed with the Court of Appeals and a true and correct copy was sent to the following counsel by email and hand delivery or US Mail:

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