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Supreme Court No. 92425-2  
Spokane Co. Superior Court Cause No. 15-2-00436-5

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SUPREME COURT OF THE STATE OF WASHINGTON

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ANASTASIA FORTSON-KEMMERER, an individual,

*Plaintiff-Petitioner,*

vs.

ALLSTATE INSURANCE COMPANY,

*Defendant-Respondent.*

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APPELLANT'S PETITIONER'S OPENING BRIEF

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 ORIGINAL

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## I.

### INTRODUCTION

Anastasia Fortson-Kemmerer (Fortson) was injured in an automobile collision caused by an uninsured motorist, and made a claim for uninsured motorist (UIM) benefits with her insurer, Allstate Insurance Company (Allstate). *See* CP 4-7 (Complaint, ¶¶ 2.1-3.2); CP 11-15 (Answer, ¶¶ 11-15). Allstate repeatedly offered \$9,978 to settle Fortson's UIM claim, despite acknowledging that it had not completed its investigation when it made the offers. *See* CP 5-6 (Complaint, ¶¶ 2.10-2.13 & 2.15); CP 13 (Answer, ¶¶ 13 & 15).

Fortson filed suit to obtain the full UIM benefits to which she was entitled under her policy with Allstate, and she received an award of \$44,151.11 in mandatory arbitration. *See* CP 5-6 (Complaint, ¶¶ 2.14 & 2.17); CP 14 (Answer, ¶ 20). After receiving the award, Allstate offered to settle the UIM claim for \$25,000. *See* CP 6 (Complaint, ¶ 2.18); CP 14 (Answer, ¶ 21). Fortson declined to accept less than the arbitrator's award, and the award was eventually reduced to judgment and paid. *See* CP 6 (Complaint, ¶ 2.18); CP 14 (Answer, ¶¶ 20-21).

Fortson then filed suit against Allstate for the tort of insurance bad faith and violations of Washington's Insurance Fair

Conduct Act (IFCA), Laws of 2007, Ch. 498 (Referendum Measure No. 67, approved Nov. 6, 2007; codified at RCW 48.30.010(7) and 48.30.015).<sup>1</sup> See CP 7-8 (Complaint, ¶¶ 4.1-5.4). Fortson alleged that Allstate failed to conduct a reasonable investigation of her claim,<sup>2</sup> the company's low settlement offers were unreasonable and constituted a constructive denial of her claim for benefits,<sup>3</sup> and the company improperly compelled her to initiate litigation and prosecute her contractual UIM claim to judgment in order to obtain benefits due under the policy.<sup>4</sup> See *id.*

Allstate filed a motion for summary judgment, seeking dismissal of Fortson's bad faith and IFCA complaint on grounds of

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<sup>1</sup> The session law and relevant excerpt of the official voter's pamphlet for IFCA are reproduced in the Appendix to this brief.

<sup>2</sup> IFCA incorporates an Insurance Commissioner regulation that prohibits "[r]efusing to pay claims without conducting a reasonable investigation." WAC 284-30-330(4) (referenced in RCW 48.30.015(5)(a)). A violation of Insurance Commissioner regulations also constitutes breach of the insurer's duty of good faith. See WPI 320.06. WAC 284-30-330 is reproduced in the Appendix.

<sup>3</sup> IFCA prohibits unreasonable denial of a claim for coverage or payment of benefits by an insurer. See RCW 48.30.010(7) and 48.30.015(1). RCW 48.30.010 and 48.30.015 are reproduced in the Appendix.

<sup>4</sup> IFCA incorporates an Insurance Commissioner regulation that prohibits "[c]ompelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings." WAC 284-30-330(7) (referenced in RCW 48.30.015(5)(a)).

res judicata. See CP 46-60.<sup>5</sup> Allstate contends that Fortson's complaint involves the same "transactional nucleus of fact," seeks redress for the same wrongs, and would involve presentation of the same evidence as the underlying contract claim for UIM benefits. See CP 55. To support this characterization of the relationship between the common law tort of insurance bad faith, a statutory claim for violations of IFCA, and a contract claim for UIM benefits, Allstate relies primarily on one unpublished decision and one published decision from the U.S. District Court for the Western District of Washington, both of which were decided after Fortson's UIM claim was litigated. See CP 49-56 (discussing *Smith v. State Farm Mut. Auto. Ins. Co.*, 2013 WL 1499265 (W.D. Wash., Apr. 11, 2013), and *Zweber v. State Farm Mut. Auto. Ins. Co.*, 39 F. Supp. 3d 1161 (W.D. Wash. 2014)).

In other cases, Allstate has successfully argued that extra-contractual claims, such as those for bad faith or IFCA violations, involve different facts, evidence and issues and seek redress for

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<sup>5</sup> Allstate also sought summary judgment based on the statute of limitations. See CP 46-60. Fortson argued that the statute of limitations had been expressly waived by Allstate's representative who promised, in writing, in exchange for more time to respond to Fortson's pre-suit notice of her IFCA claim, that "Allstate agrees not to bring any affirmative defenses with regard to the statute of limitations concerning any future bad faith lawsuit." CP 199-200 & 212. The superior court denied summary judgment based on the statute of limitations. See CP 266.

different wrongs. *See, e.g.*, CP 62, 64, 108, 118, 110-11, 125-26 & 130-32. Allstate has further argued that extra-contractual claims are not even colorable until after litigation of an underlying contract claim has been completed. *See, e.g.*, CP 63, 99-100, 107 & 117.

Fortson responded to Allstate's summary judgment motion by seeking a continuance pursuant to CR 56(f) to conduct specified discovery regarding the company's separate treatment of contractual and extra-contractual claims and its statements in court regarding the distinction between contractual and extra-contractual claims, because evidence of business practices is relevant and admissible on the issue of whether claims arise from the same transactional nucleus of fact, as required to establish a defense of res judicata, and evidence of statements in court is relevant and admissible on the issue of judicial estoppel. *See* CP 201-08 & 220.

Fortson also responded to the merits of Allstate's summary judgment motion, urging that what is known about Allstate's conduct in other cases should estop the company from claiming that a bad faith and IFCA action is "identical" to an underlying contractual UIM action, and that the company cannot otherwise satisfy the requirements of res judicata. Among other things, Fortson noted the difficulty in bringing bad faith and IFCA claims

at the same time as an underlying UIM claim. *See* RP 29:8-30:15. For example, with respect to IFCA claims based on “[c]ompelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings,” WAC 284-30-330(7) (referenced in RCW 48.30.015(5)(a)), insureds and their lawyers may not be able to establish that a violation occurred unless and until the amount in question is recovered.

The superior court denied Fortson’s request for a continuance. *See* CP 262-63. The judge acknowledged the “practical difficulty” of bringing bad faith and IFCA claims at the same time as an underlying UIM claim. RP 30:19-20. He also questioned the lack of controlling Washington authority. *See* RP 31:3-4, 33:12 & 39:2-6. Nonetheless, the judge dismissed Fortson’s complaint, relying on the federal cases cited by Allstate. *See* RP 41:16-43:21 (stating “[b]y virtue of *Zweber*, I think they meet all the criteria for res judicata and therefore I will grant summary judgment on that basis. With the hope that our Court of Appeals can take up with this and give all of us some guidance”); CP 264-67 (summary judgment order).

From these decisions, Fortson seeks direct review in this Court. *See* CP 268-73.

## II.

### ASSIGNMENTS OF ERROR

1. The superior court erred in dismissing Fortson's complaint on summary judgment. CP 264-67.
2. The superior court erred in denying Fortson's motion to continue summary judgment. CP 262-63.

## III.

### ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. What is the relationship between extra-contractual IFCA and bad faith claims and a contractual UIM claim for purposes of applying the doctrine of res judicata, and are the requirements for res judicata satisfied in this case? In particular:
  - a. Do an IFCA claim, which is statutory, and a bad faith claim, which is a common law tort, involve the same *cause of action* as a UIM claim, which is contractual, especially where conduct violating IFCA and constituting bad faith can arise independently?
  - b. Do IFCA and bad faith claims, which focus on the insurer's claims handling, involve the same *subject matter* as a UIM claim, which focuses on the damages caused by a third-party tortfeasor?
  - c. Do IFCA and bad faith claims, which arise from a first-party insured-insurer relationship, involve the same *quality of persons* as a UIM claim, where the insurer assumes an adversary posture and stands in the shoes of a third-party tortfeasor?

2. Does the doctrine of judicial estoppel preclude Allstate from arguing that an IFCA and bad faith action is “identical” to an underlying contract action for UIM benefits, as required to establish a defense of res judicata, given that Allstate has successfully argued that these claims seek redress for different wrongs, involve different facts, evidence and issues, and cannot be asserted until after an underlying contractual claim has been fully litigated?

3. Did the superior court err in denying Fortson’s motion for a continuance of summary judgment in order to obtain discovery regarding Allstate’s practice of treating extra-contractual claims and contractual UIM claims as separate, which would preclude application of res judicata, and/or to obtain discovery regarding Allstate’s statements and conduct in other cases that would give rise to judicial estoppel?

#### IV.

#### STATEMENT OF THE CASE

**A. In other cases, Allstate has successfully argued that a contractual UIM claim seeks redress for a different wrong, involves different facts, evidence and issues, and must be fully litigated before extra-contractual claims can be asserted.**

According to Allstate, contractual and extra-contractual claims are “separate and distinct” and “significantly different” from each other:

**A. The Plaintiff’s Breach Of Contract Claim and Extra-Contractual Claims Are Separate And Distinct**

A claim for breach of contract against an insurance company is significantly different than a claim that in breaching the insurance contract the insurance company somehow acted in bad faith .... the focus on the “breach of contract claim” is

the **amount** of applicable payments under the coverages provided .... Conversely, the focus of a bad faith claim centers on the insurance company's claims **handling** and whether the position taken by the insurance company was appropriate.

CP 99 (lines 11-22; formatting in original; ellipses added).

Allstate explains how contractual and extra-contractual claims involve “entirely different issues” and “completely different discovery and evidence”:

The claim for payment of UIM benefits involves the same type of issues involved in the resolution of any tort claim for damages as a result of an automobile accident. Under Washington law, for purposes of resolving the UIM claim arising out of the auto accident, Allstate, in effect, steps into the shoes of the underinsured driver. *Ellwein v. Hartford Accident & Indem. Co.*, 142 Wn.2d 766, 780, 15 P.3d 640 (2001), *overruled on other grounds by Smith v. Safeco Ins. Co.*, 150 Wn.2d 478, 78 P.3d 1274 (2003); *Dayton v. Farmers Ins. Group*, 124 Wn.2d 277, 281, 876 P.2d 896 (1994). The issues involved in plaintiff's UIM claim focus on how the accident occurred, the proximate cause, nature and extent of plaintiff's bodily injuries and emotional distress as a result of the accident, the value of his personal injury claim and wage loss claims, issues which the trier of fact will decide. The emphasis will be on the medical evidence and testimony regarding plaintiff's alleged injuries and damages resulting from the auto accident.

In contrast, plaintiff's bad faith claims against Allstate will involve entirely different issues, and will require completely different discovery and evidence. Unlike the UIM claim, the focus of plaintiff's bad faith claims will be on how Allstate handled plaintiff's UIM claim and whether the company's actions were reasonable. To establish his bad faith claims, plaintiff must prove that Allstate's claims handling decisions and conduct, and its evaluation of plaintiff's UIM claim, was

"unreasonable, frivolous and unfounded." *Kirk v. Mt. Airy Ins. Co.*, 134 Wn.2d 558, 560, 951 P.2d 1124 (1998). To that end, plaintiff will seek discovery of Allstate's policies and practices with respect to how it undertakes UIM investigations and how it evaluated plaintiff's particular UIM claim.

Thus, the evidence relevant to plaintiff's claim for UIM damages is entirely separate and distinct from the evidence that is required to support his bad faith claims. Allstate's alleged post-accident conduct has absolutely no bearing on the nature of plaintiff's injuries resulting from the accident, or on the extent of UIM damages allegedly caused by the accident. Just as the issues in the UIM claim have no relevance whatsoever to his bad faith claims, the issues in the bad faith claims unquestionably have no relevance to the bodily injury claims. Indeed, the evidence with respect to the alleged bad faith claims is not even admissible in the trial of the UIM claim.

CP 110-11 (internal 4:19-5:24; formatting & citations in original).

It is judicially recognized that the issues presented in a claim for UIM benefits are separate and distinct from the issues in a bad faith claim and that the evidence necessary to support a bad faith claim is "very different from that necessary to support a claim for UIM benefits." *Dahmen v. Am. Family Mut. Ins. Co.*, 635 N.W.2d 1, 5 (Ct. App. Wisc. 2001). The claims for UIM benefits will turn on the amount of plaintiff's damages, while the bad faith claim will focus on Allstate's actions in evaluating those claims. *Id.* The focus of discovery and trial of the UIM claims relates solely to the *plaintiff's* bodily injuries and medical treatment incurred as a result of the accident; discovery and trial on the UIM claims requires the *plaintiff's* testimony and testimony from his medical providers and fact witnesses. Conversely, the focus of discovery and trial on the bad faith claims is on *Allstate's* conduct, what Allstate did or did not do, and whether its actions were reasonable based upon the information it had at the time it evaluated and attempted to settle plaintiff's UIM claim. Discovery and trial on the bad faith claims

requires the testimony of Allstate personnel as to what they knew and the basis for their actions as well as consideration of Allstate's claim handling materials and procedures. Neither plaintiff nor his medical providers or fact witnesses can provide testimony as to what Allstate knew or the reasons for Allstate's actions.

CP 125-26 (internal 3:10-4:3; citation & italics in original).

The facts of consequence to the determination of the accident related claims are the [sic]: (1) the circumstances of the accident; (2) plaintiff's injuries and medical treatment; (3) special damages; and (4) whether the accident or any preexisting condition caused plaintiff's damages. To determine these questions, the jury will hear testimony from eyewitnesses, investigating officers, medical providers, and experts. None of these witnesses has a remote scintilla of evidence relevant to the insurance claims. Conversely, evidence about Allstate's evaluation and handling of the claim is not at all relevant to the accident-related claims ....

The claims at bar do not arise from the same event. The accident-related damages claims relate to the accident. The extra-contractual claims concern Allstate's distinct claims handling practices. Each requires substantially different witnesses and evidence. The extra-contractual claims involve the insurance claim file, claim handling procedures, and claim representatives; the accident claims involve the witnesses to the accident, treatment providers, and liability and damage experts. The only common denominator in each claim is plaintiff herself.

CP 130-31 & 132 (internal 1:20-2:6 & 3:12-17; ellipses added).

The claim for UIM benefits involves the same types of issues involved in the resolution of any tort claim for damages resulting from an automobile accident. For purposes of resolving plaintiff's UIM claim arising out of the accident, Allstate, in effect, steps into the shoes of the underinsured driver. *Sayan v. United Servs. Auto. Assoc.*, 43 Wn. App. 148, 156, 716 P.2d 895 (1986). The issues with respect to the

UIM claim focuses [sic] on how the accident occurred, the nature and extent of plaintiff's bodily injuries resulting from the accident, and the value of her personal injury claim, which the trier of fact will decide. The emphasis will be on the medical evidence and testimony regarding plaintiff's injuries allegedly caused by the accident.

In contrast, resolution of plaintiff's bad faith claims will focus on entirely different issues and will require completely different discovery and evidence. The bad faith claims are asserted against Allstate as an insurer and focus on the reasonableness of Allstate's conduct in the handling of the UIM claim. To pursue these claims, plaintiff must introduce evidence about the process Allstate used to evaluate her UIM claim. The focus of this evidence is evidence is entirely different from the evidence required to establish or defend against the claim for UIM benefits resulting from the accident. Just as plaintiff's UIM claim premised on her alleged bodily injuries from the auto accident has no relevance whatsoever to the bad faith claims, the evidence needed to support or defend against the bad faith claims unquestionably has no relevance to plaintiff's UIM claim.

CP 160-61 (internal 11:7-12:1; citation & formatting in original; brackets added). In sum, according to Allstate, "there is no overlap of the issues or discovery" between contractual and extra-contractual claims. CP 118 (line 24); *accord* CP 125 (line 1, stating "there is no overlap of issues or discovery").

Allstate contends that extra-contractual claims are "premature" until litigation of an underlying contractual claim has been completed:

Until that claim [i.e., a value dispute regarding plaintiff's UIM claim] has been resolved, and plaintiff's UIM damages

have been determined by a trier of fact, plaintiff's bad faith claims are premature[.]

CP 107 (lines 22-24; brackets added).

[P]laintiff's bad faith claims are dependent upon resolution of plaintiff's UIM claim. The reason for this is that plaintiff's bad faith claims are primarily based on the overarching allegation that Allstate wrongfully failed to properly evaluate, negotiate and settle plaintiff's UIM claim. Because there is no way to know whether a bad faith claim based upon an alleged failure to properly evaluate, negotiate and settle a UIM claim is even colorable until the fact finder has determined the dollar value of the UIM claim, plaintiff's UIM claim must be resolved before plaintiff's bad faith claims can be addressed.

CP 117 (lines 13-22; brackets added). In Allstate's view, combined litigation of contractual and extra-contractual claims "makes it literally impossible to narrow issues, determine relevancy, and triability of issues, and even to determine whether there is any question of fact as to any extra-contractual claim." CP 100 (internal 4:4-6).

Allstate further contends that litigation of the underlying contractual claim may eliminate the need for, or possibility of, extra-contractual claims:

the **results** of trial on the question of value may also be significant in determining the question of claims handling—an issue that logically cannot be resolved at the same time as the extra-contractual claims.

CP 99-100 (internal 3:26-4:3; formatting in original).

[D]epending on the result of the suit regarding the amount recoverable under the contract, there may be no need for a suit on extra-contractual matter.

CP 103 (lines 20-22; brackets added).

If the jury determines that plaintiff's damages are equal to or less than the amounts Allstate offered to settle plaintiff's UIM claim, plaintiff's claim that Allstate acted in bad faith for undervaluing plaintiff's claim and failing to settle premised on WAC 284-30-330 will be rendered moot.

CP 119 (lines 19-23).

In light of the foregoing, when contractual UIM claims and extra-contractual bad faith and/or IFCA claims are combined in the same lawsuit, Allstate hires separate counsel to defend the different claims, and seeks to bifurcate the claims and to stay discovery and litigation of the extra-contractual claims. *See* CP 62 (lines 6-15); CP 75-77 (bifurcation & stay order). For example, on May 21, 2013, Allstate convinced Hon. Ronald B. Leighton, of the U.S. District Court for the Western District of Washington, that:

The issues presented in a claim for UIM benefits are separate and distinct from the issues in a bad faith claim. The evidence necessary to support a bad faith claim is different from the evidence essential to a claim for UIM benefits. The claims for UIM benefits are directly linked to the amount and type of plaintiff's injuries and damages. In contrast, a bad faith claim focuses on Allstate's actions in evaluating those claims. The discovery and trial of the UIM claims relates solely to [Plaintiff's] bodily injuries and emotional damages, as well as medical treatment incurred as a result of the accident. Conversely, the discovery and

trial on bad faith claims is on Allstate's conduct, what Allstate did or did not do, and whether its actions were reasonable based upon the information it had at the time it evaluated and attempted to settle [Plaintiff's] UIM claims

CP 76 (brackets added).<sup>6</sup>

**B. In this case, Allstate argues that a contractual UIM claim seeks redress for the same wrong, involves the same facts, evidence and issues, and must be litigated at the same time as extra-contractual claims for violations of IFCA and bad faith.**

*Fortson's underlying UIM claim.* After Fortson was injured in the automobile collision caused by an uninsured motorist, she submitted a claim for \$75,000 to Allstate, her UIM insurer. CP 5 (Complaint, ¶ 2.9); CP 13 (Answer, ¶ 12). The claim letter included language referring to Allstate's obligations under IFCA, and the potential for an IFCA claim, along with a formal demand for her UIM benefits. CP 33-34.

In response, Allstate offered to pay Fortson \$9,978. *See* CP 5 (Complaint, ¶ 2.10); CP 13 (Answer, ¶ 13). At the time it made the offer, Allstate had not completed its investigation of Fortson's claim. *See* CP 5 (Complaint, ¶ 2.11); CP 13 (Answer, ¶ 14).

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<sup>6</sup> Allstate also relies on similar orders obtained by other insurers. *See* CP 73-74 (declaration of Allstate's counsel); CP 78-81, 82-83, 84-85, 86-90, 91-92, 93-95 (bifurcation and stay orders obtained by other insurers).

After Fortson rejected Allstate's offer, the company asked her to submit to a medical examination. *See* CP 5 (Complaint, ¶¶ 2.11-2.12); CP 13 (Answer, ¶ 14). When it received the results of the medical examination, Allstate renewed its offer to pay Fortson \$9,978. *See* CP 5 (Complaint, ¶ 2.12); CP 13 (Answer, ¶ 15). At the time it renewed the offer, Allstate still had not completed its investigation of Fortson's claim. *See* CP 5 (Complaint, ¶ 2.13).

Fortson eventually filed suit to obtain her UIM benefits. *See* CP 5 (Complaint, ¶¶ 2.14); CP 14 (Answer, ¶ 17). The suit did not allege any extra-contractual claims against Allstate. *See* CP 66 & 165-97. For a while after suit was filed, Allstate stated that it continued to investigate Fortson's claim, but the company later suspended its investigation pending court action on the claim. *See* CP 6 (Complaint, ¶ 2.15).

Fortson's suit proceeded to mandatory arbitration, and the arbitrator awarded her damages in the amount of \$43,017. *See* CP 6 (Complaint, ¶ 2.17); CP 14 (Answer, ¶ 20).<sup>7</sup> After receiving the arbitrator's award, Allstate offered to settle for \$25,000. *See* CP 6 (Complaint, ¶ 2.18); CP 14 (Answer, ¶ 21). Fortson declined to

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<sup>7</sup> The arbitrator also awarded costs in the amount of \$1,134.11, and the parties agreed to an offset of \$4,440.11. *See* CP 41-43.

accept less than the arbitration award, and the award was eventually reduced to judgment and paid. *See* CP 6 (Complaint, ¶ 2.18); CP 14 (Answer, ¶ 21).

***Fortson's IFCA and bad faith complaint.*** Fortson then filed this action against Allstate, alleging that the company violated IFCA and committed the tort of insurance bad faith in the course of handling her underlying UIM claim. *See* CP 7-8 (Complaint, ¶¶ 4.1-5.4). As noted above, she alleges that Allstate failed to conduct a reasonable investigation of her claim, the company's low settlement offers were unreasonable and constituted a constructive denial of her claim for benefits, and the company improperly compelled her to initiate litigation and prosecute her contractual UIM claim to judgment in order to obtain benefits due under the policy. *See id.*

***Allstate's motion for summary judgment.*** Allstate does not challenge the allegations of Fortson's IFCA and bad faith complaint, nor the sufficiency of those allegations to state a claim for violation of IFCA or bad faith. *See* CP 46-60. Instead, Allstate seeks summary judgment on grounds of res judicata, relying on the federal district court opinions in *Smith* and *Zweber*, *supra*, and contending that Fortson's IFCA and bad faith claims should have

been litigated at the same time as her underlying UIM claim. *See* CP 49-56.<sup>8</sup>

In support of its motion, Allstate claims that Fortson's underlying UIM claim and her IFCA and bad faith complaint seek redress for the same wrong and therefore involve the same "subject matter," stating:

both actions involve Allstate's failure to pay plaintiff Fortson-Kemmerer's UIM claim in the amount she felt she deserved. In both actions, plaintiff Fortson-Kemmerer's principal assertion is that Allstate improperly determined the amount of damages due under her policy.

CP 54 (lines 17-21).

[T]he subject matter in both actions is identical: both actions involve Allstate's alleged failure to pay plaintiff upon demand benefits due under her UIM policy because of an automobile accident.

CP 252 (lines 5-8; brackets added).

Allstate further claims that Fortson's UIM claim and her IFCA and bad faith complaint involve the same "cause of action" because they rest upon the same "evidence" and "transactional

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<sup>8</sup> As noted above, Allstate also sought summary judgment based on the statute of limitations. *See* CP 46-60. Fortson argued that the statute of limitations had been expressly waived by Allstate's representative who promised, in writing, in exchange for more time to respond to Fortson's pre-suit notice of her IFCA claim, that "Allstate agrees not to bring any affirmative defenses with regard to the statute of limitations concerning any future bad faith lawsuit." CP 199-200 & 212. The superior court denied summary judgment based on the statute of limitations. *See* CP 266.

nucleus of facts.” CP 55. In particular, with respect to evidence,

Allstate states:

the evidence presented in this case would mirror the evidence presented during the 2011 case [i.e., the underlying UIM claim].

CP 55 (lines 12-14; brackets added); *accord* CP 251 (lines 24-25, stating “the evidence in the second suit will be substantially the same as that used during the first”).

With respect to the facts, Allstate states:

At a fundamental level, in both cases, the claims are based on Allstate’s refusal to pay plaintiff Fortson-Kemmerer the amount she demanded. In the first action [i.e., the underlying UIM claim] plaintiff Fortson-Kemmerer claimed that she was entitled to more benefits than Allstate was offering her. In the section action [i.e., the IFCA and bad faith complaint], plaintiff Fortson-Kemmerer claims that Allstate violated its various duties by refusing to acknowledge that she was entitled to more benefits than Allstate was offering her. In both cases, the basic behavior being complained of is the same: refusal to pay benefits in the requested amount.

CP 55 (lines 16-23; brackets added); *accord* CP 252 (lines 2-3, stating “both suits arise out of the same transactional nucleus—they both seek to redress Allstate’s alleged refusal to pay proceeds under an insurance contract”).

**C. The superior court denies Fortson's request for a continuance and grants summary judgment in Allstate's favor.**

Fortson responded to Allstate's motion for summary judgment by arguing that the company's conduct in other cases should give rise to judicial estoppel, and foreclose a defense of res judicata in this case. *See* CP 213-14. Fortson otherwise argues that the requirements for res judicata have not been satisfied in this case. *See* CP 214-22.

In addition to responding to the merits of Allstate's motion, Fortson filed a motion for a continuance pursuant to CR 56(f), to obtain discovery of the following:

- Deposition of David Force, Allstate's lawyer in Fortson's underlying UIM claim and other cases, who could testify that the UIM claim did not raise any extra-contractual issues, and that Allstate's business practice is to treat UIM and extra-contractual claims separately;
- Deposition of Tracy Smith, Allstate's claims representative for Fortson's UIM claim, who could testify that Allstate had not evaluated any extra-contractual issues as part of handling the UIM claim, and that Allstate's business practice is to treat UIM and extra-contractual claims separately;
- Deposition of Allstate's designated representative pursuant to CR 30(b)(6), who could testify regarding Allstate's business practices regarding separate treatment of UIM and extra-contractual claims; and

- Interrogatories and requests for production regarding Allstate's business practices regarding separate treatment of UIM and extra-contractual claims, including production of Fortson's claims files.

CP 204-05.<sup>9</sup> Fortson contends that evidence of Allstate's business practices regarding separate treatment of contractual and extra-contractual claims is relevant and admissible on the issue of whether her bad faith and IFCA action is the same cause of action as her underlying UIM claim, one of the requirements for application of res judicata. *See* CP 220 (lines 4-7 & n.12, quoting 14A Karl B. Tegland, Wash. Prac., Civil Procedure § 35:26 n.8 (2d ed.)). Fortson further contends that, because Allstate's business practices involve positions taken in court, such evidence is also relevant and admissible on the issue of whether the company should be judicially estopped. *See* CP 203.

The superior court denied Fortson's request for a continuance and granted summary judgment in Allstate's favor. *See* CP 262-67. From these decisions, Fortson timely filed a notice of direct review. *See* CP 268-73.

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<sup>9</sup> Fortson had not previously conducted this discovery, because Allstate had stated its intent to limit summary judgment to the statute of limitations. *See* CP 205.

## V.

### ARGUMENT

**A. The superior court erred in granting summary judgment because Allstate cannot satisfy its burden to establish that there are no genuine issues of material fact and that it has satisfied the requirements for res judicata as a matter of law.**

The superior court granted summary judgment in favor of Allstate based on the doctrine of res judicata. Under the doctrine, a final judgment on the merits in one action generally bars a subsequent action that could have been brought with the first if the two actions are deemed to be identical. *See generally* Philip A. Trautman, *Claim and Issue Preclusion in Civil Litigation in Washington*, 60 Wash. L. Rev. 805, 812-29 (1985).<sup>10</sup>

The superior court's decision is entitled to no deference, and is subject to de novo review. *See Cummins v. Lewis County*, 156 Wn. 2d 844, 852, 133 P.3d 458 (2006). This Court engages in the same inquiry as the superior court. *See id.* Summary judgment cannot be affirmed unless there are no genuine issues of material fact in dispute, and Allstate is entitled to judgment as a matter of law. *See Young v. Key Pharmaceuticals, Inc.*, 112 Wn. 2d 216,

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<sup>10</sup> Prof. Trautman's article has been frequently cited with approval by this Court. *See, e.g., Hayes v. City of Seattle*, 131 Wn. 2d 706, 713, 934 P.2d 1179 (1997).

225-26, 770 P.2d 182 (1989). The evidence and all reasonable inferences from the evidence must be viewed in the light most favorable to Fortson as the non-moving party. *See id.*<sup>11</sup>

As the party asserting res judicata, Allstate has the burden of proving that all requirements for application of the doctrine have been satisfied. *See Hisle v. Todd Pacific Shipyards Corp.*, 151 Wn. 2d 853, 865, 93 P.3d 108 (2004). In the context of summary judgment, Allstate must produce evidence sufficient to satisfy each and every requirement of res judicata, establish an absence of any genuine issues of material fact in dispute, and demonstrate that it is entitled to judgment as a matter of law. *See Young*, 112 Wn. 2d at 225-26 (imposing burden of production on summary judgment on party with burden of proof); *Graves v. P.J. Taggares Co.*, 94 Wn. 2d 298, 302-03, 616 P.2d 1223 (1980) (reversing summary

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<sup>11</sup> There are Court of Appeals cases indicating that res judicata is a question of law for the court to decide. *See, e.g., Ensley v. Pitcher*, 152 Wn. App. 891, 899, 222 P. 3d 99 (2009), *rev. denied*, 168 Wn. 2d 1028 (2010). However, the question of whether two actions are identical for purposes of applying the doctrine may hinge on factual determinations. *See infra*. To the extent there are any genuine issues of material fact in dispute (and the Court does not otherwise find res judicata inapplicable), an evidentiary hearing may be required to resolve the factual disputes. Because res judicata is grounded in equity, the factual disputes would presumably be resolved by the court in its role as fact finder. *See In re Pearsall-Stipek*, 136 Wn. 2d 255, 262 n.3, 961 P.2d 353 (1998) (noting equitable underpinnings of res judicata); *Bird v. Best Plumbing Group, LLC*, 175 Wn. 2d 756, 769, 287 P.3d 551 (2012) (recognizing right to jury trial does not extend to equitable issues).

judgment in favor of party with burden of proof because the facts were susceptible to more than one interpretation).

In this case, Allstate cannot satisfy its burden to establish that there are no genuine issues of material fact and that all requirements for res judicata have been satisfied as a matter of law. In particular, Fortson's bad faith and IFCA action is not identical to her underlying UIM claim, and her bad faith and IFCA claims could not and should not have been brought at the same time as her UIM claim. The superior court's grant of summary judgment in favor of Allstate should be reversed.

**1. Fortson's IFCA and bad faith action is not "identical" to her underlying UIM claim.**

Res judicata does not apply unless an action is deemed to be "identical" to a prior action in four respects:

(1) persons and parties; (2) cause of action; (3) subject matter; and (4) the quality of the persons for or against whom the claim is made.

*Spokane Research & Def. Fund v. City of Spokane*, 155 Wn.2d 89, 99, 117 P.3d 1117 (2005). The actions must be identical in all four

respects, and a lack of identity in any single area is sufficient to preclude application of res judicata. *See Hisle*, 151 Wn. 2d at 866.<sup>12</sup>

Here, there is no dispute that the persons and parties are identical in Fortson’s bad faith and IFCA action and her underlying UIM claim. However, the causes of action, subject matter and quality of persons are not the same in the two actions. As noted by Allstate in the same context in another case, “[t]he only common denominator in each claim is the plaintiff herself.” CP 132.

**a. The cause of action is not the same.**

There are four factors to be analyzed in determining whether the causes of action asserted in different actions are the same:

(1) [W]hether rights or interests established in the prior judgment would be destroyed or impaired by prosecution of the second action; (2) whether substantially the same evidence is presented in the two actions; (3) whether the two suits involve infringement of the same right; and (4) whether the two suits arise out of the same transactional nucleus of facts.

*Hayes*, 131 Wn.2d at 713 (quoting *Rains v. State*, 100 Wn. 2d 660, 664, 674 P.2d 165 (1983); brackets in original). These four factors

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<sup>12</sup> In the trial court, Allstate stated: “it is not necessary that all four factors favor preclusion to bar the claim.” CP 50 (lines 6-8). Allstate’s statement is unsupported by any citation to authority, and is directly contrary to *Hisle*, which found res judicata inapplicable based solely on a lack of identical subject matter. *See* 151 Wn. 2d at 866 (stating “[b]ecause we find that identity of subject matter does not exist, and because the res judicata test is a conjunctive one requiring satisfaction of all four elements, we do not analyze the other res judicata requirements”).

provide a framework for analysis rather than a mechanistic test. *See Rains*, 100 Wn. 2d at 663-64. Nonetheless, none of the four factors militate in favor of applying res judicata in this case.

The rights established in the underlying UIM action would not be “destroyed or impaired” by prosecution of a subsequent bad faith and IFCA action. Fortson does not seek to relitigate the amount of damages awarded on her UIM claim, but rather to recover additional damages caused by Allstate forcing her to pursue litigation to recover her UIM benefits. Regardless of whether or not Fortson prevails in her bad faith or IFCA action, the judgment in the underlying UIM claim will not be disturbed.

Fortson’s bad faith and IFCA action does not involve presentation of “substantially the same evidence” as her underlying UIM action. This fact is well-attested by Allstate’s own statements. According to the company, the evidence in a bad faith or IFCA action is “completely different” and “entirely separate and distinct,” CP 110-11, “very different,” CP 125-26, and “entirely different,” CP 160-61, from an underlying UIM claim. Allstate contends that “the evidence relevant to plaintiff’s claim for UIM damages is entirely separate and distinct from the evidence that is required to support his bad faith claims,” CP 110-11, and “not at all relevant,” CP 130-31.

Fortson's bad faith and IFCA action does not "involve infringement of the same right" as her underlying UIM action. Bad faith is a common law tort and IFCA is statutory, while a claim for UIM benefits is contractual. *See, e.g., Safeco Ins. Co. v. Butler*, 118 Wn.2d 383, 389, 823 P.2d 499 (1992) (stating "[a]n action for bad faith handling of an insurance claim sounds in tort"); *Fisher v. Allstate Ins. Co.*, 136 Wn. 2d 240, 244-45, 961 P.2d 350 (1998) (noting that the relationship of the insurer and insured is essentially contractual in the UIM context, even though the obligation to offer UIM coverage is statutory). These claims are independent of each other, in that breach of an insurance contract is neither necessary, nor sufficient to establish bad faith. *See, e.g., Coventry Assocs. v. American States Ins. Co.*, 136 Wn. 2d 269, 279, 961 P.2d 933 (1998) (holding first-party insured has a cause of action for bad faith investigation of claim, even in the absence of coverage). The same is true for most, if not all, claims actionable under IFCA, which, like the tort of bad faith, hinges upon the reasonableness of the insurer's conduct and/or violation of Insurance Commissioner regulations. *See* RCW 48.30.015. As Allstate concedes, Fortson's common law and statutory rights relate to the company's claims handling, whereas the contractual rights

under a UIM policy relate to the amount of damages caused by an uninsured motorist.<sup>13</sup>

Lastly, Fortson's bad faith and IFCA action does not involve the same "transactional nucleus of facts" as her underlying UIM claim. This factor appears to overlap with the factor considering whether two actions involve the same evidence, discussed above. To the extent they involve different evidence, as Allstate acknowledges, they must involve different facts. The "transactional nucleus" of the underlying UIM claim is the motor vehicle collision between Fortson and an uninsured motorist. The "transactional nucleus" of the subsequent bad faith and IFCA claim is Allstate's handling of Fortson's UIM claim. This is confirmed by Allstate's business practice of treating bad faith and IFCA claims separately from an underlying UIM claim.<sup>14</sup>

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<sup>13</sup> Cf. *Civil Service Comm'n v. City of Kelso*, 137 Wn. 2d 166, 171-72, 969 P.2d 474 (1999) (civil service commission decision that public employee who was suspended "in good faith and for cause" was not res judicata as to subsequent arbitration under collective bargaining agreement finding no "just cause" for discipline because "[t]hese two standards are not the same" and involve "different rights" under civil service laws and collective bargaining agreement); *Habermas v. Washington Public Power Supply Sys.*, 109 Wn. 2d 107, 121-22, 744 P.2d 1032 (1987) (concluding prior litigation dealing with contract claims was not res judicata in part because subsequent action involved securities, consumer protection and common law tort claims).

<sup>14</sup> The relevance of business practice is addressed further *infra*, in connection with Fortson's CR 56(f) motion.

Considering the foregoing factors individually or together, Fortson's bad faith and IFCA action does not involve the same cause of action as her underlying UIM claim.

**b. The subject matter is not the same.**

An action that is merely premised on an obligation established in an earlier action does not involve the same subject matter as the earlier action and is not barred by the doctrine of res judicata. *See Hisle*, 151 Wn. 2d at 866. In *Hisle*, employees subject to a collective bargaining agreement (CBA) initially filed an action seeking to set aside the agreement. *See id.* at 858-59. The CBA had included a retroactive hourly wage increase as an inducement to ratify the contract, and the employer counterclaimed seeking recovery of the payment if the CBA were set aside. *See id.* The parties eventually agreed to settle the lawsuit with mutual dismissals and releases. *See id.* Certain employees who had worked overtime during the period covered by the retroactive wage increase then filed a second action seeking to apply the Minimum Wage Act, Ch. 49.46 RCW, to the wages paid. *See id.* at 859. The Court held that the second action did not involve the same subject matter as the first, reasoning as follows:

We find that this case involves a different subject matter than [the first action]. Whereas [the first action] concerned the procedures used to adopt the new CBA and sought to invalidate the new CBA, the current claim presumes the validity of the agreement and seeks to apply the MWA to it. Because we find that identity of subject matter does not exist, and because the res judicata test is a conjunctive one requiring satisfaction of all four elements, we do not analyze the other res judicata requirements.

*Id.* at 866 (brackets added).

While *Hisle* involves a much different factual context than this case, it is analogous because Fortson’s underlying UIM claim established Allstate’s contractual obligation to pay UIM benefits, and her bad faith and IFCA action is merely premised upon the existence of this obligation.<sup>15</sup> Allstate’s statements that bad faith and IFCA claims are premature and cannot be asserted until after litigation of an underlying UIM claim confirm the separate and distinct subject matter. In this sense, as in *Hisle*, a bad faith and IFCA action does not involve the same subject matter as an underlying UIM claim.

**c. The quality of persons is not the same.**

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<sup>15</sup> For example, to the extent her bad faith and IFCA claims are based on violation of WAC 284-30-330(7)—“[c]ompelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings”—the amount of the mandatory arbitration award on the underlying UIM claims a necessary element of proof in this action. See RCW 48.30.015(5)(a) (incorporating WAC 284-30-330); WPI 320.06 (indicating violation of WAC 284-30-330 constitutes breach of the duty of good faith).

There is relatively little guidance regarding the quality of persons necessary for application of res judicata, although presumably the quality of parties would not be the same if the parties act in different capacities. See Trautman, *supra*, at 821; see also *Berschauer Phillips Constr. Co. v. Mutual of Enumclaw Ins. Co.*, 175 Wn. 2d 222, 308 P.3d 681 (2013) (equating quality of persons with capacity). An insurer should be deemed to be acting in a different capacity when handling a UIM claim than when defending a bad faith and IFCA action. As Allstate acknowledges, it steps into the shoes of the tortfeasor and has different duties when defending a UIM claim. See, e.g., *Ellwein v. Hartford Accident & Indem. Co.*, 142 Wn. 2d 766, 781-82, 15 P.3d 640 (2001) (stating “UIM coverage requires that a UIM insurer be free to be adversarial within the normal rules of procedure and ethics,” while prohibiting insurers from using information gained in defense of insured against liability claim to defend UIM claim), *overruled on other grounds by Smith v. Safeco Ins. Co.*, 150 Wn. 2d 478, 486, 78 P.3d 1274 (2003). Res judicata should not apply in light of these differences between an insurer’s capacity in a UIM claim and its capacity in a bad faith and IFCA claim.

**d. The cases on which Allstate relies are neither controlling nor persuasive.**

Allstate and the superior court both rely on the opinions of the federal district court in *Smith* and *Zweber*, *supra*. CP 49-56; RP 41:16-43:21. The court acknowledged that “Washington courts have not applied *res judicata* to scenarios identical to that at hand—namely, when a plaintiff attempts to bring a subsequent bad faith insurance action following a UIM breach of contract action[.]” *Smith*, 2013 WL 1499265, at \*6 (brackets added; italics in original). The plaintiff-insureds in *Smith* and *Zweber* did not make the same arguments made in this case. *See Smith*, at \*4 (stating “[i]n the instant matter, it is largely undisputed that factors one [i.e., persons], three [i.e., subject matter], and four [i.e., quality of persons] favor preclusion”); *Zweber*, 39 F. Supp. 3d at 1166 (stating “Mr. Zweber makes few arguments in response. He principally argues that this case does not involve the same subject matter or causes of action”). In *Smith*, the court simply applied *res judicata* based on a characterization of bad faith and IFCA claims as arising from the same transactional nucleus of facts, seeking to redress the same wrong, and involving presentation of substantially the same evidence, without regard for the analysis provided above or

Allstate's own statements and conduct, and in *Zweber* the court followed *Smith*. See *Smith*, at \*5; *Zweber*, at 1168-69. These opinions are not controlling and do not have persuasive value because they do not acknowledge the significant distinctions between bad faith and IFCA claims, as evidenced by Allstate's statements and conduct.

**2. Fortson's bad faith and IFCA claims could not and should not have been brought at the same time as her underlying UIM claim.**

Res judicata only bars an action asserting claims that could and should have been brought in a prior action. See *Hisle*, 151 Wn. 2d at 865 (indicating res judicata applies to points that "the parties, exercising reasonable diligence, might have brought forward" in a prior action; quoting *Schoeman v. N.Y. Life Ins. Co.*, 106 Wn. 2d 855, 859, 726 P.2d 1 (1986); *Seattle-First Nat. Bank v. Kawachi*, 91 Wn.2d 223, 226, 588 P.2d 725 (1978) (stating "[w]hile it is often said that a judgment is res judicata of every matter which could and should have been litigated in the action, this statement must not be understood to mean that a plaintiff must join every cause of action which is joinable when he brings a suit against a given defendant"). The Court should recognize that bad faith and IFCA claims often

cannot and should not be brought at the same time as an underlying UIM claim.

*First*, many bad faith and IFCA claims do not accrue and are not ripe until the conclusion of litigation of an underlying UIM claim. For example, a claim based on a violation of WAC 284-30-330(7) for [c]ompelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings” does not accrue and is not ripe unless and until an amount is ultimately recovered.<sup>16</sup>

*Second*, insureds often do not have access to claim files or other information necessary to discover and pursue claims for bad faith or IFCA violations. *See Cedell v. Farmers Ins. Co. of Washington*, 176 Wn.2d 686, 696, 295 P.3d 239 (2013) (stating “[t]he insured needs access to the insurer's file maintained for the insured in order to discover facts to support a claim of bad faith”).

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<sup>16</sup> *Cf. Mellor v. Chamberlin*, 100 Wn. 2d 643, 647, 673 P.2d 610 (1983) (finding res judicata inapplicable in part because second action was not “ripe”); *see also* Trautman, *supra*, at 827 & n.144 (stating “[i]f the claim had not fully ripened so that complete recovery was not possible in the first action, a second proceeding may be permitted”; citing *Mellor* as an illustration).

*Third*, requiring insureds to bring bad faith and IFCA claims at the same time as an underlying UIM claim would encourage a sue-first-ask-questions-later approach that the Court has already rejected in other contexts. *See Winbun v. Moore*, 143 Wn. 2d 206, 18 P.3d 576 (2001) (holding cause of action does not accrue against individual health care provider until plaintiff has actual or constructive knowledge of the provider’s negligence to minimize the temptation “to sue first and conduct discovery later” in medical negligence litigation); *see also Webb v. Neuroeducation, Inc.*, 121 Wn. App. 336, 345, 88 P.3d 417 (2004) (stating this Court has rejected “the so-called ‘shoot first, ask questions later’ litigation style”), *rev. denied*, 153 Wn. 2d 1004 (2005).

For any and all of these reasons, the Court should decline to apply res judicata in the circumstances presented by this case.

**B. The superior court erred in declining to apply judicial estoppel.**

In this case, the statements by Allstate in other cases not only provide a persuasive analysis of why the elements of res judicata cannot be satisfied, they also give rise to judicial estoppel. Judicial estoppel is an equitable doctrine that precludes a party from asserting one position in a court proceeding and later seeking

an advantage by taking a clearly inconsistent position.” *In re Estate of Hambleton*, 181 Wn.2d 802, 833 n.5, 335 P.3d 398, 414 (2014) (quotation omitted), *cert. denied sub nom. Hambleton v. Washington Dep't of Revenue*, 136 S. Ct. 318 (2015). Three factors guide the application of judicial estoppel:

“(1) whether ‘a party’s later position’ is ‘clearly inconsistent with its earlier position’; (2) whether ‘judicial acceptance of an inconsistent position in a later proceeding would create the perception that either the first or the second court was misled’; and (3) ‘whether the party seeking to assert an inconsistent position would derive an unfair advantage or impose an unfair detriment on the opposing party if not estopped.’”

*Id.* (quotations omitted). Each of these elements is satisfied here. Allstate has previously made inconsistent statements regarding the relationship between bad faith and IFCA claims and an underlying UIM claim. These statements have led at least one court to bifurcate litigation of these different claims. The unfairness is patent, because Allstate seeks to avoid liability in this case based on its inconsistent positions. Apart from the merits of Allstate’s *res judicata* defense, the Court should hold that the company is judicially estopped from raising it.

**C. Alternatively, the superior court erred in denying Fortson's request for a continuance.**

The superior court denied Fortson's motion for a continuance pursuant to CR 56(f). In connection with her motion, Fortson identified specific discovery regarding Allstate's business practices that is relevant and admissible on the issues of res judicata and judicial estoppel. To the extent the Court does not otherwise find res judicata inapplicable or judicially estop Allstate from raising the defense, the Court should still reverse the superior court's grant of summary judgment and remand for discovery regarding Allstate's business practices.

Under the Restatement (Second) of Judgments § 24(2) (1982), the parties' "business understanding or usage" is relevant to whether actions should be deemed the same for purposes of applying res judicata. While this Court has never adopted this Restatement provision, three Court of Appeals decisions have cited it with approval, seeming to indicate it is consistent with Washington law. *See Sound Built Homes, Inc. v. Windermere Real Estate/South, Inc.*, 118 Wn. App. 617, 629 & n.23, 72 P.3d 788 (2003) (quoting § 24(2)); *Landry v. Luscher*, 95 Wn. App. 779, 783 & n.1, 976 P.2d 1274, *rev. denied*, 139 Wn. 2d 1006 (1999) (quoting

§ 24(1)); *Hadley v. Cowan*, 60 Wn. App. 433, 442 n.12, 804 P.2d 1271 (1991) (quoting § 24(2)). Professor Trautman states that Restatement § 24 has “particular relevance” in determining what constitutes the “same transactional nucleus of facts.” *See* Trautman, *supra*, at 817-18; *see also* 14A Wash. Prac., *supra* § 35:26 & n.8 (discussing Restatement and Prof. Trautman’s article).

When affidavits are unavailable within the timelines for a summary judgment motion, the court “may order a continuance to permit affidavits to be obtained ... or may make such other order as is just.” CR 56(f) (ellipses added). The court has a “duty” to give the party opposing summary judgment “a reasonable opportunity to complete the record before ruling on the case.” *Mannington Carpets, Inc. v. Hazelrigg*, 94 Wn. App. 899, 902-03 & n.5, 973 P.2d 1103, *rev. denied*, 139 Wn.2d 1003 (1999); *accord Coggle v. Snow*, 56 Wn. App. 499, 507, 784 P.2d 554 (1990).

The “primary consideration” on a motion for continuance under CR 56(f) is to ensure that justice is done. *Butler v. Joy*, 116 Wn. App. 291, 299-300, 65 P.3d 671 (2003) (quoting *Coggle*, 56 Wn. App. at 508). Justice is served when there is no prejudice to the moving party, and the schedule of the nonmoving party’s counsel would not otherwise allow sufficient time to prepare an adequate

response. *See Butler*, 116 Wn. App. at 299-300 (involving substitution of counsel); *Coggle*, at 508 (same). Justice is undermined by “draconian application of time limitations’ when a party is hobbled by legal representation that has no time to prepare a response to a motion that cuts off any decision on the true merits of a case.” *Butler*, at 300 (quoting *Coggle*, at 508). To the extent summary judgment should not be denied outright, Fortson should be allowed an opportunity to develop the record necessary to respond.<sup>17</sup>

## VII.

### CONCLUSION

Based on the foregoing, the Court should conclude that the doctrine of res judicata is inapplicable, reverse the superior court, vacate the summary judgment order in favor of Allstate, and remand this case for trial.

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<sup>17</sup> The court may only deny a continuance under CR 56(f) when: “(1) the requesting party does not have a good reason for the delay in obtaining the evidence; (2) the requesting party does not indicate what evidence would be established by further discovery; or (3) the new evidence would not raise a genuine issue of fact.” *Butler*, at 299. None of the circumstances justifying denial of a continuance are present in this case. Fortson had not previously conducted this discovery, because Allstate had stated its intent to limit summary judgment to the statute of limitations. *See* CP 205.

Respectfully submitted this 22nd day of February, 2016.

s/George M. Ahrend  
George M. Ahrend  
WSBA #25160  
AHREND LAW FIRM PLLC  
100 E. Broadway Ave.  
Moses Lake, WA 98837  
(509) 764-9000  
Fax (509) 464-6290

On behalf of Appellant Anastasia Fortson-Kemmerer

## CERTIFICATE OF SERVICE

The undersigned does hereby declare the same under oath and penalty of perjury of the laws of the State of Washington:

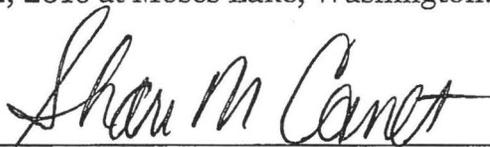
On the date set forth below, I served the document to which this is annexed by email and First Class Mail, postage prepaid, as follows:

Irene M. Hecht & Maureen Falecki  
Keller Rohrback LLP  
1201 3rd Ave., Ste. 3200  
Seattle, WA 98101-3052  
Email: [ihecht@kellerrohrback.com](mailto:ihecht@kellerrohrback.com)  
Email: [mfalecki@kellerrohrback.com](mailto:mfalecki@kellerrohrback.com)

and upon Petitioner's co-counsel, Matthew Albrecht and Brandon Casey, via email pursuant to prior agreement for electronic service, as follows:

Matthew Albrecht at [malbrecht@trialappeallaw.com](mailto:malbrecht@trialappeallaw.com)  
Brandon Casey at [Brandon@spokanelawcenter.com](mailto:Brandon@spokanelawcenter.com)

Signed on February 22, 2016 at Moses Lake, Washington.

  
\_\_\_\_\_  
Shari M. Canet, Paralegal

# APPENDIX

2007 Wash. Legis. Serv. Ch. 498 (S.S.B. 5726) (WEST)

WASHINGTON 2007 LEGISLATIVE SERVICE  
60th Legislature, 2007 Regular Session

Additions are indicated by Text; deletions by  
Text . Changes in tables are made but not highlighted.  
Vetoed provisions within tabular material are not displayed.

CHAPTER 498  
S.S.B. No. 5726  
INSURANCE—BOARDS AND COMMISSIONS—RULES AND REGULATIONS

AN ACT Relating to creating the insurance fair conduct act; amending RCW 48.30.010; adding a new section to chapter 48.30 RCW; creating a new section; and prescribing penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** This act may be known and cited as the insurance fair conduct act.

**Sec. 2.** RCW 48.30.010 and 1997 c 409 s 107 are each amended to read as follows:

<< WA ST 48.30.010 >>

(1) No person engaged in the business of insurance shall engage in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of such business as such methods, acts, or practices are defined pursuant to subsection (2) of this section.

(2) In addition to such unfair methods and unfair or deceptive acts or practices as are expressly defined and prohibited by this code, the commissioner may from time to time by regulation promulgated pursuant to chapter 34.05 RCW, define other methods of competition and other acts and practices in the conduct of such business reasonably found by the commissioner to be unfair or deceptive after a review of all comments received during the notice and comment rule-making period.

(3)(a) In defining other methods of competition and other acts and practices in the conduct of such business to be unfair or deceptive, and after reviewing all comments and documents received during the notice and comment rule-making period, the commissioner shall identify his or her reasons for defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive and shall include a statement outlining these reasons as part of the adopted rule.

(b) The commissioner shall include a detailed description of facts upon which he or she relied and of facts upon which he or she failed to rely, in defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive, in the concise explanatory statement prepared under RCW 34.05.325(6).

(c) Upon appeal the superior court shall review the findings of fact upon which the regulation is based de novo on the record.

(4) No such regulation shall be made effective prior to the expiration of thirty days after the date of the order by which it is promulgated.

(5) If the commissioner has cause to believe that any person is violating any such regulation, the commissioner may order such person to cease and desist therefrom. The commissioner shall deliver such order to such person direct or mail it to the person by registered mail with return receipt requested. If the person violates the order after expiration of ten days after the cease and desist order has been received by him or her, he or she may be fined by the commissioner a sum not to exceed two hundred and fifty dollars for each violation committed thereafter.

(6) If any such regulation is violated, the commissioner may take such other or additional action as is permitted under the insurance code for violation of a regulation.

(7) An insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant. "First party claimant" has the same meaning as in section 3 of this act.

**NEW SECTION. Sec. 3.** A new section is added to chapter 48.30 RCW to read as follows:

<< WA ST 48.30 >>

(1) Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs, as set forth in subsection (3) of this section.

(2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in subsection (5) of this section, increase the total award of damages to an amount not to exceed three times the actual damages.

(3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

(4) "First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

(5) 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"; or

(f) An unfair claims settlement practice rule adopted under RCW 48.30.010 by the insurance commissioner intending to implement this section. The rule must be codified in chapter 284-30 of the Washington Administrative Code.

(6) This section does not limit a court's existing ability to make any other determination regarding an action for an unfair or deceptive practice of an insurer or provide for any other remedy that is available at law.

(7) This section does not apply to a health plan offered by a health carrier. "Health plan" has the same meaning as in RCW 48.43.005. "Health carrier" has the same meaning as in RCW 48.43.005.

(8)(a) Twenty days prior to filing an action based on this section, a first party claimant must provide written notice of the basis for the cause of action to the insurer and office of the insurance commissioner. Notice may be provided by regular mail, registered mail, or certified mail with return receipt requested. Proof of notice by mail may be made in the same manner as prescribed by court rule or statute for proof of service by mail. The insurer and insurance commissioner are deemed to have received notice three business days after the notice is mailed.

(b) If the insurer fails to resolve the basis for the action within the twenty-day period after the written notice by the first party claimant, the first party claimant may bring the action without any further notice.

(c) The first party claimant may bring an action after the required period of time in (a) of this subsection has elapsed.

(d) If a written notice of claim is served under (a) of this subsection within the time prescribed for the filing of an action under this section, the statute of limitations for the action is tolled during the twenty-day period of time in (a) of this subsection.

Approved May 15, 2007.

Effective July 22, 2007.

WA LEGIS 498 (2007)



# REFERENDUM MEASURE 67

Passed by the Legislature and Ordered Referred by Petition

## *Official Ballot Title:*

The legislature passed (engrossed Substitute Senate Bill 5726 (ESSB 5726)) concerning insurance claim conduct related to claims for coverage or benefits and voters have filed a sufficient referendum petition on this bill.

This bill would make it unlawful for insurers to unreasonably deny certain coverage claims, and permit treble damages plus attorney fees for that and other violations. Some health insurance carriers would be exempt.

Should this bill be:

Approved  Rejected

### **Votes cast by the 2007 Legislature on final passage:**

Senate: Yeas, 31; Nays, 18; Absent, 0; Excused, 0.

House: Yeas, 59; Nays, 38; Absent, 0; Excused, 1.

Note: The Official Ballot Title was written by the court. The Explanatory Statement was written by the Attorney General as required by law and revised by the court. The Fiscal Impact Statement was written by the Office of Financial Management. For more in-depth fiscal analysis, visit [www.ofm.wa.gov/initiatives](http://www.ofm.wa.gov/initiatives). The complete text of Referendum Measure 67 begins on page 29.

## *Fiscal Impact Statement*

### **Fiscal Impact Statement for Referendum 67**

Referendum 67 is a referendum on ESSB 5726, a bill that would prohibit insurers from unreasonably denying certain insurance claims, permitting recovery up to triple damages plus attorney fees and litigation costs. This may increase frequency and amounts of insurance claims recovered by state and local government, the number of insurance-related suits filed in state courts, and increase state and local government insurance-premiums. Research offers no clear guidance for estimating the magnitude of these potential increases. Notice of insurance-related suits must be provided to the Office of the Insurance Commissioner prior to court filing, costing an estimated \$50,000 per year.

### **Assumptions for Fiscal Analysis of R-67**

- There would likely be an increase in the number of cases filed in Superior Court related to the denial of insurance claims, but there is no data available to provide an accurate estimate of that fiscal impact. It is assumed that the impact to the operations of Washington courts would be greater than \$50,000 per year.
- Premiums for state and local governments that purchase auto, property, liability or other insurance may increase due to a potential increase in insurance companies' litigation costs and the amounts awarded to claimants.
- When the state or local government is a claimant, the referendum could increase the likelihood of recovering on the claim, and the amount recovered.
- Various studies have been conducted to determine how changes in law affecting insurance can affect costs for courts, insurance premiums, and claimant recovery. However, individual study results vary widely. Due to the conflicting research, there is no clear guidance for estimating the magnitude of the fiscal impact of potential increases in court costs, insurance premiums, or recovered claims.
- It is estimated that 300 notices per year of insurance-related lawsuits would be filed with the Office of the Insurance Commissioner, resulting in a minimum cost of less than \$50,000 per year increased cost to the agency.



# REFERENDUM MEASURE 67

## *Explanatory Statement*

### **The law as it presently exists:**

The state insurance code prohibits any person engaged in the insurance business from engaging in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of their business. Some of these practices are set forth in state statute. The insurance commissioner has the authority to adopt rules defining unfair practices beyond those specified in statute. The commissioner has the authority to order any violators to cease and desist from their unfair practices, and to take action under the insurance code against violators for violation of statutes and regulations. Depending on the facts, the insurance commissioner could impose fines, seek injunctive relief, or take action to revoke an insurer's authority to conduct insurance business in this state.

Under existing law, an unfair denial of a claim against an insurance policy could give the claimant a legal action against the insurance company under one or more of several legal theories. These could include violation of the insurance code, violation of the consumer protection laws, personal injuries or property losses caused by the insurer's acts, or breach of contract. Depending on the facts and the legal basis for recovery, a claimant could recover money damages for the losses shown to have been caused by the defendant's behavior. Additional remedies might be available, depending on the legal basis for the claim.

Plaintiffs in Washington are not generally entitled to recover their attorney fees or litigation costs (except for small amounts set by state law) unless there is a specific statute, a contract provision, or recognized ground in case law providing for such recovery. Disputes over insurance coverage have been recognized in case law as permitting awards of attorney fees and costs. Likewise, plaintiffs in Washington are not generally entitled to collect punitive damages or damages in excess of their actual loss (such as double or triple the amount of actual loss), unless a statute or contract specifically provides for such payment.

### **The effect of the proposed measure, if approved:**

This measure is a referral to the people of a bill (ESSB 5726) passed by the 2007 session of the legislature. The term "this bill" refers here to the bill as passed by the legislature. A vote to "approve" this bill is a vote to approve ESSB 5726 as passed by the legislature. A vote to "reject" this bill is a vote to reject ESSB 5726 as passed by the legislature.

ESSB 5726 would amend the laws concerning unfair or deceptive insurance practices by providing that an insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any "first party claimant." The term "first party claimant" is defined in the bill to mean an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

ESSB 5726 would authorize any first party claimant to bring a lawsuit in superior court against an insurer for unreasonably denying a claim for coverage or payment of benefits, or violation of specified insurance commissioner unfair claims handling practices regulations, to recover damages and reasonable attorney fees, and litigation costs. A successful plaintiff could recover the actual damages sustained, together with reasonable attorney fees and litigation costs as determined by the court. The court could also increase the total award of damages to an amount not exceeding three times the actual damages, if the court finds that an insurer has acted unreasonably in denying a claim or has violated certain rules adopted by the insurance commissioner. The new law would not limit a court's existing ability to provide other remedies available at law. The claimant would be required to give written notice to the insurer and to the insurance commissioner's office at least twenty days before filing the lawsuit.

ESSB 5726 would not apply to a health plan offered by a health carrier as defined in the insurance code. The term "health carrier" includes a disability insurer, a health care service contractor, or a health maintenance organization as those terms are defined in the insurance code. The term "health plan" means any policy, contract, or agreement offered by a health carrier to provide or pay for health care services, with certain exceptions set forth in the insurance code. These exceptions include, among other things, certain supplemental coverage, disability income, workers' compensation coverage, "accident only" coverage, "dental only" and "vision only" coverage, and plans which have a short-term limited purpose or duration. Because these types of coverage fall outside the definition of "health plan," ESSB 5726's provision would apply to these exceptions to "health plans."



**Statement For Referendum Measure 67**

**APPROVE 67 - MAKE THE INSURANCE INDUSTRY TREAT ALL CONSUMERS FAIRLY.**

Referendum 67 simply requires the Insurance Industry to be fair and pay legitimate claims in a reasonable and timely manner. Without R-67, there is no penalty when insurers delay or deny valid claims. R-67 would help make the Insurance Industry honor its commitments by making it against the law to unreasonably delay or deny legitimate claims.

**APPROVE 67 - RIGHT NOW, THERE IS NO PENALTY FOR DELAYING OR DENYING YOUR VALID CLAIM.**

R-67 encourages the Insurance Industry to treat legitimate insurance claims fairly. R-67 allows the court to assess penalties if an insurance company illegally delays or denies payment of a legitimate claim.

**APPROVE 67 - YOU PAY FOR INSURANCE. THEY SHOULD KEEP THEIR PROMISES.**

When you pay your premiums on time, the Insurance Industry is supposed to pay your legitimate claims. Unfortunately, the Insurance Industry sometimes puts profits ahead of people and intentionally delays or denies valid claims. R-67 makes the Insurance Industry keep its promises and pay legitimate claims on time. That is why the Insurance Industry is spending millions of dollars to defeat it.

**APPROVE 67 - JOIN BIPARTISAN OFFICIALS AND CONSUMER GROUPS SUPPORTING FAIR TREATMENT BY THE INSURANCE INDUSTRY.**

Insurance Commissioner Mike Kriedler, former Insurance Commissioners, seniors, workers, and consumer groups urge you to approve R-67. Supporters include the Puget Sound Alliance of Senior Citizens, former Republican Party State Chair Dale Foreman, the Labor Council, and the Fraternal Order of Police.

**APPROVE 67 - R-67 SIMPLY MAKES SURE CLAIMS ARE HANDLED FAIRLY.**

If the Insurance Industry honors its commitments, R-67 does not impose any new requirements - other than making sure all claims are handled fairly. R-67 would have an impact only on those bad apples that unreasonably delay or deny valid insurance claims.

For more information, visit [www.approve67.org](http://www.approve67.org).

**Rebuttal of Statement Against**

Washington is one of only 5 states with no penalty when the Insurance Industry intentionally denies a valid claim. That is why the Insurance Industry is spending millions to defeat R67. Referendum 67 is only on the ballot because the Insurance Industry used its special-interest influence to block it from becoming law. Now you can vote to *approve* R67 to make fair treatment by the Insurance Industry the law. Approve R67 for Insurance Fairness.

**Voters Pamphlet Argument Prepared by:**  
STEPHEN KIRBY, Chair, House Insurance, Financial Services, Consumer Protection Committee; ALONN CAMPBELL, Chair, House Environmental Health Committee; DIANE SOSNE, RN, President, SEUWA; SKIP DREPS, Government Relations Director, Northwest Paralyzed Veterans; KELLY FOX, President, Washington State Council of Homeowners; STEVE DYBAK, Director, Alliance for Retired Americans.

**Statement Against Referendum Measure 67**

**REJECT FRIVOLOUS LAWSUITS. REJECT HIGHER INSURANCE RATES. REJECT R-67.**

As if there weren't enough frivolous lawsuits jacking up insurance rates, Washington's trial lawyers have invented yet another way to file more lawsuits to fatten their pocketbooks. They wrote and pushed a law through the Legislature that permits trial lawyers to threaten insurance companies with *triple damages* to force unreasonable settlements that will *increase insurance rates for all consumers*. The trial lawyers also included a provision that *guarantees payment of attorneys' fees*, sweetening the incentive to file frivolous lawsuits. There's no limit on the fees they can charge. What does this mean for consumers? You guessed it: *higher insurance rates*.

**TRIAL LAWYERS WIN. CONSUMERS LOSE.**

R-67 is a *windfall for trial lawyers* at the expense of consumers. Trial lawyers backed a similar law in California, but the resulting explosion of fraudulent claims and frivolous lawsuits caused auto insurance prices to increase 48% more than the national average (according to a national actuarial study) and *it was later repealed*.

**CURRENT LAW PROTECTS CONSUMERS.**

Insurance companies have a legal responsibility to treat people fairly, and *consumers can sue insurance companies under current law* if they believe their claim was handled improperly. The Insurance Commissioner can—and does—levy stiff fines, or even ban an insurance company from the state, if the company mistreats consumers.

**R-67 IS BAD NEWS FOR CONSUMERS. REJECT R-67.**

Not only does R-67 raise auto and homeowners insurance rates, it applies to small businesses and doctors as well. That means *higher medical bills and higher prices for goods and services*.

Laws should reduce frivolous lawsuits, not create more. Reject R-67!

See for yourself. Visit [www.REJECT67.org](http://www.REJECT67.org).

**Rebuttal of Statement For**

Don't be fooled.

Trial lawyers didn't push this law through the legislature to protect *your* rights. They want this law because it gives them new opportunities to file *frivolous lawsuits* and collect *fat lawyers' fees*.

Trial lawyers don't care if frivolous lawsuits jack up our insurance rates. *Consumers, doctors and small businesses will pay more* so trial lawyers can file more lawsuits and collect larger fees.

Reject frivolous lawsuits and excessive lawyers' fees. Reject 67.

**Voters Pamphlet Argument Prepared by:**  
W. HUGH MALONEY, M.D., President, Washington State Medical Association; DON BRUNELL, President, Association of Washington Business; RICHARD BIGGS, President, Professional Insurance Agents of Washington; DANA CHIDDERS, Executive Director, Disability Reform Coalition; TROY NICHOLS, Washington State Director, National Federation of Independent Business; BILL GARRITY, President, Washington Construction Industry Council.

The Office of the Secretary of State is not authorized to edit statements, nor is it responsible for their contents.

West's Revised Code of Washington Annotated Title 48. Insurance (Refs & Annos) Chapter 48.30. Unfair Practices and Frauds (Refs & Annos)
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West's RCWA 48.30.010

48.30.010. Unfair practices in general--Remedies and penalties

Effective: December 6, 2007

Currentness

- (1) No person engaged in the business of insurance shall engage in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of such business as such methods, acts, or practices are defined pursuant to subsection (2) of this section.
- (2) In addition to such unfair methods and unfair or deceptive acts or practices as are expressly defined and prohibited by this code, the commissioner may from time to time by regulation promulgated pursuant to chapter 34.05 RCW, define other methods of competition and other acts and practices in the conduct of such business reasonably found by the commissioner to be unfair or deceptive after a review of all comments received during the notice and comment rule-making period.
- (3)(a) In defining other methods of competition and other acts and practices in the conduct of such business to be unfair or deceptive, and after reviewing all comments and documents received during the notice and comment rule-making period, the commissioner shall identify his or her reasons for defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive and shall include a statement outlining these reasons as part of the adopted rule.
- (b) The commissioner shall include a detailed description of facts upon which he or she relied and of facts upon which he or she failed to rely, in defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive, in the concise explanatory statement prepared under RCW 34.05.325(6).
- (c) Upon appeal the superior court shall review the findings of fact upon which the regulation is based de novo on the record.
- (4) No such regulation shall be made effective prior to the expiration of thirty days after the date of the order by which it is promulgated.
- (5) If the commissioner has cause to believe that any person is violating any such regulation, the commissioner may order such person to cease and desist therefrom. The commissioner shall deliver such order to such person direct or mail it to the person by registered mail with return receipt requested. If the person violates the order after expiration of ten days after the cease and desist order has been received by him or her, he or she may be fined by the commissioner a sum not to exceed two hundred and fifty dollars for each violation committed thereafter.
- (6) If any such regulation is violated, the commissioner may take such other or additional action as is permitted under the insurance code for violation of a regulation.

(7) An insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant. "First party claimant" has the same meaning as in RCW 48.30.015.

**Credits**

[2007 c 498 § 2 (Referendum Measure No. 67, approved November 6, 2007); 1997 c 409 § 107; 1985 c 264 § 13; 1973 1st ex.s. c 152 § 6; 1965 ex.s. c 70 § 24; 1947 c 79 § .30.01; Rem. Supp. 1947 § 45.30.01.]

Notes of Decisions (70)

West's RCWA 48.30.010, WA ST 48.30.010

Current with all laws from the 2015 Regular and Special Sessions and Laws 2016, chs. 1 and 2

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End of Document

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West's Revised Code of Washington Annotated  
Title 48. Insurance (Refs & Annos)  
Chapter 48.30. Unfair Practices and Frauds (Refs & Annos)

West's RCWA 48.30.015

48.30.015. Unreasonable denial of a claim for coverage or payment of benefits

Effective: December 6, 2007

Currentness

(1) Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs, as set forth in subsection (3) of this section.

(2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in subsection (5) of this section, increase the total award of damages to an amount not to exceed three times the actual damages.

(3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

(4) "First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

(5) 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"; or

(f) An unfair claims settlement practice rule adopted under RCW 48.30.010 by the insurance commissioner intending to implement this section. The rule must be codified in chapter 284-30 of the Washington Administrative Code.

(6) This section does not limit a court's existing ability to make any other determination regarding an action for an unfair or deceptive practice of an insurer or provide for any other remedy that is available at law.

(7) This section does not apply to a health plan offered by a health carrier. "Health plan" has the same meaning as in RCW 48.43.005. "Health carrier" has the same meaning as in RCW 48.43.005.

(8)(a) Twenty days prior to filing an action based on this section, a first party claimant must provide written notice of the basis for the cause of action to the insurer and office of the insurance commissioner. Notice may be provided by regular mail, registered mail, or certified mail with return receipt requested. Proof of notice by mail may be made in the same manner as prescribed by court rule or statute for proof of service by mail. The insurer and insurance commissioner are deemed to have received notice three business days after the notice is mailed.

(b) If the insurer fails to resolve the basis for the action within the twenty-day period after the written notice by the first party claimant, the first party claimant may bring the action without any further notice.

(c) The first party claimant may bring an action after the required period of time in (a) of this subsection has elapsed.

(d) If a written notice of claim is served under (a) of this subsection within the time prescribed for the filing of an action under this section, the statute of limitations for the action is tolled during the twenty-day period of time in (a) of this subsection.

#### **Credits**

[2007 c 498 § 3 (Referendum Measure No. 67, approved November 6, 2007).]

Notes of Decisions (46)

West's RCWA 48.30.015, WA ST 48.30.015

Current with all laws from the 2015 Regular and Special Sessions and Laws 2016, chs. 1 and 2

Washington Administrative Code  
Title 284. Insurance Commissioner, Office of  
Chapter 284-30. Trade Practices (Refs & Annos)  
the Unfair Claims Settlement Practices Regulation

WAC 284-30-330

284-30-330. Specific unfair claims settlement practices defined

Currentness

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:

- (1) Misrepresenting pertinent facts or insurance policy provisions.
- (2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- (3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
- (4) Refusing to pay claims without conducting a reasonable investigation.
- (5) Failing to affirm or deny coverage of claims within a reasonable time after fully completed proof of loss documentation has been submitted.
- (6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to promptly pay property damage claims to innocent third parties in clear liability situations. If two or more insurers share liability, they should arrange to make appropriate payment, leaving to themselves the burden of apportioning liability.
- (7) Compelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.
- (8) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.
- (9) Making a claim payment to a first party claimant or beneficiary not accompanied by a statement setting forth the coverage under which the payment is made.

(10) Asserting to a first party claimant a policy of appealing arbitration awards in favor of insureds or first party claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring a first party claimant or his or her physician to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

(12) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(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.

(14) Unfairly discriminating against claimants because they are represented by a public adjuster.

(15) Failing to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three working days after notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of a draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.

(16) Failing to adopt and implement reasonable standards for the processing and payment of claims after the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver a check or draft to the payee in payment of a settled claim within fifteen business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to a claimant, it must do so within twenty working days after a settlement has been reached.

(17) Delaying appraisals or adding to their cost under insurance policy appraisal provisions through the use of appraisers from outside of the loss area. The use of appraisers from outside the loss area is appropriate only where the unique nature of the loss or a lack of competent local appraisers make the use of out-of-area appraisers necessary.

(18) Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.

(19) Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent. This does not prohibit routine inquiries to a first party claimant to identify the claimant or to obtain details concerning the claim.

#### **Credits**

Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-330, filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-330, filed 4/21/87. Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-330, filed 7/27/78, effective 9/1/78.

Current with amendments adopted through the 15-24 Washington State Register dated, December 16, 2015.

WAC 284-30-330, WA ADC 284-30-330

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Please accept for filing the attached Petitioner's Opening Brief. Thank you.

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