

No. 88706-3
IN THE SUPREME COURT OF THE
STATE OF WASHINGTON

CERTIFICATION FROM THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON IN RE:

ENZO MORELLA,

Appellant,

v.

SAFECO INSURANCE COMPANY OF ILLINOIS,

Respondent.

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TABLE OF CONTENTS

TABLE OF AUTHORITIES	iii
I. INTRODUCTION	1
II. STATEMENT OF ISSUE	2
III. STATEMENT OF THE CASE	2
IV. ARGUMENT	5
A. Standard of Review and Interpretation of a Referendum	5
B. The Meaning of “Actual Damages” in the IFCA	6
1. Statutory Language	6
2. Case Law on “Actual Damages”	8
a. “Actual Damages” Means “Full Compensatory Damages”	8
b. “Actual Damages” Includes Emotional Harm Damages	10
c. CPA Cases are of Limited Value, But Support an Award of Interest and Litigation Fees/Costs for Non-IFCA Litigation as “Actual Damages”	12
3. The Meaning of “Actual Damages” in the IFCA is Ambiguous	16
C. Application of the Intent of the Voters to the Meaning of “Actual Damages” Under the IFCA	18
1. Read in Light of the Intent of the Voters, “Actual Damages” Must Include the Amount Wrongfully Withheld by the Insurer Even if the Insurer was Later Forced by Litigation to Make Payment	18

2.	A Hypothetical Illustration of Damages Under the IFCA	23
V.	CONCLUSION	25

TABLE OF AUTHORITIES

Case Law

<i>Amalgamated Transit Union Local 587 v. State</i> , 142 Wn.2d 183, 11 P.3d 762 (2001)	5-6
<i>American Legion Post #149 v. Washington State Dept. of Health</i> , 164 Wn.2d 570, 192 P.3d 306 (2008)	15
<i>American Manufacturers Mut. Ins. Co. v. Osborn</i> , 104 Wn. App. 686, 17 P.3d 1229 (Div. 2 2001)	11
<i>Anderson v. State Farm Mut. Ins. Co.</i> , 101 Wn. App. 323, 2 P.3d 1029 (Div. 1 2000)	11
<i>In re Appeal of Chiyoda Chemical Engineering and Const. Co., Ltd.</i> , 35 Wn. App. 785, 670 P.2d 663 (Div. 1 1983)	3
<i>Belas v. Kiga</i> , 135 Wn.2d 913, 959 P.2d 1037 (1998)	6
<i>Blaney v. International Ass'n of Machinists and Aerospace Workers</i> , 151 Wn.2d 203, 87 P.3d 757 (2004)	9-10
<i>Bradburn v. N. Cent. Reg'l Library Dist.</i> , 168 Wn.2d 789, 231 P.3d 166 (2010)	5
<i>Broughton Lunber Co. v. BNSF Ry. Co.</i> , 174 Wn.2d 619, 278 P.3d 173 (2012)	13
<i>Bylsma v. Burger King Corp.</i> , 176 Wn.2d 555, 293 P.3d 1198 (2013)	5
<i>City of Seattle v. McCready</i> , 131 Wn.2d 266, 931 P.2d 156 (1997)	14
<i>City of Tacoma v. State</i> , 117 Wn.2d 348, 816 P.2d 7 (1991)	5

<i>Coventry Associates v. American States Ins. Co.</i> , 136 Wn.2d 269, 961 P.2d 933 (1998)	8, 11
<i>Cox v. Helenius</i> , 103 Wn.2d 383, 693 P.2d 683 (1985)	15
<i>In re Estate of Blessing</i> , 174 Wn.2d 228, 273 P.3d 975 (2012)	13
<i>In re Forfeiture of One 1970 Chevrolet Chevelle</i> , 166 Wn.2d 834, 215 P.3d 166 (2009)	13
<i>Gertz v. Robert Welch, Inc.</i> , 418 U.S. 323, 94 S.Ct. 2997, 41 L.Ed.2d 789 (1974)	10
<i>Lynch v. Dep't of Labor & Indus.</i> , 19 Wn.2d 802, 145 P.2d 265 (1944)	6
<i>Martini v. The Boeing Co.</i> , 137 Wn.2d 357, 971 P.2d 45 (1999)	8-9, 10
<i>McIllwain v. State Farm Mut. Auto. Ins. Co.</i> , 133 Wn. App. 439, 136 P.3d 135 (Div. 3 2006)	19
<i>Panag v. Farmers Ins. Co. of Washington</i> , 166 Wn.2d 27, 204 P.3d 885 (2009)	8, 12, 13
<i>Panorama Village Condominium Owners Ass'n Bd. of Directors v. Allstate Ins. Co.</i> , 144 Wn.2d 130, 26 P.3d 910 (2001)	14
<i>Razor v. Retail Credit Company</i> , 87 Wn.2d 516, 554 P.2d 1041 (1976)	8, 9, 10-11, 21
<i>Rest. Dev., Inc. v. Cananwill, Inc.</i> , 150 Wn.2d 674, 80 P.3d 598 (2003)	16
<i>Safeco Ins. Co. v. Butler</i> , 118 Wn.2d 383, 823 P.2d 499 (1992)	20
<i>Seattle Times Co. v. Benton County</i> , 99 Wn.2d 251, 661 P.2d 964 (1983)	3

<i>Senate Republican Campaign Comm. v. Pub. Disclosure Comm'n</i> , 133 Wn.2d 229, 943 P.2d 1358 (1997)	5
<i>Sing v. John L. Scott, Inc.</i> , 83 Wn. App. 55, 920 P.2d 589 (1996), <i>rev'd on other grounds</i> , 134 Wn.2d 24, 948 P.2d 816 (1997)	9
<i>Snyder v. Tompkins</i> , 20 Wn. App. 167, 579 P.2d 994 (Div. 2 1978)	14
<i>Sorrel v. Eagle Healthcare Inc.</i> , 110 Wn. App. 290, 38 P.3d 1024 (Div. 1 2002)	13
<i>State v. Brown</i> , 139 Wn.2d 20, 983 P.2d 608 (1999)	5
<i>State v. Budik</i> , 173 Wn.2d 727, 272 P.3d 816 (2012)	16, 18
<i>State v. Thorne</i> , 129 Wn.2d 736, 921 P.2d 514 (1996)	6
<i>State Farm Ins. Co. v. Huynh</i> , 92 Wn. App. 454, 962 P.2d 854 (Div. 1 1998)	13
<i>Tobin v. Dept. of L&I</i> , 145 Wn. App. 607, 187 P.3d 780 (Div. 2 2008)	3
<i>Wash. State Dep't of Revenue v. Hoppe</i> , 82 Wn.2d 539, 512 P.2d 1094 (1973)	5
<i>Wells v. Aetna Ins. Co.</i> , 60 Wn.2d 880, 376 P.2d 644 (1962)	14
<i>Werlinger v. Clarendon Nat. Ins. Co.</i> , 129 Wn. App. 804, 120 P.3d 593 (Div. 1 2005)	11

Statutes and Court Rules

15 U.S.C. § 1681	10
Ch. 19.86, RCW	12

Laws of 2007, ch. 496	2
RCW 19.86.090	12
RCW 48.30.010(7)	2
RCW 48.30.015	1, <i>passim</i>
RCW 49.60.030(2)	8, 9
RCW 49.60.180(3)	9
WAC 284-30-330(7)	4, 19, 24
WAC 284-30-380(1)	16, 19, 22, 24
Other Authorities	
<i>Black's Law Dictionary</i> (6 th ed. 1990)	9
<i>State of Washington Voter's Pamphlet, General Election, November 6, 2007</i>	3, 19, 20

I. INTRODUCTION

As a matter of first impression, this Court is asked by the United States District Court for the Western District of Washington to provide guidance on the meaning of “actual damages” as that term is used in the Insurer Fair Conduct Act, RCW 48.30.015 (“IFCA”). Plaintiff Enzo Morella asks this Court to hold that “actual damages” means full compensatory damages, which includes the following components: (1) the value of the wrongfully denied or delayed claim under the insurance policy; (2) emotional harm damages; (3) attorneys’ fees and costs incurred outside the IFCA action in establishing the value of the wrongfully denied or delayed claim; and (4) interest from the date that the claim should have been paid under applicable insurance regulations, to the date of IFCA judgment or actual payment. To avoid double recovery, after the discretionary enhancement of damages permitted by RCW 48.30.015(2), the trial court should subtract any amount already paid by the insurer on the wrongfully denied or delayed claim.

II. STATEMENT OF ISSUE

The question certified to this Court by the United States District Court for the Western District of Washington is:

How are “actual damages” calculated or defined under the Insurance Fair Conduct Act (RCW 48.30.015) where, as in this case, the insured obtained a \$62,000 arbitration award in his favor prior to initiating the IFCA action in state court?

U.S. Dist.Ct., W.D.Wa. Case #2:12-cv-00672, Docket #33 at 10 (attached hereto as Appendix A) (hereinafter “Certification Order”).

III. STATEMENT OF THE CASE

Appellant Enzo Morella accepts the Statement of Facts at pages 2-4 of the Certification Order, Appendix A to this Brief. To help orient the Court, a brief summary of the case is provided below.

In November 2007, the voters approved Referendum Measure 67, the Insurance Fair Conduct Act (“IFCA”). Laws of 2007, ch. 496, codified at RCW 48.30.010(7) and 48.30.015 (key provisions attached hereto as Appendix B); *see, Historical Note* after RCW 48.30.015. Among other things, the IFCA grants to first-party insureds a cause of action for up to three times their “actual damages” for any unreasonable denial of “a claim for coverage or payment of benefits by an insurer . . .” RCW 48.30.015(1), (2). According to the “Statement For Referendum

Measure 67” published in the Official State Voter’s Guide for the 2007 general election:

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.

State of Washington Voter’s Pamphlet, General Election, November 6, 2007 at 15 (relevant excerpts attached hereto as Appendix C) (hereinafter “2007 Voter’s Pamphlet”).¹

Enzo Morella was a passenger injured in an automobile accident in January 2006. *Certification Order* at 2. As a passenger, he was a covered “insured” under the Safeco automobile insurance policy. *Id.* Despite ongoing pain and suffering and medical treatments lasting at least through April 2007, and contrary to its own internal analysis, Safeco stuck to a “low-ball” settlement offer of \$1,500 until one week before the scheduled arbitration, when it raised its offer to \$45,000. *Id.* at 2-4. On November

¹ This Court can take judicial notice of the legislative history of a statute. *Seattle Times Co. v. Benton County*, 99 Wn.2d 251, 255 n.1, 661 P.2d 964 (1983); *Tobin v. Dept. of L&I*, 145 Wn. App. 607, 616 n.7, 187 P.3d 780 (Div. 2 2008); *In re Appeal of Chiyoda Chemical Engineering and Const. Co., Ltd.*, 35 Wn. App. 785, 795 n.2, 670 P.2d 663 (Div. 1 1983). An online version of this Voter’s Pamphlet can be found here: <http://www.clark.wa.gov/elections/documents/2007/general%20election%20voters%20pamphlet.pdf> (accessed 5/29/13).

22, 2010, the arbitrator awarded Mr. Morella \$62,000. *Id.* at 4. Safeco paid the award. *Id.* at 8.

Mr. Morella then filed an action in state court asserting claims of breach of contract, violations of Washington insurance regulations, bad faith, and violation of the IFCA. The action was removed to federal court in April 2012. *Certification Order* at 4.

On Plaintiff's Motion for Summary Judgment, the U.S. District Court ruled as follows:

- Safeco's "lowball offer in the hopes that its insured would accept less than adequate compensation for his damages in order to avoid the delay and expense of litigation" violated WAC 284-30-330(7), *Certification Order* at 4-5; and
- This conduct by an insurer constitutes an "unreasonable denial" of "a claim for . . . payment of benefits" within the meaning of the IFCA, RCW 48.30.015, *Certification Order* at 5-8.

The District Court then confronted the meaning of "actual damages" under the IFCA. Because this is relatively recent legislation, no definitive judicial interpretation of "actual damages" under the IFCA could be found. According to the District Court:

Morella argues that his damages under IFCA are the \$62,000 awarded in arbitration, *i.e.*, the amount that was necessary to compensate Morella for Safeco's unreasonable denial of payment of benefits owed under the policy. Safeco, on the other hand, rightly points out that the \$62,000 had already been paid at the time this action was filed and cannot be re-awarded in this lawsuit. What, then, are the "actual damages" that may be recovered in this IFCA action? Is it the

\$62,000 awarded in arbitration or is it simply the loss of use of that money for some period of time, the costs of the arbitration proceeding itself, or some other compensable injury?

Certification Order at 8-9. That is the question of first impression squarely presented to this Court for resolution.

IV. ARGUMENT

A. Standard of Review and Interpretation of a Referendum

This Court has stated that “[c]ertified questions from federal courts are pure questions of law that we review de novo.” *Bylsma v. Burger King Corp.*, 176 Wn.2d 555, 558, 293 P.3d 1198 (2013); *Bradburn v. N. Cent. Reg’l Library Dist.*, 168 Wn.2d 789, 799, 231 P.3d 166 (2010).

The following rules of statutory interpretation apply here:

[I]n determining the meaning of a statute enacted through the initiative process, the court's purpose is to ascertain the collective intent of the voters who, acting in their legislative capacity, enacted the measure. *Wash. State Dep’t of Revenue v. Hoppe*, 82 Wn.2d 539, 552, 512 P.2d 1094 (1973). Where the voters' intent is clearly expressed in the statute, the court is not required to look further. *Senate Republican Campaign Comm. v. Pub. Disclosure Comm’n*, 133 Wn.2d 229, 242, 943 P.2d 1358 (1997); *City of Tacoma v. State*, 117 Wn.2d 348, 356, 816 P.2d 7 (1991). . . . In determining intent from the language of the statute, the court focuses on the language as the average informed voter voting on the initiative would read it. *State v. Brown*, 139 Wn.2d 20, 28, 983 P.2d 608 (1999); *Senate Republican Campaign Comm.*, 133 Wn.2d at 243, 943 P.2d 1358. Where the language of an initiative enactment is plain, unambiguous, and well understood according to its natural and ordinary sense and meaning, the enactment is not subject to

judicial interpretation. *State v. Thorne*, 129 Wn.2d 736, 762-63, 921 P.2d 514 (1996). However, if there is ambiguity in the enactment, the court may examine the statements in the voters pamphlet in order to determine the voters' intent. *Thorne*, 129 Wn.2d at 763, 921 P.2d 514; *see, Lynch v. Dep't of Labor & Indus.*, 19 Wn.2d 802, 812-13, 145 P.2d 265 (1944).

Amalgamated Transit Union Local 587 v. State, 142 Wn.2d 183, 205-06, 11 P.3d 762 (2001); *see also, Belas v. Kiga*, 135 Wn.2d 913, 934, 959 P.2d 1037 (1998) (Court examines voter's pamphlet to help construe the meaning of a Referendum).

B. The Meaning of "Actual Damages" in the IFCA

1. Statutory Language

The relevant provisions of IFCA state:

(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 . . . , 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.

RCW 48.30.015(1), (2), (3) (emphasis added).

Simply reading the statutory language with the eye of the average informed voter, the following plain, ordinary meaning is apparent:

- (1) “Unreasonable denial” results in a right to recover (1) “the actual damages sustained,” and (2) litigation costs and attorneys’ fees. RCW 48.30.015(1).
- (2) Increasing the recovery up to three times the “actual damages” is within the trial court’s discretion. *Id.* § .015(2) (“may . . . increase”).
- (3) The award of “actual and statutory litigation costs” to the prevailing first-party insured includes “expert witness fees.” *Id.* § .015(3).
- (4) The award of litigation costs, including attorneys’ fees and expert witness fees, is mandatory. *Id.* § .015(3) (“shall . . . award”).

This still does not tell us what “actual damages” means, but it is a start. Because the plain language is not self-evident on its face, we need to examine case law on other similar statutes that use the phrase “actual damages.”

2. Case Law on “Actual Damages”

Washington cases have considered the meaning of the phrase “actual damages” in the context of the Washington Law Against Discrimination, *e.g.*, *Martini v. The Boeing Co.*, 137 Wn.2d 357, 971 P.2d 45 (1999), the Fair Credit Reporting Act, *e.g.*, *Rasor v. Retail Credit Company*, 87 Wn.2d 516, 554 P.2d 1041 (1976), and the Consumer Protection Act (“CPA”), *e.g.*, *Panag v. Farmers Ins. Co. of Washington*, 166 Wn.2d 27, 204 P.3d 885 (2009). In addition, Washington cases have considered appropriate remedies for the related tort of first-party insurer bad faith. *E.g.*, *Coventry Associates v. American States Ins. Co.*, 136 Wn.2d 269, 961 P.2d 933 (1998). While each of these authorities add something to the mix, Appellant will argue that the voters intended something more in the IFCA.

a. “Actual Damages” Means “Full Compensatory Damages”

Under the Washington Law Against Discrimination (“WLAD”):

Any person deeming himself or herself injured by any act in violation of this chapter shall have a civil action in a court of competent jurisdiction to enjoin further violations, or to recover **the actual damages sustained** by the person, or both, together with the cost of suit including reasonable attorneys’ fees

RCW 49.60.030(2) (emphasis added). In *Martini v. Boeing, supra*, 137 Wn.2d 357, a case involving disability discrimination by a former

employer, the issue was whether front pay and back pay were recoverable “actual damages” under the WLAD. *Id.* at 359. In answering “yes,” this Court explained the meaning of the term “actual damages” as follows:

“Actual damages” is a

[t]erm used to denote the type of damage award as well as the nature of injury for which recovery is allowed; thus, actual damages flowing from injury in fact are to be distinguished from damages which are nominal, exemplary or punitive. *Rasor v. Retail Credit Co.*, 87 Wn.2d 516, 554 P.2d 1041, 1049. “Actual damages” are synonymous with compensatory damages.

Black’s Law Dictionary 35 (6th ed. 1990).

As the dictionary definition notes, Washington courts have interpreted the term “actual damages” in this manner. *Rasor v. Retail Credit Co.*, 87 Wn.2d 516, 530, 554 P.2d 1041 (1976) (stating that actual damages “Encompass all the elements of compensatory awards”); *Sing v. John L. Scott, Inc.*, 83 Wn. App. 55, 70, 920 P.2d 589 (1996), *rev’d on other grounds*, 134 Wn.2d 24, 948 P.2d 816 (1997). Thus RCW 49.60.030(2) provides a person who has been discriminated against in violation of RCW 49.60.180(3) with a remedy for full compensatory damages, excluding only nominal, exemplary or punitive damages.

Martini, supra, 137 Wn.2d at 367-68.

The primary and most generally-applicable meaning of “actual damages” under Washington law is, therefore: **“full compensatory damages, excluding only nominal, exemplary or punitive damages.”**

Id. at 368 (emphasis added); *accord, Blaney v. International Ass’n of*

Machinists and Aerospace Workers, 151 Wn.2d 203, 216, 87 P.3d 757 (2004).

b. “Actual Damages” Includes Emotional Harm Damages

Full compensatory damages in tort includes mental distress damages, and so does the term “actual damages” under Washington case law. In *Rasor v. Retail Credit*, *supra*, 87 Wn.2d 516, the case most heavily relied upon by the Court in *Martini*, *supra*, this Court confronted the meaning of “actual damages” under the Federal Fair Credit Reporting Act, 15 U.S.C. § 1681 et. seq. *Rasor*, *supra*, 87 Wn.2d at 517. Ms. Rasor, a small-town businesswoman, applied for life insurance required for a business loan, and was turned down after a shoddy investigation disclosed alleged past extramarital living arrangements and drinking. *Id.* at 518. The trial court instructed the jury that “actual damages” could include “any injury which she has sustained by way of injuries to her feelings,” and “the mental suffering, if any, produced by such violation of the act.” *Id.* at 525. Citing *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 94 S.Ct. 2997, 41 L.Ed.2d 789 (1974) for the proposition that defamation damages include recovery for “personal humiliation, and mental anguish and suffering,” *Rasor*, *supra*, 87 Wn.2d at 529 (*quoting Gertz*, *supra*, 418 U.S. at 350), this Court affirmed that instruction:

[W]e hold that ‘actual damages’ under the Fair Credit Reporting Act are not limited to out-of-pocket losses, but encompass all the elements of compensatory awards generally, including those stated in the trial court’s instruction in the present case.

Rasor, supra, 87 Wn.2d at 530.

This view that “actual damages” encompasses emotional harm is in accord with cases holding that general tort compensatory damages for insurer bad faith include recovery of emotional harm damages. *Anderson v. State Farm Mut. Ins. Co.*, 101 Wn. App. 323, 333, 2 P.3d 1029 (Div. 1 2000); *Werlinger v. Clarendon Nat. Ins. Co.*, 129 Wn. App. 804, 809, 120 P.3d 593 (Div. 1 2005); *American Manufacturers Mut. Ins. Co. v. Osborn*, 104 Wn. App. 686, 697-98, 17 P.3d 1229 (Div. 2 2001); *see also, Coventry Associates v. American States Ins., supra*, 136 Wn.2d at 284 (“Because actionable bad faith is a tort, a plaintiff should not be limited to the economic damages within the contemplation of the parties at the time the contract was made.”). Insurance is purchased in order to buy **peace of mind**:

[T]he insurance contract brings the insured a certain peace of mind that the insurer will deal with it fairly and justly when a claim is made. Conduct by the insurer which erodes the security purchased by the insured breaches the insurer’s duty to act in good faith.

Coventry v. American States Ins., supra, 136 Wn.2d at 283. The disruption of that peace of mind by unreasonable denials of coverage or

delay in payment of benefits that are due is compensable in tort, and therefore part of the full compensatory damages under the IFCA.

c. CPA Cases are of Limited Value, But Support an Award of Litigation Fees/Costs for Non-IFCA Litigation

Other case law considering the meaning of “actual damages” arises under the Washington Consumer Protection Act, ch. 19.86, RCW (“CPA”). Part of the CPA’s damages language is very similar to the IFCA:

[Suit authorized] to recover the actual damages sustained by him or her, or both, together with the costs of the suit, including a reasonable attorney's fee . . .

RCW 19.86.090. However, the remedy under the CPA is limited to “[a]ny person who is injured in his or her **business or property** . . .,” *id.* (emphasis added), and the IFCA contains no such limitation. *Compare id.*, with RCW 48.30.015(1). The limitation to injury to “business or property” under the CPA is significant:

Personal injuries, as opposed to injuries to “business or property,” are not compensable and do not satisfy the injury requirement. Thus, damages for mental distress, embarrassment, and inconvenience are not recoverable under the CPA.

Panag, supra, 166 Wn.2d at 57 (citations omitted). This key difference in statutory language and purpose is reason to reject authorities under the CPA as a complete and reliable guide to the meaning of “actual damages”

under the IFCA. *See, e.g., Broughton Lumber Co. v. BNSF Ry. Co.*, 174 Wn.2d 619, 639-40, 278 P.3d 173 (2012) (similar statutes with differing language rejected as guide to construction of statute at bar); *In re Estate of Blessing*, 174 Wn.2d 228, 237, 273 P.3d 975 (2012) (differences in purpose of other statutes precludes their use in statutory construction); *In re Forfeiture of One 1970 Chevrolet Chevelle*, 166 Wn.2d 834, 842, 215 P.3d 166 (2009) (“Where the legislature uses certain statutory language in one statute and different language in another, a difference in legislative intent is evidenced.”).

With this caveat in mind, it is still possible to rely on CPA authorities for guidance on the pecuniary losses that might constitute “actual damages” under the IFCA. In that regard, *Panag v. Farmers Ins.*, *supra*, 166 Wn.2d 27, demonstrates that the full and comprehensive litigation expenses incurred, including attorneys’ fees, expert witness fees, postage, parking, client time assisting the attorney, disruption to the client’s business, and interest for the delay in payment of money, are all recoverable as “actual damages” in CPA claims, where the deceptive act forces the plaintiff into litigation. *Id.* at 58, 62-64; *accord, e.g., Sorrel v. Eagle Healthcare Inc.*, 110 Wn. App. 290, 298, 38 P.3d 1024 (Div. 1 2002); *State Farm Ins. Co. v. Huynh*, 92 Wn. App. 454, 470, 962 P.2d 854 (Div. 1 1998). Because denial of coverage or delay in payment can force

the insured into arbitration to establish the value of the amount due under the policy, these enhanced litigation costs and interest damages should be considered a component of “actual damages” under the IFCA.²

This line of authority creates the appearance of an anomaly under the language of the IFCA. The IFCA §§ .015(1) and (3) appear to treat “actual damages” and “costs of the action, including reasonable attorneys’ fees and litigation costs” separately, as two different things. Yet the CPA decisions treat fees and costs incurred when a deceptive act involves the consumer in litigation as “actual damages.” Further complicating the question, under the facts of this case, Mr. Morella has incurred fees and costs in two different (but closely related) proceedings: the UIM arbitration against Safeco to establish the value of his claim, and the IFCA action to establish Safeco’s unreasonable denial of payment under the policy.

² See also, *Panorama Village Condominium Owners Ass’n Bd. of Directors v. Allstate Ins. Co.*, 144 Wn.2d 130, 143-45, 26 P.3d 910 (2001) (“reasonable attorneys’ fees” automatically includes such litigation costs as expert witness fees when insureds are forced to file suit in order to obtain the benefit of their insurance contract). This outcome is further supported by analogy to the case law that finds an equitable exception to the American Rule on attorneys’ fees when the tortious conduct of one party exposes another party to litigation with a third person. *City of Seattle v. McCready*, 131 Wn.2d 266, 274, 931 P.2d 156 (1997); *Wells v. Aetna Ins. Co.*, 60 Wn.2d 880, 882-83, 376 P.2d 644 (1962); *Snyder v. Tompkins*, 20 Wn. App. 167, 174, 579 P.2d 994 (Div. 2 1978). While in this case Safeco Insurance, not the underinsured driver, was the opposing party in the UIM arbitration, that was only because Safeco stood in the shoes of the underinsured driver for purposes of UIM coverage. Safeco’s tortious conduct in low-balling its offer of the amounts due under the UIM coverage forced Mr. Morella into an arbitration to prove the amount due on his claim against the underinsured driver.

The resolution of this apparent dilemma is found in a close reading of the IFCA. Section .015(1) creates the IFCA cause of action to recover “actual damages” and fees/costs for unreasonable denial of coverage or payment of benefits. RCW 48.30.015(1). Section .015(3) provides for an award of fees and costs “**in such action.**” RCW 48.30.015(3) (emphasis added). It thus appears that fees and costs incurred in the IFCA action are recoverable under IFCA § .015(3) as fees / costs, whereas any attorneys fees, expert witness fees, or other costs incurred outside of the IFCA in the course of arbitrating or litigating to prove the value of the unreasonably denied claim constitute “actual damages,” recoverable under IFCA § .015(1), and subject to trebling under IFCA § .015(2).

A court must, when possible, “give effect to every word, clause and sentence of a statute.”

American Legion Post #149 v. Washington State Dept. of Health, 164 Wn.2d 570, 585, 192 P.3d 306 (2008) (quoting, *Cox v. Helenius*, 103 Wn.2d 383, 387, 693 P.2d 683 (1985)). This differing treatment of IFCA-related fees/costs versus non-IFCA fees/costs is the best way to give effect to every word in the IFCA.³

³ It should be noted that not every case will even involve litigation outside the IFCA action, since some parties will immediately sue under the IFCA, rather than arbitrate the amount due under the UIM provisions of the policy. Under those circumstances, all the attorneys fees and other litigation expense will be outside the scope of “actual damages” under the IFCA, because recoverable under RCW 48.30.015(3).

3. The Meaning of “Actual Damages” in the IFCA is Ambiguous

This Court has a precise test for determining whether a statute is ambiguous:

If the statute remains susceptible to more than one reasonable interpretation, it is ambiguous, and we “look to the legislative history of the statute and the circumstances surrounding its enactment to determine legislative intent.” *Rest. Dev., Inc. v. Cananwill, Inc.*, 150 Wn.2d 674, 682, 80 P.3d 598 (2003).

State v. Budik, 173 Wn.2d 727, 733, 272 P.3d 816 (2012) (emphasis added).

Having considered the term “actual damages” in light of the meaning given by an average informed voter, and in light of case law for other similar statutory provisions, we conclude that “actual damages” in the IFCA means:

- (1) Full compensatory damages;
- (2) Including emotional harm damages; and
- (3) Interest from the time that payment should have been made under WAC 284-30-380(1) until the time it is made or, if not made, until the date of the IFCA judgment;⁴ and

⁴ “Within fifteen working days after receipt by the insurer of fully completed and executed proofs of loss, the insurer must notify the first party claimant whether the claim has been accepted or denied. . . .” WAC 284-30-380(1).

- (4) Attorneys' fees, expert witness fees, and broad litigation costs, incurred in non-IFCA litigation caused by the unreasonable denial; but
- (5) Excluding costs of litigation, such as attorneys' fees and expert witness fees, in the IFCA claim against the insurer, because these are separately provided for by RCW 48.30.015(3).

Elements (2) - (5) of "actual damages" are clear, but with respect to point (1) the difficulty remains: *what are "full compensatory damages" under the circumstances of a low-ball offer by the insurer that forces the insured to litigate to judgment, after the judgment has been paid?* The answer to this question is reasonably susceptible to more than one interpretation. Mr. Morella's interpretation is that his actual damages are the amount that he should have been paid under the policy without any need for litigation, along with emotional harm damages, the costs of non-IFCA arbitration to establish the value of his claim, and interest for delay in payment. But, as the District Court noted, there is another possible interpretation: "Safeco, on the other hand, rightly points out that the \$62,000 had already been paid at the time this action was filed and cannot be re-awarded in this lawsuit." *Certification Order* at 8. Significantly, the District Court also found that Mr. Morella's \$62,000 arbitration award would clearly be the correct measure, but for

the procedural posture of this particular case which led the insurer to make payment after entry of the arbitration award:

It seems clear that, had Morella filed suit seeking both a benefits determination and relief under IFCA upon receipt of Safeco's lowball offer of \$1,500, his "actual damages" in that combined action would likely have been the amount of benefits awarded – \$62,000.

Certification Order at 9.

Because the meaning of "actual damages" in the IFCA is susceptible to more than one reasonable interpretation, it is ambiguous. *State v. Budik, supra*, 173 Wn.2d at 733. Because it is ambiguous, this Court needs to consider the intent of the voters as expressed in the 2007 Voter's Pamphlet in determining its meaning.

C. Application of the Intent of the Voters to the Meaning of "Actual Damages" Under the IFCA

1. Read in Light of the Intent of the Voters, "Actual Damages" Must Include the Amount Wrongfully Withheld by the Insurer Even if the Insurer was Later Forced by Litigation to Make Payment

The argument that the amount awarded to Mr. Morella is not part of his "actual damages" for violation of the IFCA reduces to this:

By engaging in the very misconduct that the IFCA was intended to prevent – forcing insureds to litigate to obtain the benefits to which

they are entitled under the policy – insurers can reduce their IFCA damages and avoid the penalty intended by the voters.

Recall that the purpose of Referendum 67 was to require “the Insurance Industry to be fair and pay legitimate claims in a reasonable and timely manner.” *2007 Voter’s Pamphlet* at 15. Under the first-party insurance coverage in this case, a timely payment would have been made “[w]ithin fifteen working days after receipt by the insurer of fully completed and executed proofs of loss,” WAC 284-30-380(1), not after the claim was litigated to conclusion. Safeco promised to “pay damages which an insured is legally entitled to recover from the owner or operator of an underinsured motor vehicle because of bodily injury: 1. Sustained by an insured; and 2. Caused by an accident.” *U.S. Dist.Ct., W.D.Wa. Case #2:12-cv-00672, Docket #24, ex. 1 p.8*. The insured is not required to “prove fault in [a] court action or obtain judgment from the tortfeasor” in order to trigger his or her rights under the UIM coverage of the policy; all that is required is “that an action against the tortfeasor would have been viable if the other party would have been insured.” *McIllwain v. State Farm Mut. Auto. Ins. Co.*, 133 Wn. App. 439, 446, 136 P.3d 135 (Div. 3 2006). Indeed, compelling a first party insured to litigate to obtain benefits due under the policy is itself an unfair claims practice, WAC 284-30-330(7), which is specifically prohibited by the IFCA. RCW

48.30.015(5)(a). Because the insurer's first-party obligation to make fair payment is not contingent on a litigated outcome, the actual damages were proximately caused by Safeco's violation of the promise of **prompt payment** of the amounts to which its insured **was legally entitled without the necessity of litigation.**

It could be argued that this breach is fully remedied by payment of interest for the delay in payment plus some fees and costs, but that would not satisfy the intent of the voters in enacting the IFCA:

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. . . . R-67 allows the court to assess penalties if an insurance company illegally delays or denies payment of a legitimate claim.

2007 Voter's Pamphlet at 15. In light of this intent to impose a penalty on insurers when they force insureds to litigate in order to get paid their legitimate claims, this Court should not interpret "actual damages" so narrowly that little incentive is created to avoid the low-ball tactics employed here. An insurer should not be permitted to "act in bad faith without risking any additional loss." *Safeco Ins. Co. v. Butler*, 118 Wn.2d 383, 394, 823 P.2d 499 (1992). Only by counting the **value of the payment that was due under the policy without litigation** as part of the "actual damages" under the IFCA, can the intent of the voters be

effectuated in every case. If insurers were permitted to low-ball their offers in hopes that the insured will simply cave in rather than endure the expense and emotional strain of litigation, and then just pay a small amount for lost interest and attorneys fees in those few cases in which they are sued under the IFCA, the purpose of creating a disincentive to unreasonable delay would be frustrated. Indeed, the very action that the voters intended to penalize – unreasonable delay in payment of legitimate claims – would become the best way to avoid or to minimize the penalty under the Act.

This does not mean that the insured is entitled to double recovery. Instead, it means that the UIM award or other damages award set by a finder of fact after an insured is forced into full litigation is the best measure of the amount that should have been paid in a timely fashion under the policy, and therefore it is one key component of “actual damages.” *Rasor, supra*, 87 Wn.2d at 530-31 (court accepts the jury verdict damages as the correct measure of “actual damages” because “[n]either the trial court nor any appellate court should substitute its judgment for that of the jury as to the amount of damages.”); *Certification Order* at 9 (“It seems clear that, had Morella filed suit seeking both a benefits determination and relief under IFCA upon receipt of Safeco’s lowball offer of \$1,500, his “actual damages” in that combined action

would likely have been the amount of benefits awarded – \$62,000.”). The other components are emotional harm caused by the denial or delay, the non-IFCA fees and costs,⁵ and the interest on the amount due under the policy from the time that payment should have been made under WAC 284-30-380(1), to the time that it was actually made (or if not made, until entry of the IFCA judgment). Once this total amount is calculated, then the trial court can decide whether to enhance the damages up to three times the actual damages under RCW 48.30.015(2), in order to achieve the punitive and deterrent effect intended by the voters. **Then, and only then, the trial court should subtract the amount that the insurer has actually (and belatedly under compulsion of a judgment) paid to its insured.** Finally, the trial court should add the IFCA litigation costs, including attorneys’ fees and expert witness fees, to the award, as specified under RCW 48.30.015(3).

A first-party insured asserting a claim against an insurer will have a loss. If coverage is wrongfully denied, then it will not have been paid. But if there is a wrongful delay in payment, there may or may not have been payment by the time that the IFCA claim goes to judgment. Absent

⁵ As previously noted, not every case will involve non-IFCA fees/costs. *See note 3, supra.* This is another reason that the value of the claim must be included in “actual damages” in order to carry out the intent of the voters that a meaningful penalty be imposed for unreasonable denial or delay in payment of a claim.

clear and unequivocal contrary language in the statute, **the procedural posture ought not to determine the penalty.** As a matter of substance, whether paid after litigation or not, the insured was wrongfully and tortiously denied the benefit of the insurance policy in violation of the IFCA. In all cases, the proper compensatory award of “actual damages” is the amount to which the insured was legally entitled under the policy, plus emotional distress damages for breach of the promise of peace of mind, plus non-IFCA fees/costs and interest for delay in payment. The fact that the amount due under the policy was ultimately paid does not change the “actual damages” under the IFCA, but only means that the insurer is entitled to a credit for the amount of that payment after the penalty of the act – discretionary trebling – has been calculated.

2. A Hypothetical Illustration of Damages Under the IFCA

In an IFCA claim, assume that the compensatory harm has been reduced to judgment by a finder of fact at \$50,000 and paid one year after the date it should have been paid. Also assume that the finder of fact in the IFCA case has found emotional harm damages of \$25,000, and \$15,000 in non-IFCA litigation costs and attorneys’ fees to establish the value of the claim. In such a case, the “actual damages” are:

Amount to which the insured was legally entitled without litigation
– \$50,000; and

Emotional harm - \$25,000; and

Judgment rate interest on \$50,000 for one year (\$6,000); and

Non-IFCA litigation fees/costs - \$15,000.

This sum – \$96,000 – is the “actual damages” used for possible trebling under .015(2). The offense under the IFCA was committed at the time that payment was not made as specified in WAC 284-30-380(1), not when payment was ultimately made after entry of the arbitration award, and therefore the penalty must be based on the actual offense. It cannot be that by doing the very thing the voters intended to prevent – pushing the insured to litigate to judgment in contravention of RCW 48.30.015(5) and WAC 284-30-330(7) – the insurer can reduce its IFCA penalty.

Assume for purposes of this hypothetical that the trial court decides to treble the actual damages, for a total award of \$288,000. At that point, the trial court should subtract the \$50,000 already paid by the insurer, so that the award under IFCA § .015(2) is \$238,000. **This prevents double recovery, while preserving the penalty intended by the voters.**

Added to this, under .015(3), are all litigation costs for the IFCA action, including attorneys’ fees and expert witness fees. Assume in our hypothetical that these total \$20,000. In that case, the total IFCA

judgment will be \$258,000. Note that the IFCA litigation fees/costs are not part of the “actual damages” used for possible trebling.

V. CONCLUSION

The answer to the certified question should be:

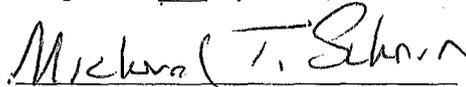
Actual damages under the IFCA means full compensatory damages, which includes the following components: (1) the value of the wrongfully denied or delayed claim under the insurance policy; (2) emotional harm damages; (3) attorneys’ fees and costs incurred outside the IFCA action in establishing the value of the wrongfully denied or delayed claim; and (4) interest from the date that the claim should have been paid under applicable insurance regulations, to the date of IFCA judgment or actual payment. To avoid double recovery, after the discretionary enhancement of damages permitted by RCW 48.30.015(2), the trial court should subtract any amount already paid by the insurer on the wrongfully denied or delayed claim.

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DATED at Seattle, Washington, this 14th day of June, 2013.



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APPENDIX A

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

ENZO MORELLA,

Plaintiff,

v.

SAFECO INSURANCE COMPANY OF
ILLINOIS,

Defendant.

No. C12-0672RSL

ORDER GRANTING IN PART
PLAINTIFF'S MOTION FOR
SUMMARY JUDGMENT AND
CERTIFYING QUESTION TO
STATE SUPREME COURT

This matter comes before the Court on "Plaintiff's Motion for Summary Judgment." Dkt. # 23. Summary judgment is appropriate when, viewing the facts in the light most favorable to the nonmoving party, there is no genuine dispute as to any material fact that would preclude the entry of judgment as a matter of law. Addisu v. Fred Meyer, Inc., 198 F.3d 1130, 1134 (9th Cir. 2000). The party seeking summary dismissal of the case "bears the initial responsibility of informing the district court of the basis for its motion" (Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986)) and identifying those portions of the materials in the record that show the absence of a genuine issue of material fact (Fed. R. Civ. P. 56(c)(1)). Once the moving party has satisfied its burden, it is entitled to summary judgment if the non-moving party fails to designate "specific facts showing that there is a genuine issue for trial." Celotex Corp., 477 U.S. at 324. "The mere existence of a scintilla of evidence in support of the non-moving

ORDER GRANTING IN PART PLAINTIFF'S
MOTION FOR SUMMARY JUDGMENT AND
CERTIFYING QUESTION TO SUPREME COURT

1 party's position is not sufficient." the opposing party must present probative evidence in support
2 of its claim or defense. Arpin v. Santa Clara Valley Transp. Agency, 261 F.3d 912, 919 (9th Cir.
3 2001); Intel Corp. v. Hartford Accident & Indem. Co., 952 F.2d 1551, 1558 (9th Cir. 1991). In
4 other words, "summary judgment should be granted where the nonmoving party fails to offer
5 evidence from which a reasonable jury could return a verdict in its favor." Triton Energy Corp.
6 v. Square D Co., 68 F.3d 1216, 1221 (9th Cir. 1995).

7 Having reviewed the memoranda, declarations, and exhibits submitted by the
8 parties and taking the evidence in the light most favorable to Safeco Insurance Company, the
9 Court finds as follows:

10 **BACKGROUND**

11 On January 13, 2006, plaintiff Enzo Morella was injured when the truck in which
12 he was riding was struck from behind by an uninsured motorist. Although Morella did not
13 require medical attention at the scene, he went to the doctor shortly thereafter and reported that
14 he had been experiencing neck pain and headaches since the accident. When anti-
15 inflammatories and ice did not relieve the neck pain, Morella was given muscle relaxants and
16 sent to physical therapy. He also went to a massage therapist. Morella discontinued physical
17 therapy after eleven sessions because he had exhausted his medical benefits. More than six
18 months later, in October 2006, he returned to the doctor complaining of neck pain and headaches
19 and exhibiting the same sort of tenderness and mobility restrictions he had shown before. The
20 doctor again prescribed physical therapy. In April 2007, the doctor noted that Morella's
21 recurring mechanical dysfunction fit the injury patterns associated with rear-end collisions,
22 found that his injuries were "resolved" or "mostly resolved," and released Morella from his care.

23 Safeco had issued a policy of insurance to the driver of the truck, and Morella was
24 covered as an "insured" under that policy. Although it is not clear when or how Safeco received
25 notice of Morella's claim for uninsured motorist benefits, on May 13, 2008, Safeco offered
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1 \$1,500 in full settlement of his claim. At the time, Safeco calculated past medical expenses at
2 \$5,151.30 and estimated general damages between \$1,500 and \$3,000. Safeco did not include in
3 its evaluation any wage loss, but was aware that Morella was employed as a landscaper. The
4 \$1,500 settlement offer seems to have been prompted by the belief that Morella's recurring pain
5 and medical treatments were not causally related to the accident. The unidentified evaluator
6 states, "If insd would have continued treatment feel this would have resolved quickly with his
7 physical therapy treatment." Decl. of Sarah L. Eversole (Dkt. # 26), Ex. 1. Morella rejected the
8 settlement offer, noting that he had out of pocket healthcare expenses, was still in pain, had lost
9 time at work because of the injury and his various appointments, and had to hire someone to do
10 his job when he could not. Safeco requested additional information regarding the claimed
11 losses.

12 After rejecting Safeco's settlement offer, Morella consulted a chiropractor. He
13 described the January 2006 car accident and complained of neck, should, and back pain.
14 Morella underwent chiropractic and massage therapy treatments between May 23, 2008, and
15 November 26, 2008. On March 6, 2009, plaintiff provided to Safeco additional information
16 regarding his various courses of treatment and the impact the accident had on his work and
17 personal life. He claimed special damages of slightly over \$10,000 (including both medical
18 costs and mileage expenses), reserved the right to make a wage loss claim, and proposed a
19 settlement amount of \$75,000. Safeco again evaluated the claim file, both internally and using a
20 service called Mitchell Medical. The unidentified Safeco evaluator noted past medical expenses
21 of \$9,694.80 and estimated general damages between \$1,500 and \$6,000. Although the
22 evaluator had doubts about the causal connection between the accident and any medical
23 expenses after April 2007, he or she acknowledged that, in the context of an uninsured motorist
24 bodily injury claim, Safeco might be required to cover all of the medical costs. Although
25 Morella's claim was evaluated at between \$11,194.80 and \$15,694.80, Safeco opted to repeat its
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1 original settlement offer of \$1,500. No explanation of how this number was generated was
2 provided to Morella or his counsel.

3 On July 9, 2009, Morella demanded arbitration under the terms of the insurance
4 policy. Toward the end of 2010, as the arbitration date approached, Safeco hired experts to
5 evaluate whether the medical treatments Morella received were reasonable and necessary and to
6 quantify his economic damages. The medical examiner generally agreed with Safeco's internal
7 assessment that medical treatment after April 2007, at the latest, was not attributable to the
8 accident. The wage loss analysis resulted in an opinion that Morella had economic damages of
9 no more than \$1,755 as a result of the accident. Despite the fact that these two expert reports
10 actually reduced the estimated value of Morella's claim from the value that had been assigned by
11 Safeco's internal evaluator, Safeco revised its settlement offer from \$1,500 to \$45,000 in
12 October 2010. Morella again rejected the offer and the parties went to arbitration. The arbitrator
13 issued his decision on November 22, 2010, awarding \$62,000 in general damages (Morella had
14 waived his claim to recover medical expenses).

15 Morella then filed this action in state court asserting claims of breach of contract,
16 violations of the Washington insurance regulations, bad faith, and violations of the Washington
17 Insurance Fair Conduct Act ("IFCA"). The action was removed in April 2012 and discovery has
18 been completed. Through the pending motion, Morella seeks summary determinations that
19 (a) Safeco violated WAC 284-30-330(7), (b) Safeco violated IFCA, and (c) Morella suffered
20 "actual damages" for purposes of IFCA in the amount of \$62,000.

21 DISCUSSION

22 I. VIOLATION OF WAC 284-30-330(7)

23 The Washington insurance regulations identify "[c]ompelling a first party claimant
24 to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an
25 insurance policy by offering substantially less than the amounts ultimately recovered in such
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1 actions or proceedings” as an unfair method of competition and an unfair or deceptive act or
2 practice in the settlement of insurance claims. WAC 284-30-330(7). Safeco’s conduct in this
3 matter falls squarely within this regulation. Over the course of a year, Safeco twice offered
4 \$1,500 in settlement of a claim that was ultimately valued by the arbitrator at \$62,000,
5 substantially more than the amount offered. The insured initiated arbitration in order to recover
6 amounts due under the policy. Safeco suggests that Morella was not “compelled” to initiate
7 arbitration because he acted too soon: he should have given Safeco an opportunity to sweeten
8 the pot and negotiate a more reasonable settlement amount. Safeco offers no case law or other
9 authority suggesting that WAC 284-30-330(7) requires an insured to negotiate to an impasse
10 before seeking third-party assistance in obtaining the benefits of the insurance policy. Safeco’s
11 conduct in this matter – a lowball offer in the hopes that its insured would accept less than
12 adequate compensation for his damages in order to avoid the delay and expense of litigation – is
13 exactly the type of unfair act or practice at which WAC 284-30-330(7) is aimed.

14 **II. VIOLATION OF THE INSURANCE FAIR CONDUCT ACT (RCW 48.30.015)**

15 The Insurance Fair Conduct Act (“IFCA”) authorizes “first party claimant[s] to a
16 policy of insurance who [are] unreasonably denied a claim for coverage or payment of benefits
17 by an insurer [to] bring an action in superior court of this state to recover the actual damages
18 sustained, together with the costs of the action, including reasonable attorneys’ fees and
19 litigation costs.” RCW 48.30.015(1). The acts giving rise to an IFCA claim are described in the
20 disjunctive – the insured must show that the insurer unreasonably denied a claim for coverage or
21 that the insurer unreasonably denied payment of benefits. Safeco argues that IFCA is applicable
22 only if there is an outright denial of a claim for benefits under the policy. The argument is not
23 persuasive.

24 Safeco’s interpretation impermissibly conflates the two acts identified by the
25 legislature in RCW 48.30.015(1). Under the ordinary rules of statutory construction, all of the
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1 words of the statute must be given effect, so that no provision is rendered meaningless or
2 superfluous. State v. Roggenkamp, 153 Wn.2d 614, 624 (2005). Use of a conjunction in RCW
3 48.30.015(1) strongly suggests that the two elements are distinct, and use of the disjunctive
4 suggests that if either element is present, a claim exists under IFCA. A “denial of a claim for
5 coverage” cannot, therefore, be construed as the same thing as a “denial of payments of
6 benefits.”

7 Thus, the fact that Safeco did not deny Morella’s claim for coverage does not end
8 the analysis.¹ The Court must construe “denial of payments of benefits” to determine whether an
9 outright refusal to pay a specific benefit promised by the policy is required or whether an
10 unreasonably low payment will trigger the statute. Having reviewed RCW 48.30.015 as a whole
11 and virtually all of the relevant case law, the Court concludes that an insurer cannot escape IFCA
12 simply by accepting a claim and paying or offering to pay an unreasonable amount. The benefits
13 to which a first-party insured is entitled are generally described as payment of the reasonable
14 expenses or losses incurred as a result of an insured event. See Decl. of James E. Banks (Dkt.
15 # 24), Ex. 1 (Safeco Policy No. H1874894). Where the insurer pays or offers to pay a paltry
16 amount that is not in line with the losses claimed, is not based on a reasoned evaluation of the
17 facts (as known or, in some cases, as would have been known had the insurer adequately
18 investigated the claim), and would not compensate the insured for the loss at issue, the benefits
19 promised in the policy are effectively denied. If, on the other hand, the insurer makes a
20 reasonable payment based on the known facts or is making a good faith effort to appropriately
21 value the loss, the fact that the insured did not immediately get all of the benefits to which it may
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23 ¹ The many cases cited by Safeco do not compel a different result. Most of the cases either did
24 not involve a denial of a claim or the denial of payments at all (see Lease Crutcher Lewis WA, LLC v.
25 Nat’l Union Fire Ins. Co. of Pittsburgh, PA, No. C08-1862RSL, 2010 WL 4272453, at *5 (W.D. Wash.
26 Oct. 15, 2010)) or involved denials that were reasonable (see Travelers Indem. Co. v. Bronsink, No.
C08-1524JLR, 2010 WL 148366, at *2 (W.D. Wash. Jan. 12, 2010)).

1 ultimately be entitled does not establish an “unreasonable denial of payment of benefits.” See
2 Country Preferred Ins. Co. v. Hurless, No. C11-1349RSM, 2012 WL 2367073 (W.D. Wash.
3 June 21, 2012) (no IFCA claim where insurer paid medical expenses and property damage
4 claims and was attempting to resolve ambiguities in the record regarding wage loss claim when
5 plaintiff demanded arbitration); Pinney v. Am. Family Mutual Ins. Co., No. C11-0175MJP, 2012
6 WL 584961 (W.D. Wash. Feb. 22, 2012) (no IFCA claim where insurer paid \$6,500 in advance
7 while experts appraised damages, which were ultimately established at \$8,798.89).²

8 The question in this case is whether an offer of \$1,500 to settle Morella’s claim
9 was, as a matter of law, an unreasonable denial of the payments to which he was entitled under
10 the policy. The Court finds that it was. In evaluating this matter, the Court is not overly
11 persuaded by the fact that Morella was eventually awarded \$62,000 as compensation for his
12 losses. The vagaries of litigation/arbitration are hard to predict, and, while the ultimate outcome
13 may inform the analysis, hindsight is not the most accurate lens through which to evaluate the
14 reasonableness or unreasonableness of a pre-suit settlement offer. Rather, the Court’s analysis
15 focuses primarily on what Safeco knew and/or should have known at the time the offer was
16 made to determine whether the proffered payment effectively denied Morella the benefits of the
17 insurance policy.

18 By Safeco’s own estimation, Morella’s claim was appropriately valued at
19 \$11,194.80 - \$15,694.80 at the time Safeco chose to offer \$1,500 in full settlement. This
20 evaluation was based primarily on a review of Morella’s medical records and a letter from
21 counsel indicating that the accident “had a deeply adverse impact on Mr. Morella[’s] life” and
22

23 ² Morella argues that an IFCA cause of action exists if the insurer unreasonably denies a claim
24 for coverage, unreasonably denies payment of benefits, or violates one of the WAC provisions
25 enumerated in RCW 48.30.015(5). While treble damages and attorney’s fees are available under RCW
26 48.30.015(2) and (3) if a violation of the WAC provisions is established, a regulatory violation, standing
alone, does not trigger the right to bring a state court action under RCW 48.30.015(1).

1 reserving a wage loss claim. Morella requested \$75,000 to cover all insured losses arising from
2 the accident. Safeco did not investigate the impact the accident had on Morella's daily activities,
3 the extent of his discomfort or impairment, or the scope of the potential claim for lost wages.
4 Safeco's estimate of general damages in the range of \$1,500 - \$6,000 does not, therefore, appear
5 to have a factual basis (a conclusion that is supported by the fact that the actual value of
6 Morella's losses, including general damages and lost wages, was much higher). Even if
7 Safeco's March 2009 valuation were reasonable despite the failure to investigate, the amount the
8 insurer chose to offer Morella reflected the lowest estimate of general damages and excluded all
9 other expenses and losses covered by the policy. Given the undisputed facts of this case, the
10 Court finds that an offer of \$1,500 in payment of a claim that Safeco internally valued at seven
11 to ten times as much and which had not been fully investigated was an unreasonable denial of
12 the payment of benefits to which Morella was entitled.

13 III. "ACTUAL DAMAGES" UNDER IFCA

14 Pursuant to RCW 48.30.015(2), where, as here, the Court finds that an insurer has
15 unreasonably denied payment of benefits and/or violated WAC 284-30-330(7), it may "increase
16 the total award of damages to an amount not to exceed three times the actual damages." "Actual
17 damages" are not defined in IFCA, but are generally understood as the amount necessary to
18 compensate plaintiff for an injury or loss. Blaney v. Int'l Ass'n of Machinists and Aerospace
19 Workers, Dist. No. 160, 114 Wn. App. 80, 96 (2002). Unfortunately, this general understanding
20 does not resolve the ambiguity identified by the parties.

21 Morella argues that his damages under IFCA are the \$62,000 awarded in
22 arbitration, *i.e.*, the amount that was necessary to compensate Morella for Safeco's unreasonable
23 denial of payment of benefits owed under the policy. Safeco, on the other hand, rightly points
24 out that the \$62,000 had already been paid at the time this action was filed and cannot be re-
25 awarded in this lawsuit. What, then, are the "actual damages" that may be recovered in this
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1 IFCA action? Is it the \$62,000 awarded in arbitration or is it simply the loss of use of that
2 money for some period of time, the costs of the arbitration proceeding itself, or some other
3 compensable injury?

4 The legislative history of IFCA suggests that one of the motivating factors behind
5 the treble damages provision was to provide more incentive for insurers to treat their insureds
6 fairly. Before IFCA, an unreasonable refusal to pay benefits or a violation of the WAC might
7 result in an order to pay what the insurer already owed, with the threat of an enhanced award
8 under the Consumer Protection Act. IFCA provided a direct private cause of action designed to
9 rectify unreasonable coverage and payment decisions and to provide for treble damages and
10 cost/fee shifting. It seems clear that, had Morella filed suit seeking both a benefits determination
11 and relief under IFCA upon receipt of Safeco's lowball offer of \$1,500, his "actual damages" in
12 that combined action would likely have been the amount of benefits awarded – \$62,000.
13 Morella was precluded from following that course of action, however. The insurance policy
14 compels arbitration if the parties do not agree on the amount of damages involved in an
15 uninsured motorist claim (Decl. of James E. Banks (Dkt. # 24), Ex. 1 at 19 (Safeco Policy No.
16 H1874894)), and there is no indication that the parties agreed to arbitrate an IFCA claim. Thus,
17 Morella was unable to follow the path set forth by the legislature when it enacted IFCA and is
18 now left in a position where the most natural reading of the phrase "actual damages" does not fit
19 the procedural posture of this case.

20 In his motion to remand, Morella noted the novelty and difficulty of determining
21 "actual damages" in this litigation. Dkt. # 13 at 6. The Court raised the possibility of certifying
22 the question to the Washington State Supreme Court (Dkt. # 20 at 4), and hereby finds that
23 certification is appropriate in this case.

1 **IV. CERTIFICATION TO THE WASHINGTON STATE SUPREME COURT**

2 Pursuant to RCW 2.60.020, “[w]hen in the opinion of any federal court before
3 whom a proceeding is pending, it is necessary to ascertain the local law of this state in order to
4 dispose of such proceeding and the local law has not been clearly determined, such federal court
5 may certify to the supreme court for answer the question of local law involved and the supreme
6 court shall render its opinion in answer thereto.” The certification process serves the important
7 judicial interests of efficiency and comity: as noted by the United States Supreme Court,
8 certification saves “time, energy and resources and helps build a cooperative judicial
9 federalism.” Lehman Bros. v. Schein, 416 U.S. 386, 391 (1974). Because this matter involves
10 issues of first impression regarding the definition of “actual damages” under IFCA, this issue
11 should be presented for expedited review to the Washington State Supreme Court.

12 The following question is hereby certified to the Supreme Court of Washington:

13 How are “actual damages” calculated or defined under the Insurance Fair Conduct
14 Act (RCW 48.30.015) where, as in this case, the insured obtained a \$62,000
15 arbitration award in his favor prior to initiating the IFCA action in state court?

16 The Clerk of Court is directed to submit to the Supreme Court of Washington certified copies of
17 this Order, a copy of the docket in the above-captioned matter, and Dkt. # 1, 2, 5, 7-11, 13, 14,
18 16, 17, 20, and 23-28. The record so compiled contains all matters in the pending cause deemed
19 material for consideration of the local law question certified for answer.

20 The plaintiff in this action is designated as the appellant before the Supreme Court
21 of Washington. The Clerk of Court shall notify the parties as soon as possible, but no more than
22 three days, after the above-described record is filed in the Supreme Court of Washington. The
23 parties are referred to state RAP 16.16 for additional information regarding procedure before the
24 Supreme Court.
25
26

APPENDIX B

APPENDIX B – MORELLA v. SAFECO – Docket No. 88706-3

RCW 48.30.015

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

(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.

RCW 48.30.015

Unreasonable denial of a claim for coverage or payment of benefits (cont'd)

(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.

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

Notes:

Short title -- 2007 c 498: "This act may be known and cited as the insurance fair conduct act." [2007 c 498 § 1.]

APPENDIX C

Table of Contents

Voting in Washington State	4	Substitute House Joint Resolution 4215	22
Public Disclosure and Federal Tax Information	5	Complete Text of Measures	24
Presidential Primary.....	6	MyVote: Your Personalized Voter Information	30
Major Political Party Caucuses and Conventions	6	Change of Address Information	33
Nomination Process for Independent and Minor Party Candidates ...	7	Clark County Local Voters' Pamphlet.....	34
Ballot Measure Process.....	8	Kids' Activity Book Available	74
Initiative Measure 960	9	2007 Mock Election.....	75
Referendum Measure 67	13	Online Voter Registration.....	76
Engrossed Substitute Senate Joint Resolution 8206	16	Washington State Quarter	77
Senate Joint Resolution 8212	18	County Elections Departments	78
Engrossed House Joint Resolution 4204	20	Absentee Ballot Applications	79

Help America Vote Act Information

Under Section 402(a)(2) of the Help America Vote Act of 2002 (HAVA), P.L. 107-252 and Washington Administrative Code, Chapter 434-263, any person who believes that a violation of any provision of Title III of HAVA has occurred, is occurring, or is about to occur, may file a complaint with the Office of the Secretary of State. A complaint form can be found at www.secstate.wa.gov/elections/reform_federal.aspx or a letter containing the following information will be considered an acceptable complaint.

A. Person making complaint

Name, address, city, state, ZIP, county, home and work phone numbers.

B. Description of the alleged violation

Please identify:

1. The facts of the alleged violation;
2. Witnesses, if any, and contact information if you have it;
3. Date and time you became aware of the alleged violation;
4. Location where the alleged violation occurred;
5. Who is responsible for the alleged violation; and
6. Other information that you think will be helpful in resolving your complaint.

All complaints must be **notarized** and filed no later than 30 calendar days of the date after the certification of the election at issue and sent to the Washington Secretary of State, Elections Division, PO Box 40229, Olympia, WA 98504-0229. The state shall make a final determination within 90 days of receiving the complaint.

Address Confidentiality Program

If you are a victim of domestic violence, sexual assault or stalking who has chosen not to register to vote because you are afraid your perpetrator will track you down through voter registration records, the Office of the Secretary of State has a program that might be able to help you. The Address Confidentiality Program (ACP) works together with community domestic violence and sexual assault programs in an effort to keep crime victims safer. The ACP provides participants with a substitute mailing address that can be used when the victim conducts business with state or local government agencies. The ACP also provides participants with the option of confidential voter registration. All ACP participants must be referred to the program by a local domestic violence or sexual assault advocate who can help develop a comprehensive safety plan.

Need More Information?

For more information about the ACP and the phone number of victim resources in your community, call the ACP toll-free at (800) 822-1065, TDD/TTY at (800) 664-9677 or visit www.secstate.wa.gov/acp.



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 fair 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. 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.

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:

STEVE KIRBY, Chair, House Insurance, Financial Services, Consumer Protection Committee; TOM CAMPBELL, Chair, House Environmental Health Committee; DIANE SOSNE, RN, President SEIU 1199; SKIP DREPS, Government Relations Director Northwest Paralyzed Veterans; KELLY FOX, President, Washington State Council of Firefighters; STEVE DZIELAK, 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.

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 CHILDERS, Executive Director, Liability Reform Coalition; TROY NICHOLS, Washington State Director, National Federation of Independent Business; BILL GARRITY, President, Washington Construction Industry Council.

Complete Text of



INITIATIVE MEASURE NO. 960

(continued)

to, and answer questions from, the public. For the purposes of this subsection, "names of legislators, and their contact information" includes each legislator's position (Senator or Representative), first name, last name, party affiliation (for example, Democrat or Republican), city or town they live in, office phone number, and office email address.

PROTECTING TAXPAYERS BY REQUIRING FEE INCREASES TO BE VOTED ON BY ELECTED REPRESENTATIVES, RATHER THAN IMPOSED BY UNELECTED OFFICIALS AT STATE AGENCIES

Sec. 14. RCW 43.135.055 and 2001 c 314 s 19 are each amended to read as follows:

(1) No fee may be imposed or increased in any fiscal year (~~by a percentage in excess of the fiscal growth factor for that fiscal year~~) without prior legislative approval and must be subject to the accountability procedures required by section 2 of this act.

(2) This section does not apply to an assessment made by an

Complete Text of



REFERENDUM MEASURE NO. 67

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:

(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.

agricultural commodity commission or board created by state statute or created under a marketing agreement or order under chapter 15.65 or 15.66 RCW, or to the forest products commission, if the assessment is approved by referendum in accordance with the provisions of the statutes creating the commission or board or chapter 15.65 or 15.66 RCW for approving such assessments.

CONSTRUCTION CLAUSE

NEW SECTION. Sec. 15. The provisions of this act are to be liberally construed to effectuate the intent, policies, and purposes of this act.

SEVERABILITY CLAUSE

NEW SECTION. Sec. 16. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

MISCELLANEOUS

NEW SECTION. Sec. 17. Subheadings and part headings used in this act are not part of the law.

NEW SECTION. Sec. 18. This act shall be known and cited as the Taxpayer Protection Act of 2007.

NEW SECTION. Sec. 19. This act takes effect December 6, 2007.

(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

Complete Text of



REFERENDUM MEASURE NO. 67

(continued)

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:

(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.



Your personalized voter information is coming soon with **MyVote**, a new website offered by the Office of the

Secretary of State in collaboration with your county elections department.

Simply sign onto the system using your voter registration name and birthdate to access:

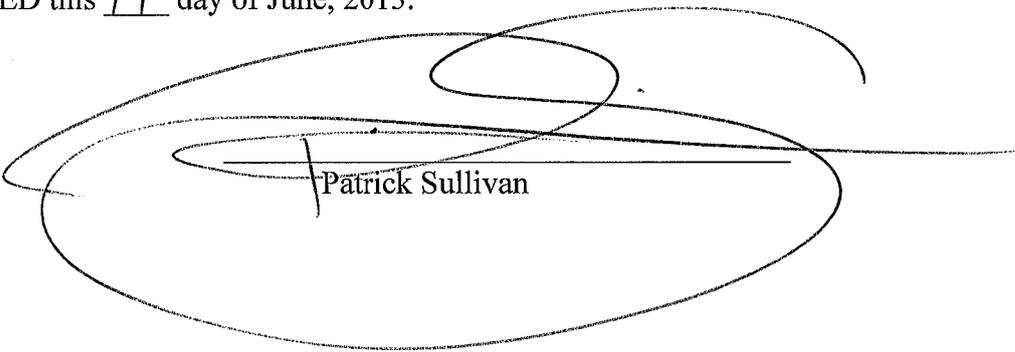
- ✓ **Your personalized ballot;**
- ✓ **Your voting history;**
- ✓ **Your name and address online;**
- ✓ **Your nearest ballot drop box; and**
- ✓ **Your ballot status.**

CERTIFICATE OF SERVICE

I, Patrick Sullivan, legal assistant to Sullivan Law Firm, hereby certify that on the date set forth below I caused a copy of the within BRIEF OF APPELLANT to be served by email and by U.S. Mail, first class postage prepaid, upon counsel of record for Respondent at the following address:

John Michael Silk
silk@wscd.com
Sarah Eversole
eversole@wscd.com
Wilson Smith Cochran Dickerson
901 5th Avenue, Suite 1700
Seattle, WA 98164-2050

DATED this 14th day of June, 2013.



Patrick Sullivan