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COURT OF APPEALS, DIVISION I  
OF THE STATE OF WASHINGTON

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CHRISTOPHER NELSON, a person,  
REBECCA WIRTEL, a person,  
and ALLI NELSON, a minor,

Appellants,

v.

GEICO GENERAL INSURANCE COMPANY, an insurance company,

Respondent.

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OPENING BRIEF OF APPELLANTS

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ORIGINAL

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## *INTRODUCTION*

While walking with her mother on a sidewalk, Appellant Alli Nelson suffered a crippling foot-injury when a car driven by a fleeing criminal hit her. Her parents, Appellants Chris Nelson and Rebecca Wirtel, both had coverage with Geico General Insurance Company (Geico) for injuries caused by underinsured motorists (UIM). Appellants were unsophisticated in insurance and initially assumed their personal auto insurance policies would not apply to Alli's injury. As a result, they waited four months to notify Geico.

Because the driver did not have insurance, Appellants' UIM coverage provided that Geico must compensate Alli for her medical expenses, pain, and suffering. When Geico was notified of the claim, it had a duty to promptly investigate the claim and promptly make a fair settlement offer to Appellants. This duty arose from the general duty of good faith and from WAC 284-30-330(6).<sup>1</sup>

The total policy limits for the UIM claim was \$25,000. Upon learning of the claim, Geico did not inform Appellants of the policy limits or discuss settlement of the claim. Geico failed to make any settlement

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<sup>1</sup> It is an unfair practice to do the following: "Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." WAC 284-30-330(6).

offer until *at least* 13 months after the date it was notified of the injury. Geico has not presented any excuse for its delay.

Because Alli is a minor, Geico filed a minor settlement approval action about 14 months after it was notified of the claim. But Appellants were not aware of any settlement and were confused about what Geico was doing. They were also frustrated because they could not afford the massage therapy and acupuncture treatment that Alli needed to alleviate her pain. As a result, they retained attorney Joel Hanson to investigate what benefits were available. Finally, more than two years after the date of the injury, Geico made an explicit, written offer of the full policy limits of \$25,000. If Geico had offered this money earlier, Appellants could have placed the money in a bank account, accumulated interest, and paid for Alli's pain treatment.

At a summary judgment hearing, Geico successfully argued that it did not have a duty to make a settlement offer to Appellants. Geico also successfully argued that its delay in settlement was harmless. The Superior Court granted summary judgment in favor of Geico and dismissed Appellants' claims of breach of the duty of good faith, violation of the Consumer Protection Act, and violation of the Insurance Fair Conduct Act.

### ***ASSIGNMENTS OF ERROR***

1. The Superior Court erred in dismissing all claims against Geico based on its ruling that there was no duty to make a settlement offer during an insurance claim.
2. The Superior Court erred in dismissing all claims against Geico based on its ruling that Appellants were not harmed by Geico's delay in making a settlement offer.

***ISSUES PERTAINING TO ASSIGNMENTS OF ERROR***

This appeal raises the following questions of law:

1. Does an insurer have a duty to make a prompt settlement offer pursuant to WAC 284-30-330(6), the duty of good faith, the Consumer Protection Act (CPA), and the Insurance Fair Conduct Act (IFCA)? Yes.
2. When an insurer waits more than a year to make a settlement offer, fails to inform its insureds of the available insurance funds, and fails to explain what is necessary to obtain those funds, does that insurer violate the WAC claim handling regulations, the duty of good faith, the CPA, and the IFCA? Yes.
3. When an insured's receipt of settlement funds is delayed by more than a year, the insured loses more than one year of bank interest on those funds, is forced to forgo medical treatment without those funds, and hires an attorney in response to the delay, is that sufficient harm to sustain the claims of breach of the duty of good faith, violation of the CPA, and violation of the IFCA? Yes.

***STATEMENT OF THE CASE***

***A. Alli Nelson's Foot is Crushed by a Stolen SUV Fleeing on the Sidewalk.***

On May 30, 2011, Rebecca and her 9-year-old daughter, Alli, were walking in downtown Seattle. CP 198-199. Unknown to them, a stolen

sports utility vehicle (SUV) was speeding in their direction.<sup>2</sup> The driver swerved onto the sidewalk in order to evade police. *Id.* Rebecca did not see the SUV until it was just behind her. CP 199. Rebecca pulled Alli out of the way and saved her life. However, despite Rebecca's efforts, Alli's foot was crushed under one of the tires. CP 199.

Alli was rushed to Harborview Medical Center, where they performed 9 surgeries and kept her in the hospital for the next 18 days. CP 200. During the three years since the accident, Alli has received numerous additional surgeries to her foot. CP 200. For example, as she grows, the pins and other hardware in her foot need to be removed or replaced. CP 200.

Alli was discharged from Harborview on June 17, 2011. CP 200.<sup>3</sup> Soon after that discharge date, her parents received a record of charges for \$139,438 for the care Harborview had provided. CP 200 and 204. Alli continues to need treatment and her medical expenses have exceeded

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<sup>2</sup> *Young victim on the mend as police search for hit-and-run driver*, KOMONews.com, August 3, 2011.

Available at:

<http://www.komonews.com/news/local/126740823.html?tab=video&c=y>

Also available at:

<https://web.archive.org/web/20150302234449/http://www.komonews.com/news/local/126740823.html?tab=video&c=y>

<sup>3</sup> Wirtel's declaration contains a typographical error and indicates April instead of June. CP 183, n.1.

\$200,000. CP 200 Alli will need additional surgeries as her foot outgrows the pins and other hardware that have been inserted. CP 200. She continues to need crutches for walking and cannot run or play sports. CP 200.

Most of Alli's medical treatment was covered by a basic health insurance plan through the State of Washington, but some of her treatment was not covered and Appellants could not afford to pay for it. CP 206. Alli was forced to forgo treatments such as massage therapy and acupuncture not covered by Alli's health insurance plan. CP 206.

The alarming nature of Alli's story drew attention from the local news media.<sup>4</sup>

***B. Appellants Are Unaware that Their Insurance with Geico Covers Alli's Injury***

Chris and Rebecca had separate automobile insurance policies with Geico that included coverage for Uninsured Motorists (UIM) such as the hit-and-run driver that struck Alli. They also had Personal Injury Protection (PIP) coverage that covered medical bills. Rebecca and Chris

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<sup>4</sup> ***Young victim on the mend as police search for hit-and-run driver***, KOMONews.com, August 3, 2011.

Available at:

<http://www.komonews.com/news/local/126740823.html?tab=video&c=y>

Also available at:

<https://web.archive.org/web/20150302234449/http://www.komonews.com/news/local/126740823.html?tab=video&c=y>

did not share a policy because they were divorced and did not live together. It is undisputed that Alli's injury was covered under both policies because she was a relative of both Chris and Rebecca.

Initially, Appellants did not notify Geico of Alli's injury because they did not realize that their auto insurance would apply. *See* CP 205-06. Later, the staff at the Washington State Crime Victim's Compensation Fund informed Chris that Geico might cover the injury. CP 205-06. He notified Geico immediately. CP 205-06. This notification occurred on August 10, 2011. CP 563. Which was about 70 days after the collision.

Upon being notified of the claim, Geico agreed to pay for Alli's medical expenses under the PIP coverage. *See* CP 206 at lines 5-6. The PIP limits of the two policies were \$35,000 and \$10,000. CP 38 and 62; CP 68 and 92. This \$45,000 in PIP coverage was not nearly enough to pay for Alli's medical bills.

***C. Geico Fails to Inform Appellants that the UIM Funds Are Available and Waits More than a Year to Make Any Settlement Offer***

The UIM coverage for Chris and Rebecca was limited to \$25,000. CP 38 and 68. This was a small fraction of the special and general damages suffered by Alli. There should have been no dispute that Appellants were entitled to the full \$25,000 available because personal injury victims may recover damages for their medical expenses, pain, suffering, loss of

enjoyment of life, and disability.<sup>5</sup> The funds available were not enough to cover Alli's six-figure medical expenses let alone compensate her for pain, suffering, disability, and loss of enjoyment of life. Accordingly, Geico should have immediately determined that Appellants were entitled to the full \$25,000.

Despite this clear liability, Geico never informed Appellants that these UIM funds were available. CP 206 at ¶ 3. Appellants were only informed of the PIP coverage. *Id.* For reasons that Geico has never explained, Geico never made a UIM settlement offer to Appellants. *Id.*

Chris was responsible for handling Appellants' communications with Geico. When Geico's employees called Rebecca, she referred them to Chris and told them he was handling the insurance issues. CP 200-01 at ¶ 10. There is evidence that, after waiting about 16 months from the date of the injury, Geico asked Chris and Rebecca if they were interested in an unspecified settlement. CP 201 at lines 3-6; *see also* CP 70 at lines 15-20. But there is no evidence that Geico ever made an explicit monetary offer to Rebecca or Chris. Rebecca does not recall Geico doing so. CP 200-01 at ¶ 10-13. Chris testified that they never made an explicit offer. CP 206 at ¶ 3.

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<sup>5</sup> A personal injury victim is may recover general damages "including, but not limited to pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress . . ." RCW 4.56.250. Loss of enjoyment of life is also compensable. WPI 30.05.

Appellants were not informed of a specific settlement amount offered by Geico until after they had retained an attorney, Joel Hanson. *Id.* Hanson was retained on May 23, 2013, which was two full years after the injury. CP 729.

***D. Appellants Are Harmed by Geico's Failure to Inform Them of the Existence of the UIM Funds and Failure to Offer Those Funds***

Geico's failure to offer the available funds to Appellants delayed their receipt of the funds by more than a year. *See* CP 201 at line 19; CP 206 at ¶3. It is indisputable that if Geico had immediately offered the funds, Appellants could have placed those funds in an interest-bearing savings account. *See* VRP 32 at lines 3-6. Accordingly, Geico's delay reduced the bank interest that the Appellants received.<sup>6</sup>

Geico's delay also harmed Alli's ability to afford treatment. The PIP funds from Geico were rapidly exhausted and, without the use of the UIM funds that Geico was secretly holding, Appellants could not afford to pay for certain treatments needed by Alli that were not covered by Medicaid.<sup>7</sup> CP

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<sup>6</sup> After litigation was commenced, those settlement funds were obtained by Appellants and placed in an interest-bearing bank account.

<sup>7</sup> Most of Alli's medical treatment was covered by a basic health insurance plan through Medicaid and the State of Washington, but some of her treatment was not covered by that health insurance and Plaintiffs could not afford to pay for it. CP 206 at ¶ 5. That uncovered treatment included massage therapy and acupuncture. *Id.*

206-07 at ¶ 5-6. After the PIP funds were exhausted, Chris spent some of his own money to pay for some of Alli's massage therapy. CP 1003 at lines 8-13. But Chris and Rebecca could not afford to pay more. CP 207. As a result, Alli was forced to suffer pain that could have been avoided. CP 201 at ¶ 13.

***E. Geico Concedes that No UIM Settlement Offer Was Made for More than a Year***

Geico's internal notes associated with Chris Nelson's insurance policy show that Geico was notified of Alli's injury on August 10, 2011. CP 563.<sup>8</sup> A 3:16 p.m. note states that "Coverage was not explained because Cov[erage] pending". CP 563. Geico was uncertain if there was coverage. Its abbreviated notes say it "adv[ised]" Chris that "since the ped[estrian] [is] not on policy [we] will invest[igate] if cov[erage] extends to ped[estrian] – st[ated] ped[estrian] is daughter, lives with ph [policy holder]." CP 565. Ultimately, Geico conceded that Alli's injury was covered under the UIM provisions in both Chris and Rebecca's policy. *See* CP 577. Accordingly, there is no dispute concerning the applicability of that UIM coverage. *See* CP

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<sup>8</sup> Geico's notes are in reverse chronological order. The earliest entry for Nelson's policy is the August 10, 2011 3:06 p.m. entry that states "New loss". CP 563.

577.<sup>9</sup>

Geico's notes also indicate initial confusion about whether Chris was represented by an attorney.<sup>10</sup> At the time, he was consulting with attorney Chris Carney about filing a suit against the city's police department for negligently pursuing the hit-and-run driver prior to the collision. *See* CP 558. No such suit was ever filed. When asked, Carney informed Geico that he did not formally represent Chris or Rebecca. CP 574 at lines 19-20.

Geico also generated a separate string of internal claim notes associated with Rebecca's policy.<sup>11</sup> Those notes show that Geico opened a

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<sup>9</sup> In its motion for summary judgment, Geico argued that "GEICO promptly paid Plaintiffs entire available Personal Injury Protection ('PIP') benefits and tendered Plaintiffs' full available Underinsured Motorist ('UIM') benefits to the Plaintiffs. . . ." CP 577.

<sup>10</sup> For an unknown reason, some of Geico's digital notes indicate that Joel Hanson, Appellants' current attorney, was involved during the first days of the claim. But that is impossible because Hanson had not even met Appellants until about two years later, in 2013. It appears that those electronic notes were edited sometime after Hanson became involved, possibly as a result of a mistaken attempt by Geico to correct the names and addresses of attorneys it had on record.

<sup>11</sup> Those notes for Rebecca's policy list the insured as "Michael Scott Craft". Craft was Rebecca's husband and was the first named insured on Rebecca's policy. All of Geico's notes for Rebecca's policy are located at CP 787-834. All of Geico's notes for Chris' policy are located at CP 836-932.

separate claim under Rebecca's policy on September 26, 2011.<sup>12</sup> CP 567-68. On that same day, Geico was informed that there was no insurance for the driver's vehicle because the vehicle had been stolen and the owner's insurance company had denied coverage. CP 570. That September 26 note also shows that Geico was aware Alli's injuries had resulted in more than "150k" in medical expenses. The note also demonstrates that Geico knew Alli had suffered a "severe crushed foot injury" requiring 18 days of hospital care. CP 570.

Geico acknowledged that Plaintiffs' PIP coverage applied to Alli's medical expenses. CP 206 at ¶ 3. But it did nothing to investigate, settle, and pay the UIM claim. The \$25,000 coverage limit was a small fraction of Alli's medical expenses and general damages. It should have taken a few minutes for Geico to calculate that it owed Appellants the full policy limits. But Geico did not promptly offer the policy limits to Appellants. CP 206 at ¶ 3-4; *see also* CP 200-01 at ¶ 10-11. Nor did Geico explain to Appellants that such funds existed. *Id.*

Geico has conceded that it did not make any settlement offer within a year of being notified of Appellants claims. *See* CP 573 at lines 11-19. Geico has stated that its first UIM settlement offer was extended in writing on

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<sup>12</sup> That note, at 4:41 p.m., states that this is a "New loss" and a "New Claim." CP 567.

October 26, 2012, which was about 14 months after Geico was notified of the claims. *Id.* During the subject litigation, Geico was unable to produce a copy of the written settlement offer it claims to have sent Appellants. CP 943-44 at lines 25-1. Appellants have testified that they never received such an offer. CP 206 at ¶ 3; CP 200-01 at ¶ 10-13.

During the litigation, Geico produced almost 150 pages of internal notes associated with the claim. CP 787-932. The vast majority of those notes appear to be automated entries associated with the payment of individual medical expenses under the PIP coverage. The notes do not contain a single entry where a Geico employee states that they made a specific dollar-value settlement offer to Chris or Rebecca. CP 787-932. This fact is not in dispute and it is the reason that Geico concedes it did not make a settlement offer during the first 14 months after being notified of the claim.

Geico's internal notes indicate that, approximately 13 months after notification of the claim, there was a telephone discussion with Chris concerning settlement. But there is no evidence that an explicit offer was actually made. On September 12, 2012 at 12:42 p.m., Geico's notes show that it finally discussed the possibility of settlement with Chris. CP 607. The note states that:

I have updated ciq based on the records we received under the PIP on this claim for Allis Nelson; policy limits are \$25k, crime victims is also involved. [T]here is another UM policy

under the child's mom's policy. Nikki is handling that policy. [T]he dad is ready to settle the claim for his daughter, he advised they are not represented by an attorney . . . .

CP 607. It does not appear that Geico actually made a settlement offer to Chris that day, because Geico reduced its anticipated settlement amount after the conversation with Chris. Geico's notes show that five hours later, at 5:42 p.m., Geico determined there was a "New Available Reserve Amount: \$12,500". CP 607. This is because Geico determined that the 'anti-stacking' provisions in Chris and Rebecca's policy meant that each policy should only pay out \$12,500 even though each policy had a UIM limit of \$25,000.

During litigation, Appellants' sent an interrogatory asking for the precise amount Geico offered them during the claim, but Geico declined to answer that part of the question. CP 573 at lines 11-19. Geico's interrogatory answers also failed to provide a reasonable explanation for Geico's extensive delay in offering the policy limits to Appellants. CP 572 at lines 4-12. Appellants asked why there was a delay in payment under the UIM coverage, but Geico's answer did not address the UIM coverage and instead focused on payments made under the PIP coverage. *Id.*

***F. Appellants Retain an Attorney When They Learn Geico Has Initiated a Settlement Approval Action Without Informing Them***

Alli's legal status as a minor meant that the parties needed court approval for any settlement. *See* SPR 98.16W. But Geico never informed the

Appellants about this process. CP 206 at ¶ 4; CP 201 at ¶ 11. If Appellants had been told that Geico was offering them the policy limits, that they needed to accept the offer to move the process forward, and that a court's approval was also needed, they would have accepted the policy limits and promptly participated in the approval process. CP 206 at ¶ 4; CP 201 at ¶ 12. But Geico never communicated any of this. *Id.*

On April 18, 2013, Chris received a notice of a hearing date for a case titled "The Settlement of Alli Nelson." CP 734-36. That action had been filed by Geico in order to seek a trial court's approval of a settlement with Alli. But Chris and Rebecca were unaware of any settlement, and Geico had not explained what it was doing. *See* CP 206 at ¶ 3-4; CP 201 at ¶ 11-12. Apparently, someone inside Geico's bureaucracy noticed that there had been a prolonged delay in the settlement process despite there being no dispute that Geico should have offered the full \$25,000 policy limits. That unknown person then decided to move forward with the court approval process without first reaching a settlement agreement with Appellants. But Appellants were never told this and had no idea who had filed the court case or what it was about. (*See* CP 206 at ¶ 4; *see also* CP 201 at ¶ 11-12.)

Upon seeing that an unknown case had been filed in the name of their daughter, Chris and Rebecca knew they needed an attorney's help. On May 23, 2013, Appellants met with attorney Joel Hanson and signed a

contract for him to assist them with any claims arising from Alli's injury. CP 729-32. The contract allowed Hanson to charge Appellants by the hour on a contingent basis.<sup>13</sup> *Id.*

***G. Geico Informs Appellants' Attorney that it is Seeking Approval for a \$25,000 Settlement, But Geico Cannot Find One of the Insurance Policies***

*Note:* The following facts are included in this opening brief in response to Geico's arguments made to the Superior Court. Geico argued that Hanson's actions after his retention on May 23, 2013 somehow rendered harmless the wrongful conduct by Geico that occurred prior to Hanson's retention.

After Appellants retained Hanson, he contacted Geico's attorney, Morgan Chaput, in an effort to learn who had filed the case titled "The Settlement of Alli Nelson" and what the coming hearing would decide. *See* CP 738. On May 30, 2013, Geico responded to Hanson with a phone call and an email. CP 738. Hanson immediately requested that Geico refrain from any filings or hearings until Hanson learned the details of the ongoing action. CP 740. Hanson asked that Geico postpone the hearing date by 30 days. CP 744. Geico then moved the hearing to July 29, 2013. CP 746.

On June 20, 2013, Hanson sent an email to Chaput that asked how

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<sup>13</sup> The contract provided that Hanson's hourly fee was contingent and would not be paid unless Appellants recovered money for Alli's injury.

much Geico had paid Appellants to date and what was the settlement for which Geico was seeking approval. CP 748. Hanson also requested copies of the applicable insurance policies for Chris and Rebecca. *Id.*

Chaput sent an email explaining that there was a \$25,000 settlement agreement based on the UIM coverage limits in the two policies. CP 750. This is the first time that Geico ever put a settlement offer or agreement in writing. And it is the first time that Appellants learned how much Geico was offering. *See* CP 206 at ¶ 3; *see also* CP 201.

Unfortunately, Chaput was not able to locate both policies in order to confirm the coverage limits. CP 750. Chaput informed Hanson that he should contact Geico adjuster Melanie Cron for more information. CP 750.

Hanson immediately sent an email to Cron asking for the basic details of any payments and the settlement. CP 752. Hanson also requested the policy that Chaput had been unable to locate. CP 752.

20 days later, on July 9, 2013, Cron finally responded and apologized for the delay.<sup>14</sup> CP 754. Cron said she only had access to one of the policies, and would need to contact someone else to locate the other

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<sup>14</sup> Washington law required that Cron respond within 10 working days. WAC 284-30-360(3) provided: “For all other pertinent communications from a claimant reasonably suggesting that a response is expected, an appropriate reply must be provided within ten working days for individual insurance policies. . . .”

policy. *Id.* Cron did not know what Geico employee was responsible for the other policy and claim. *Id.* She asked Hanson if he knew the claim number so she could attempt to contact the appropriate person. *Id.*

That same day, Hanson asked Cron some clarifying questions about how much money had been paid, including whether Geico had yet paid the settlement money. CP 756.

Cron informed Hanson that Kristine Bovee was handling Rebecca's policy and claim. CP 760. Cron then sent another email saying she had gotten the policies confused. CP 762. Cron said she was requesting the other policy and would provide it "shortly". *Id.*

A month later, on August 13, 2013, Hanson sent a letter to Bovee and Cron expressing frustration that he still had not received a copy of both policies. CP 765. Hanson asked Bovee the same questions he had asked of Cron. *Id.*

On August 22, 2013, Hanson sent a letter confirming he had received copies of both policies. CP 768. This was almost two months after Hanson had first requested them.

***H. Appellants' Attorney Request that Geico Stack the Insurance Policy Limits and Pay \$50,000***

On August 22, 2013, after receiving both policies, Hanson asked Geico to pay \$50,000 for the combined ("stacked") UIM policy limits of

both policies. CP 768.

On September 11, 2013, the court-appointed Settlement Guardian Ad Litem (SGAL), Laura Jaeger, sent an email to Hanson and Chaput stating she could not finalize her report until all issues had been resolved. CP 744. She asked that the coming hearing be delayed. *Id.*

On October 9, 2013, Hanson sent Geico a notice that it had violated the Insurance Fair Conduct Act and requested “immediate payment of all sums due under the policy.” CP 778. Hanson stated that it appeared that Geico owed an additional \$50,000. *Id.*

***I. Appellants File a Lawsuit***

On November 26, 2013, Hanson spoke with Jennafer Swearingen, another Geico employee. CP 780. Hanson asked whether Geico was willing to pay the undisputed \$25,000 without requiring Appellants to waive their position that Geico might actually owe \$50,000. CP 780. Swearingen stated that Geico would not agree to payment of the \$25,000 because Appellants were taking the position that Geico might owe more. CP 780. Hanson sent a letter to Swearingen confirming this conversation. *Id.*

The next day, on November 27, 2013, Appellants filed the underlying action in King County Superior Court. CP 1. Appellants sought compensation for Geico’s delay in the settlement and payment of the UIM claims. CP 1-5.

***J. After the Lawsuit is Filed, Geico Agrees to Pay the Undisputed \$25,000 and Proceed with the Court's Approval of that Settlement***

After Geico was served with the lawsuit, it changed its position and agreed to proceed with the approval and payment of the undisputed \$25,000 despite Appellant's position that \$50,000 might actually be available. On December 5, 2013, Swearingen sent a letter stating that Geico would allow an undisputed \$25,000 settlement to proceed and also allow for the possibility of a total payment of \$50,000 "if it is determined that additional coverage is available". CP 782. That same day, Geico attorney Paul Crowley sent Hanson a letter confirming that Geico was willing to pay the undisputed \$25,000 "without compromising your client's right to litigate the coverage question". CP 784.

The parties then proceeded with the approval process of a \$25,000 UIM settlement while Plaintiffs pursued the underlying action against Geico.

***K. Geico Moves for Summary Judgment***

Geico filed a motion for summary judgment on March 13, 2014. CP 20. On April 18, 2014, the Superior Court ruled on Geico's motion for summary judgment. CP 462. The Superior Court found that the insurance contracts contained enforceable anti-stacking language which limited the available UIM funds to a total \$25,000. CP 462. The Superior Court declined to rule on Appellants' other contractual and extra-contractual claims. CP

462.

On June 13, 2014, Appellants filed a motion for partial summary judgment seeking a finding that Geico had violated the WAC insurance claim handling regulations. CP 536 and 538. That same day, Geico filed its second motion for summary judgment, which sought dismissal of all Appellants' claims. CP 577. Geico argued that it had "provided all PIP and UIM benefits to Plaintiffs without delay". CP 581 at line 23.

On June 30, 2014, Appellants filed a response to Geico's motion for summary judgment. CP 630. Appellants cited *Anderson v. State Farm Mut. Ins. Co.*, 101 Wn. App. 323, 332-33, 2 P.3d 1029 (2000) as authority for the proposition that a delay of 10 or more months in disclosing UIM benefits and attempting to settle a UIM claim is bad faith as a matter of law. CP 630, 636, 642, 643, 644-45.

On July 11, 2014, the Superior Court heard oral argument on both Appellants' and Respondent's motions for summary judgment. VRP 1. Counsel for Respondent asserted that Geico had made a settlement offer on September 12, 2012, approximately 13 months after the date that Geico was notified of the injury. VRP 6-7. Geico argued that its delay in making a settlement offer was due to the non-responsiveness of Joel Hanson, counsel for Appellants. VRP 6-8 at lines 6-25. But Hanson had no involvement with the claim until he was retained by Appellants on May 23, 2013, which was

many months after Geico's delay. CP 729; *see also* CP 946 at lines 6; *see also* CP 940-41 at lines 14-12.

***L. At the Summary Judgment Hearing Geico Falsely States that an Insurer Has No Duty to Make a Settlement Offer, and the Superior Court Agrees***

While making its reply statement during oral argument, Geico represented to the Superior Court:

Your Honor, there's no WAC other provision, case law, statute that says that an insurer must make a UIM settlement offer. Plaintiff hasn't cited one. There's no such thing. There's no duty to just start offering, so.

VRP 26-27 at lines 21-3. Geico's motion for summary judgment and reply brief contained no such argument. CP 577-90 and 694-699. The hearing was the first time that Geico made such an argument. *See id.* This argument was repeated by Geico several times during the hearing. *See, e.g.,* VRP 32 at lines 7-8 ("Geico has no duty to make a settlement offer."). Geico also re-asserted its argument that there was "no delay" and that, even if there was a delay, Hanson and another attorney were responsible for any delay that had occurred. VRP 27 at lines 6 and 12-18.

Though Plaintiffs has also filed a motion to be heard that day, they were not allowed make a reply statement, which the Superior Court characterized as a "surreply". VRP 33 at lines 19-21.

The Superior Court agreed with Geico that there was no duty to

make a settlement offer. VRP 34 at lines 4-7. “I don’t think that the statute or the WAC says that they have to offer settlement within 30 days; they just have to complete their investigation within 30 days.” *Id.* The Superior Court explained that Geico’s failure to explain the SGAL process was inconsequential because “it was going to be halted anyway because when [Hanson] entered the case, [he] said, ‘All settlement negotiations are off, you know, we want the 50.’”

On July 11, 2014, the Superior Court dismissed all of Appellants’ claims except for their Consumer Protect Act claim. CP 710-11.

***M. After the Hearing, Appellants Provide Authority that Insurers Have a Duty to Make Settlement Offers, But the Superior Court Rejects the Authority as Untimely***

Three days later, on Monday, July 14, 2014, Appellants filed a motion for reconsideration and cited WAC 284-30-330(6) as authority that Geico was required to make a prompt settlement offer. CP 716-17.

On July 30, 2014, the Superior Court issued an order that denied Geico’s motion for summary judgment concerning the CPA claim. CP 943-944. The Superior Court agreed with Appellants that WAC 284-30-330(6) was authority that Geico was required to make a prompt settlement offer. CP 943. The Superior Court noted that there was evidence that Appellants were harmed because Geico delayed their ability to afford Alli’s massage and acupuncture treatments. CP 944.

That same day, the Superior Court issued an order denying Appellants' motion for reconsideration on their IFCA and bad faith claims. CP 945-46. This second order appeared to contradict the Superior Court's first order filed on that day. The Superior Court stated that Appellants had failed to preserve their argument that Geico had violated WAC 284-30-330(6) because they had not cited that WAC in their original motion for summary judgment. CP 946 at lines 17-21. The Superior Court also found there was "no evidence that they sustained any damages" when Geico failed to inform them of their UIM benefits. CP 946 at lines 12-17.

Defendant then filed a motion for reconsideration concerning the Superior Courts refusal to dismiss Appellants' CPA claim. CP 949. Defendant again argued that there was no evidence Appellants were harmed by the delay by Geico in making a settlement offer and paying their claim. *Id.* On September 5, 2014, the Court denied Geico's motion for reconsideration. CP 1023. The Court explained that the cost incurred by Appellants to retain an attorney to investigate Geico's unfair or deceptive practice was sufficient harm to support a CPA claim. CP 1023.

On September 15, 2014, Geico filed a motion for clarification and/or certification for discretionary review. CP 1036. Geico again argued that Appellants had not presented any evidence of harm. *Id.* On September 26, 2014, the Superior Court granted Geico's motion for clarification and

dismissed Appellants' CPA claim. CP 1094-95. That was Appellants' sole remaining claim. The Superior Court explained that attorney fees incurred by Appellants could not constitute harm because their attorney had used a contingent fee agreement. CP 1095.

Appellants filed a motion for reconsideration. CP 1089. The Superior Court denied that motion. CP 1096.

This appeal follows.

### *ARGUMENT*

Geico successfully argued that it did not have duty to make a settlement offer to Appellants. This is contrary to law. Geico had both a statutory and a common law duty to make a prompt, good faith settlement offer. If it were otherwise, insurers could delay payments indefinitely simply by withholding settlement offers from unsophisticated claimants. Washington common law provides that insurers have a quasi-fiduciary duty of good faith to their customers during the claim investigation and payment process. Washington statutory law requires that insurers make efforts to effectuate the prompt settlement of insurance claims.

Geico also successfully argued that any delay in settlement was harmless. But Geico's lengthy delay of the settlement process delayed Alli's ability obtain the insurance funds. Washington law is clear that the loss of use of funds is sufficient to establish harm. Here, Appellants' loss of use of

the funds caused them to 1) lose more than a year of bank interest, 2) pay their own money for medical treatment, and 3) forgo medical treatment that they could not afford. This harm was sufficient to preserve Appellants' claims.

Geico also argued, without any citation to the record, that Hanson's involvement caused the delay during the first year. But Hanson was not involved until two years after the injury. If Geico's argument is to be entertained, it is a question of fact that cannot be decided as a matter of law.

**A. *Standard of Review for Summary Judgment***

Appellate review of a Superior Court's decision on summary judgment is de novo. *Jones v. Allstate Ins. Co.*, 146 Wn.2d 291, 300-01, 45 P.3d 1068 (2002). The appellate court performs the same inquiry as the Superior Court. *Id.* The court considers the facts and the inferences from the facts in a light most favorable to the nonmoving party. *Id.* The court may not grant summary judgment unless the pleadings, affidavits, and depositions establish that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. *Id.*

**B. *This Case Is Very Similar to Anderson v. State Farm***

In *Anderson*, the insurer informed their customer of PIP benefits for the medical expenses, but did not inform her of the UIM coverage.

*Anderson*, 101 Wn. App. at 327. Appellants allege the same thing happened to them. In *Anderson*, the injured customer did not learn of their UIM coverage until they retained an attorney eight months after the accident. *Id.* at 327-28. Appellants allege the same thing happened to them. They did not learn of the available funds under the UIM coverage until they retained Hanson about two years after the injury.

In *Anderson*, the insurer did an investigation but did not open a UIM file until the customer's attorney contacted the insurer 10 months after the injury. *Id.* at 327-28. The insurer finally made its first settlement offer about 16 months after the injury. *Id.* at 328. Division I of the Court of Appeals found that the insurer's delay in informing the customer of her UIM coverage was bad faith as a matter of law and violated the CPA as a matter of law.<sup>15</sup> *Id.* at 330-33. That ruling reversed the trial court's ruling, which had dismissed those claims. *Id.* at 339. The Court of Appeals also found that a 10-month delay in payment of a UIM claim was sufficient harm to preserve those claims. *Id.* at 333.

In *Anderson*, the insurer had an excuse for its lengthy delay. *Id.* 326-27. The insurer relied on a police report to find that there was no uninsured driver involved in the accident and, accordingly, there was no

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<sup>15</sup> The *Anderson* decision did not address the IFCA because that statute did not exist until 2007, which was seven years after *Anderson*.

UIM coverage. *Id.* 326-27. While this was unreasonably self-serving, it did explain why no settlement offer was ever made.

In this case, Geico has not even offered an excuse for its delay in making a settlement offer. The facts in Appellants' claim are even more egregious than the facts in *Anderson*. The delay was longer and, unlike *Anderson*, there was never any dispute that Alli was entitled to the full UIM policy limits.

The precedent set by *Anderson* should be followed. During the litigation, Geico never cited any authority that contradicted or distinguished *Anderson*. The summary judgment dismissal of Appellants' bad faith, CPA, and IFCA claims should be reversed. Like *Anderson*, this Court should find that Geico's conduct violated the duty of good faith, the CPA, and the IFCA as a matter of law and instruct the Superior Court to enter partial summary judgment on that issue. *Id.* at 339.

***C. Insurers Owe a Quasi-Fiduciary Duty to their Customers During the Claim Settlement Process***

A fundamental conflict of interest exists when insurers engage in the claim settlement process. The insurer controls that process and is obligated to pay the full amount of a claim, but the insurer's profit motive creates a compelling incentive to delay and underpay claims at every opportunity. Accordingly, Washington law provides that "an insurance

company has a quasi-fiduciary duty to its insured and that insurance contracts, practices, and procedures are highly regulated and of substantial public interest.” *Cedell v. Farmers Ins. Co. of Washington*, 176 Wash.2d 686, 698, 295 P.3d 239 (2013). Washington insurance contracts and regulations should be interpreted in light of this quasi-fiduciary duty. This quasi-fiduciary duty is often referred to as the duty of “good faith”.<sup>16</sup> An insurer is liable for bad faith if its actions during the claim settlement process were unreasonable, frivolous, or unfounded. *Mut. of Enumclaw Ins. Co. v. Dan Paulson Const., Inc.*, 161 Wn.2d 903, 916, 169 P.3d 1 (2007). Such a breach of the duty of good faith sounds in tort. *Id.* at 915. This duty of good faith establishes the general standard by which insurers must behave during the claim settlement process.

***D. The WAC Claim Settlement Regulations Establish Strict Standards in Addition to the General Duty of Good Faith***

In addition to the general duty of good faith, there are strict statutory standards that insurers must follow during the claim settlement process.

**1. Insurers Must Promptly Investigate the Claim and Make a Reasonable Determination of the Amount Owed**

Washington’s insurance regulations provide that it is an unfair or deceptive act when an insurer fails to investigate a claim within 30 days.

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<sup>16</sup> The duty to act in good faith and liability for acting in bad faith refer to the same obligation.

The insurance regulations provide:

Every insurer must complete its investigation of a claim within thirty days after notification of claim, unless the investigation cannot reasonably be completed within that time. All persons involved in the investigation of a claim must provide reasonable assistance to the insurer in order to facilitate compliance with this provision.

WAC 284-30-370. In this context, ‘investigation’ includes the insurer’s valuation of the loss and the amount owed by the insurer. The regulations provide:

‘Investigation’ means all activities of the insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

WAC 284-30-320(9). The Washington Supreme Court has explained:

[A]n insured receives more for its premium than just the possibility its claim will be covered when appropriate. In the relationship between the insured and insurer, the insurer receives both the premium and control over the arrangement. In first party situations, the insurer establishes the conditions for making and paying claims. The insurer evaluates the claim, determines coverage, and assesses the monetary value of the coverage.

*Coventry Associates v. American States Ins. Co.*, 136 Wn.2d 269, 283 (1998) (emphasis added). Further, the “insurer is required to fulfill its contractual and statutory obligation to fully and fairly investigate the claim.” *Id.* at 279.

Geico violated WAC 284-30-370 when it failed to determine that Appellants were entitled to the policy limits within 30 days of learning of Alli's catastrophic injury and six-figure medical expenses.

## **2. Insurers Must Disclose All Available Insurance Benefits**

The insurance regulations provide:

No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

WAC 284-30-350(1). Geico violated this provision when it failed to promptly disclose the UIM benefits available to Plaintiffs and failed to promptly offer the full \$25,000 benefit to them.

## **3. Insurers Must Attempt to Promptly and Fairly Settle Claims**

An insurer must make a good faith effort to promptly settle claims. WAC 284-30-330(6) provides that it is an "unfair claim settlement practice" to do the following:

Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

It should go without saying that there can be no settlement until the insurer has made a settlement offer. Accordingly, an insurer must make a prompt settlement offer in order to start the settlement process.

Geico violated this regulation when it waited more than a year to make any settlement offer whatsoever. Geico has offered no excuse for this delay. Instead, Geico argued that it had no duty whatsoever to make a settlement offer. Geico's representation of the law during oral argument was incorrect.

The Superior Court's ruling that an insurer has no duty to make a settlement offer is in direct opposition to this regulation.

#### **4. Insurers Must Instruct Claimants on How to Obtain a Settlement**

Geico did not provide Appellants with any instruction or assistance on what they needed to do to initiate and complete the settlement process.

WAC 284-30-360(4) provides:

Upon receiving notification of a claim, every insurer must promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements.

Geico violated this provision when it failed to instruct the Plaintiffs on what they needed to do in order to settle the claim and recover the funds available under their UIM coverage.

**5. Taken Together, the Insurance Regulations Establish a Framework that Requires Insurers to Promptly Settle Claims**

The insurance regulations in WAC 284-30-330 through 380 establish a framework that is intended to prevent insurers from formulating creative excuses for delaying the settlement or payment of claims. The regulations are intended prevent what happened to Appellants.

If an insurer says a settlement was delayed because it had not completed its investigation, that may violate WAC 284-30-370. If an insurer says a settlement was delayed because the claimants were ignorant of the settlement process, that would violate WAC 284-30-360(4). If, as here, an insurer argues that it did not make a settlement offer because no such duty exists, that is a violation of WAC 284-30-330(6).

***E. A Violation of the Claim Settlement Regulations or the General Duty of Good Faith Constitutes Bad Faith, Violation of the CPA, and Violation of the IFCA***

**1. Breach of the Duty of Good Faith Constitutes a Violation of the CPA**

An insurer's breach of the duty of good faith constitutes a *per se* violation of the CPA. *Salois v. Mut. of Omaha Ins. Co.*, 90 Wn.2d 355, 359, 581 P.2d 1349 (1978). As mentioned above, an insurer is liable for bad faith if its actions were unreasonable, frivolous, or unfounded. *Mut. of Enumclaw*

*Ins. Co.*, 161 Wn.2d at 916.

**2. Violation of the WAC Claims Settlement Regulations Constitutes *per se* Bad Faith and a Violation of the CPA**

In addition to the broad duty of good faith, insurers must follow the specific regulations set forth in WAC 284-30-330 through 800. As a matter of law, a violation of any one of the regulations set forth in WAC 284-30-300 through 800 constitutes a breach of the insurer's duty of good faith. *Rizzuti v. Basin Travel Service of Othello, Inc.*, 125 Wn. App. 602, 615-16, 105 P.3d 1012 (2005) citing *Am. Mfrs. Mut. Ins. Co. v. Osborn*, 104 Wn. App. 686, 697, 17 P.3d 1229 (2001).

Also as a matter of law, a single violation of any one of these WAC regulations is an unfair or deceptive act or practice under the CPA. *Anderson v. State Farm Mut. Ins. Co.*, 101 Wn. App. 323, 331, 2 P.3d 1029 (2000) citing *Industrial Indem. Co. v. Kallevig*, 114 Wn.2d 907, 924, 792 P.2d 520 (1990).<sup>17</sup>

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<sup>17</sup> To prevail in a private CPA action, the plaintiff must show that the defendant's conduct met the elements of the *Hangman Ridge* five-part test: (1) an unfair or deceptive act or practice, (2) occurring in trade or commerce, (3) impacting the public interest, (4) injuring plaintiff in his or her business or property, and (5) causation. *Hangman Ridge v. Safeco Title*, 105 Wn.2d 778, 780, 719 P.2d 531 (1986). The first element is met by a violation of WAC 284-30-330 through 800. *Osborn*, 104 Wn. App. at 697. The second and third elements are automatically met in the context of insurance because it is a business which affects the public interest. See RCW 48.01.030. Therefore, in Washington, to prove an insurer violated the CPA, the insured only has to show that the insurer breached one of

**3. Violation of the WAC Claim Settlement Regulations Constitutes Violation of the IFCA**

Geico's violations of the WAC regulations constituted violations of the IFCA. The IFCA statute provides:

A violation of any of the following is a violation for the purposes of subsections (2) and (3) of this section:

- (a) WAC 284-30-330, captioned "specific unfair claims settlement practices defined";
- (b) WAC 284-30-350, captioned "misrepresentation of policy provisions";
- (c) WAC 284-30-360, captioned "failure to acknowledge pertinent communications";
- (d) WAC 284-30-370, captioned "standards for prompt investigation of claims";
- (e) WAC 284-30-380, captioned "standards for prompt, fair and equitable settlements applicable to all insurers"

RCW 48.30.015 (5). Accordingly, a violation of any of the WAC insurance regulations constitutes a violation of the IFCA.

***F. Geico Violated the WAC Regulations, the Duty of Good Faith, the CPA, and the IFCA***

Appellants testified that Geico failed to promptly investigate its own liability and determine what was owed, failed to inform Appellants of

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more of the WAC regulations and that the insured was injured by that breach. *Osborn*, 104 Wn. App. at 697-98.

the UIM benefits available, and failed to make a prompt settlement offer. For the purposes of Geico's motion for summary judgment, Appellants' declarations must be assumed to be truthful and accurate.

Geico has offered no reasonable excuse for its delay. The alleged conduct violated the WAC settlement regulations, which constituted a violation of the duty of good faith, the CPA, and the IFCA. Even if the specific WAC regulations did not exist, it was unreasonable for Geico to delay making a settlement offer for more than a year. This unreasonable delay violated the general duty of good faith, which constituted a violation of the CPA and the IFCA.

There exists a genuine issue of material fact. Accordingly, it was error for the Superior Court to dismiss Appellants' claims for breach of the duty of good faith, violation of the CPA, and violation of the IFCA.

***G. This Court Should Find that Geico Violated the Duty of Good Faith, the CPA, and the IFCA as a Matter of Law***

In addition to Appellants' testimony, Geico has conceded that it did not make a settlement offer for more than a year. Geico has taken the position that it did not make a prompt settlement offer to Appellants because it had no duty to do so. This directly contravenes WAC 284-30-330(6). Additionally, Geico presented no evidence to dispute Appellants'

testimony that Geico waited more than a year to inform Appellants that the UIM funds existed. This was a violation of WAC 284-30-350(1).

In *Anderson*, this Court reversed the Superior Court's dismissal and found that the insurer's delay in informing the plaintiff of her UIM coverage was bad faith and violated the CPA as a matter of law. 101 Wn. App. at 330-33. This Court should follow the precedent it set in *Anderson* and find that Geico violated the WAC insurance regulations and, accordingly, violated the duty of good faith, the CPA, and the IFCA as a matter of law.

#### ***H. Geico's Delay Harmed Appellants***

Under *Anderson*, an insurer's delay in payment of UIM benefits is sufficient to establish injury for the purpose of the CPA and the tort of bad faith. As this Court explained in *Anderson*:

State Farm argues *Anderson* has not proved damage or injury to property because her recovery in the arbitration ultimately made her whole despite the 10-month delay before State Farm opened a UIM file. *Anderson*, however, alleges loss of the interest on the value of her eventual recovery over that ten-month period. She seeks recovery of the attorney fees and costs she expended in initiating the claim. She also claims to have experienced financial penalties attributable to the delay because she and her husband were short of funds to pay bills associated with the accident. Such evidence is sufficient to raise an issue of fact as to economic harm. Moreover, because bad faith is a tort, a plaintiff is not limited to economic damages. . . . In summary, *Anderson* has established

as a matter of law the elements of a bad faith claim and a Consumer Protection Act claim arising from State Farm's failure to disclose the UIM coverage.

*Anderson*, 101 Wn. App. at 333. Here, Appellants have lost more than a year of bank interest that would have been earned on the \$25,000 that Geico owed them. They also lost the ability to pay for medical treatment needed by Alli to alleviate her pain.

**1. Emotional Injury and the Loss of Use of Money Is Sufficient Harm for the Tort of Bad Faith and Violation of the IFCA**

Like other torts, to prevail in a claim for breach of the duty of good faith or violation of the IFCA, the plaintiff must establish that the breach or violation was a proximate cause of some harm.

In Washington, a plaintiff is entitled to recover damages for any injury, including an emotional injury, that is caused by an insurer's breach of the duty of good faith. *See, e.g., Woo v. Fireman's Fund Ins. Co.*, 161 Wn. 2d 43, 70, 164 P.3d 454, 467 (2007) (affirming award of emotional distress damages for breach of duty of good faith despite the fact that there was no expert testimony concerning the emotional distress). Similarly, this Court found that the plaintiff in *Anderson* was harmed by the loss of interest on the insurance proceeds, the loss of her ability to afford medical care, and her general damages. 101 Wn. App. at 333.

IFCA allows the plaintiff to recover “actual damages”. RCW 48.30.015 (1), (2), and (3). Actual damages is not defined, but there is no reason to think that IFCA was intended to provide a more narrow remedy than the tort of bad faith. Washington has previously interpreted “actual damages” in other statutes to include both general and economic damages. “[A]lthough the [Washington Law Against Discrimination] statute does not specify that . . . mental anguish, and emotional distress are within the scope of the term ‘actual damages,’ case authority makes clear that each is compensable under the WLAD.” *Blaney v. Int’l Ass’n of Machinists & Aerospace Workers, Dist. No. 160*, 114 Wn. App. 80, 97, 55 P.3d 1208, 1216 (2002) *aff’d in part on other grounds sub nom.* 151 Wn. 2d 203, 87 P.3d 757 (2004). *See also, Ellingson v. Spokane Mortgage Co.*, 19 Wn. App. 48, 56-57, 573 P.2d 389 (1978) (holding that mental anguish and emotional distress are “actual damages” under WLAD). In addition to the WLAD, Washington interprets “actual damages” to include emotional distress under the Fair Credit Reporting Act. *Rasor v. Retail Credit*, 87 Wn.2d 516 (1976) citing *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 349, 94 S.Ct. 2997 (1974).

## **2. Loss of Use of Money is Sufficient Injury for the CPA**

Unlike the tort of bad faith and the IFCA, emotional distress alone is not a sufficient injury to meet the elements of the CPA. To prevail in

CPA claim, the plaintiff must show that he or she was injured in his business or property as a result of the unfair act. *Hangman Ridge*, 105 Wn.2d at 780. In Appellants' case, their temporary loss of use of the UIM money owed to them is sufficient injury for the purposes of the CPA.

Courts construe the CPA's injury requirement liberally to include any deprivation of money or property, however slight. "The injury element will be met if the consumer's property interest or money is diminished because of the unlawful conduct even if the expenses caused by the statutory violation are minimal." *Mason v. Mortgage Am., Inc.*, 114 Wn.2d 842, 854, 792 P.2d 142, 148 (1990) (where plaintiffs lost use of real property for several months because wrong mobile home was on it, and had to live in a garage apartment for that time, that was sufficient injury to meet CPA element despite the fact that there was no significant monetary expense). The injury need not be quantifiable. *Id.* at 854. "No monetary damages need be proven so long as there is some injury to property or business." *Sorrel v. Eagle Healthcare, Inc.*, 110 Wn. App. 290, 298, 38 P.3d 1024, 1029 (2002) (unlawful retention of pre-paid funds for a period of two weeks by healthcare services provider was sufficient to satisfy CPA injury requirement). "In this case, [Plaintiff] was denied rightful possession of his funds for a period of two weeks. His CPA claim should not have been dismissed for failure to establish injury." *Id.* at 298-99. As

in *Sorrel*, Appellants' acquisition of the money owed to them was delayed. That alone is sufficient injury.

Courts have repeatedly found that the loss of use of property is sufficient injury for the CPA even when there is no quantifiable monetary damage. *See, e.g., Tallmadge v. Aurora Chrysler Plymouth, Inc.*, 25 Wn. App. 90, 93-94, 605 P.2d 1275 (1979) (holding that inconvenience of dealing with defective vehicle and deprivation of use and enjoyment of property were sufficient injury for CPA even though no pecuniary damages were awarded by trial court); *Griffin v. Hartford Ins. Co.*, 108 Wn. App. 133, 148-49, 29 P.3d 777 (2001) ("The Griffins' loss of use of their own money constitutes damages under the CPA.").

At least one case has found that the loss of just a few dollars interest is sufficient injury to meet the elements of the CPA. *Banuelos v. TSA Washington, Inc.*, 134 Wn. App. 607, 614-15, 141 P.3d 652, 657 (2006). In *Banuelos*, a car dealer refused to timely return a down-payment for a car. The Court of Appeals held that \$4.27 in lost interest was sufficient to prove a CPA claim. *Id.*

### **3. Under the *Banuelos* Calculation, Appellants Lost \$3,000 Per Year of Geico's Delay**

In *Banuelos*, the plaintiff was deprived of \$1,000 for 13 days. 134 Wn. App. at 614-15. The decision applied a statutory rate of 12 percent

per year because the parties had not contracted for a specific interest rate. *Id.* This rate was based on RCW 19.52.010 (“Rate in absence of agreement”), which applies a 12 percent interest rate on the “forebearance of money”. If the same interest rate is applied to the \$25,000 owed by Geico to the Appellants, then they lost \$3,000 for each year, or \$250 per month, that Geico delayed making a settlement offer.

**4. This Court Need Not Rule on the Cost of Retaining an Attorney to Investigate Geico’s WAC Violations**

The Superior Court’s inquiry into injury under the CPA emphasized Appellants’ retention of Hanson to investigate what Geico was doing. There is authority that the cost of consulting an attorney is sufficient injury. *Stephens v. Omni Ins. Co.*, 159 P.3d 10, 138 Wn. App. 151 (2007) (holding that the time and expense of consulting an attorney to investigate possible damage to credit rating was a CPA injury); *but see also Sign-O-Lite Signs, Inc. v. DeLaurenti Florists, Inc.*, 64 Wn. App. 553, 825 P.2d 714, 720 (1992) (holding that lost time, outside of litigation, spent dealing with dispute was a CPA injury but that it was error for trial court to treble the money spent on an attorney to litigate the case).

In this case, the Superior Court found that Appellants’ retention of an attorney to investigate Geico’s WAC violations was not an injury because Appellants had retained Hanson on a contingent basis. Appellants

are unaware of authority in support of this ruling that contingent fees should be treated differently than non-contingent fees. But this Court need not decide this issue, because the Superior Court's dismissal of Plaintiffs' CPA can be reversed on other grounds. The loss of use of Plaintiffs' UIM funds, the loss of their ability to use that money to pay for medical expenses, and the loss of interest on that money are all sufficient injuries for the purposes of the CPA, the tort of bad faith, and the IFCA. Additionally, the tort of bad faith and IFCA claims may proceed solely based on the general damages suffered by Appellants for the emotional pain that resulted from their inability to afford medical treatment to alleviate Alli's physical pain in her crushed foot.

***APPELLANTS ARE ENTITLED TO ATTORNEY FEES***

Appellants respectfully request the award of attorney fees and all litigation costs and expenses incurred through this appeal pursuant to RAP 18.1. Appellants are entitled to their attorney fees and litigation costs and expenses from Geico pursuant to the Insurance Fair Conduct Act (RCW 48.30.015) and the Consumer Protection Act (RCW 19.86.090).

***CONCLUSION***

Geico waited more than a year before informing Appellants that they had funds available under their UIM coverage, before making any settlement offer, and before explaining what Appellants needed to do to obtain the

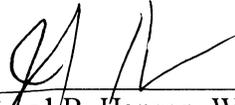
available funds. Appellants have testified they did not learn these things until they retained Hanson, which was two years after Alli's injury. During litigation, Geico stated that it made a settlement offer 13 or 14 months after being notified of the injury. But it did not dispute Appellants' other allegations. Regardless of whether the delay was one year or two years, it was unreasonably long.

Geico has offered no excuse for its delay. Instead, Geico incorrectly argued it had no duty to make any settlement offer at all. As a result of Geico's delay, Appellants lost thousands of dollars in bank interest, lost the ability to pay for medical treatments to alleviate Alli's pain, and did not learn what was happening until they hired an attorney.

The Superior Court's dismissal of Appellant's claims for bad faith, violation of the CPA, and violation of the IFCA should be reversed and remanded for trial. The Superior Court should be directed to enter a partial summary judgment finding that Geico breached the duty of good faith, violated the CPA, and violated the IFCA as a matter of law.

RESPECTFULLY SUBMITTED this 17<sup>th</sup> day of April 2015.

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