I. REGULATORY LIMITS ON CLAIMS HANDLING

A. Timing for Responses and Determinations

Washington enacted “prompt pay” legislation for claims under health benefit plans, which are defined to include health insurance policies, medical service contracts, and HMOs. WAC 284-43-130(15). Regulations contained in Washington Administrative Code 284-43 set forth the relevant time limitations involved with the filing, payment and denial of claims. The initial limiting period for insurers is that ninety-five percent (95%) of the monthly volume of clean claims must be paid within thirty (30) days after receipt of the claim. Ninety-five percent (95%) of the monthly volume of all claims shall be paid or denied within sixty (60) days of receipt by the carrier. WAC 284-43-321(2). Any carrier failing to pay claims within the required time period must pay interest of one percent (1%) per month on undenied and unpaid clean claims more than sixty-one days old until the claim is paid or denied. WAC 284-43-321(2)(d).

Examples of statutory requirements for responses and determinations:
RCW 48.18.200(1)(c) – Insurance policies may not limit the time period for which an action may be brought against an insurer to less than one year. RCW 48.43.055 – Every health care provider shall have procedures providing a fair review for consideration of complaints. Every health carrier shall provide reasonable means whereby any person aggrieved by actions of the health carrier may be heard in person or by their authorized representative on their written request for review. These procedures for review and adjudication of complaints initiated by covered persons or health care providers shall be filed by the commissioner. RCW 48.43.055.

Accident only coverage which provides coverage for death, dismemberment, disability or hospital and medical care caused by an accident is not subject to the provisions of WAC 284-43-321. Insurers providing accident only coverage are subject to the general requirement of investigating all claims within thirty (30) days of notification. WAC 284-30-370. A disability insurer’s denial of a claim based on an experimental or investigational limitation must be done within twenty (20) defined as working days of receipt. WAC 284-50-377.

B. Standards for Determinations and Settlements
Claims handling standards are set forth in WAC 284 governing the Office of the Insurance Commissioner. “Prompt pay” provisions applying specifically to health carriers and health plans are described in WAC 284-43-321. The prompt pay provision requires payment within 30 days for clean claims. A clean claim is defined as a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments. Whether or not a private cause of action exists in regard to this regulation has not yet been decided by Washington Courts.

In Washington it is an unfair practice for any insurer to limit the benefits in case of accidental death or accidental injury to losses occurring within a stated period of time after the accident unless it extends coverage for a death that occurs within a year of the accident or services incurred within one year of the accident. WAC 284-30-620.

C. Privacy Protections

Washington enacted the Uniform Health Care Information Act in 1991 which is codified at RCW 70.02 et seq. The Washington Uniform Health Care Information Act (WUHClA) primarily governs the disclosure of health care information. In some instances Washington State law offers more strict protection than is found in the federal HIPAA Act. Where Washington law offers more stringent protection than HIPAA, Washington law is not pre-empted by the HIPAA federal statute. Under the WUHClA patient disclosure authorization (1) must be in writing and signed by the patient; (2) identify the nature of the information to be disclosed; (3) identify the name and institutional affiliation of the person or class of persons to whom the information is to be disclosed; (4) identify the provider or class of providers who are to make the disclosure; (5) identify the patient; and (5) Contain an expiration date or an expiration event that relates to the patient or the purpose of the use or disclosure. Health care providers do not need patient authorization to disclose health care information to law enforcement authorities or other health care providers with a relationship to the patient for the purpose of quality assessment and improvement activities.

The privacy of consumers’ financial and health information is regulated by WAC 284-04 et seq. Insurers are required to provide their insured a “clear and conspicuous notice” that accurately reflects its privacy policies and practices. WAC 284-04-200. This privacy notice must be provided initially at the beginning of the relationship between the insured and insurer, and at least once every year. WAC 284-04-205. Further, WAC 284-04-210 sets forth the relevant information that must be included in the notice.

WAC 284-04-300 further limits the disclosure of nonpublic personal financial information to nonaffiliated third parties unless certain conditions are met. Insurers are also required to develop and implement written policies, standards and procedures for the management of health information. WAC 284-04.500. Insurers are prohibited from disclosing nonpublic personal health information about its insured unless authorization from the insured is first obtained. WAC 284-04-505.

II. PRINCIPLES OF CONTRACT INTERPRETATION

Insurance policies are construed as contracts, meaning that they are interpreted as a matter of law. Allstate Ins. Co. v. Peasley, 131 Wn.2d 420, 423-24, 932 P.2d 1244 (1997). The language of an insurance contract is

When a clause in an insurance policy is ambiguous, the parties may present extrinsic evidence of their intent in order to resolve the ambiguity. Panorama Vill. Condo. Owners Ass'n Bd. of Dirs. v. Allstate Ins. Co., 144 Wn.2d 130, 137, 26 P.3d 910 (2001). This extrinsic evidence, however, is admitted only in aid of the interpretation of the words employed, not to show intention independent of the instrument. Lynott v. Nat'l Union Fire Ins. Co., 123 Wn.2d 678, 683-84, 871 P.2d 146 (1994) (citing Berg v. Hudesman, 115 Wn.2d 657, 669, 801 P.2d 222 (1990)). Because the key is what the parties negotiated for, parol evidence is admissible only if it "'goes no further than to show the situation of the parties and the circumstances under which the instrument was executed . . . .'" Berg, 115 Wn.2d at 669 (quoting J.W. Seavey Hop Corp. v. Pollock, 20 Wn.2d 337, 348-49, 147 P.2d 310 (1944)), quoted in Lynott, 123 Wn.2d at 684. Usually the terms of insurance policies are not negotiated. Lynott, 123 Wn.2d at 684. Where there were actual negotiations, however, extrinsic evidence is admissible to show the parties' mutual intentions as manifested in the terms. Id.; Key Tronic Corp., Inc. v. Aetna (CIGNA) Fire Underwriters Ins. Co., 124 Wn.2d 618, 629, 881 P.2d 201 (1994).

III. CHOICE OF LAW


In the instant matter, though the choice-of-law provision is found in the Master Policy rather than the Certificate of Insurance, it governs both. The Supreme Court, in Boseman v. Connecticut Gen. Life Ins. Co., 301 U.S. 196, 57 S. Ct. 686, 81 L. Ed. 1036 (1937), held that a choice-of-law provision in a group insurance policy governed the individual insured's coverage as manifested by a certificate of insurance. The Supreme Court explained that

"The certificate is not a part of the contract of, or necessary to, the insurance. It is not included among the documents declared to constitute the entire contract of insurance. It did not affect any of the terms of the policy. It was issued to the end that the insured employee should have the insurer's statement of specified facts in respect of protection to which he had become entitled under the policy. It served merely as evidence of the insurance of the employee. [Plaintiff's] rights and [the
insurance company's] liability would have been the same if the policy had not provided for issue of the certificate."

Boseman, 301 U.S. at 203.

"Rights against the insurer under a group policy are generally governed by the law of the state where the master policy was delivered." Erickson v. Sentry Life Ins. Co., 43 Wn. App. 651, 719 P.2d 160, 162 (1986). The rationale behind this rule recognizes that "it is desirable that each individual insured should enjoy the same privileges and protection." Restatement (Second) of Conflict of Laws § 192, comment h (1971). When coupled with a choice-of-law provision, this rule gives effect to the "purpose of the parties to the contract that everywhere it shall have the same meaning and give the same protection, and that inequalities and confusion liable to result from applications of diverse state laws shall be avoided." Boseman, 301 U.S. at 206. The validity of a choice-of-law provision is even more likely to be upheld in the group disability insurance context than the individual insurance context due to the stronger bargaining position that the organization procuring the master policies possesses relative to the individual. Restatement § 192, comment h (explaining that the choice-of-law provision for a group disability insurance contract "is less likely to have a 'take-it-or-leave-it' character").

IV. EXTRACONTRACTUAL CLAIMS AGAINST INSURERS: ELEMENTS AND REMEDIES

A. Bad Faith

Both insurer and insured are obligated to exercise good faith regarding all insurance contracts and transactions. This duty to act in good faith has been created judicially, Burnham v. Commercial Casualty Ins. Co., 10 Wn.2d 624, 118 P.2d 644 (1941), legislatively, RCW 48.01.030, and administratively. The Insurance Commissioner, pursuant to legislative authority under RCW 48.30.010, promulgated regulations defining specific acts and practices that constitute a breach of an insurer's duty of good faith. These requirements, imposed by WAC 284-30-300 et seq., are minimum standards. The insurer's duty of good faith implies more than honesty and lawfulness of purpose: "an insurer must deal fairly with an insured, giving equal consideration in all matters to the insured's interests." Tank v. State Farm Fire & Cas. Co., 105 Wn.2d 381, 386, 715 P.2d 1133 (1986).

A violation of the duty of good faith may give rise to a tort action for bad faith. Truck Ins. Exch. v. Vanport Homes, Inc., 147 Wn.2d 751, 765, 58 P.3d 276 (2002). Whether an insurer acted in bad faith is a question of fact. Smith v. Safeco Ins. Co., 78 P.3d 1274 (2003) (citing Van Noy v. State Farm Mut. Auto. Ins. Co., 142 Wn.2d 784, 796, 16 P.3d 574 (2001)). The insured bears this heavy burden of proof. Smith, 78 P.3d 1274; Overton v. Consolidated Ins. Co., 147 Wn.2d 784, 796, 16 P.3d 574 (2001)). To succeed on a bad faith claim, the insured must show the insurer’s breach of the insurance contract was unreasonable, frivolous, or unfounded. Smith, 78 P.3d 1274 (2003) (trial court properly granted summary judgment where Insurer’s failure to disclose policy limits to third party claimant was not "unreasonable, frivolous or untenable"); Overton, 145 Wn.2d at 433, 38 P.3d 322 (2002). If the insurer’s denial of coverage is based on a reasonable interpretation of the insurance policy, there is no action for bad faith. Overton, 145 Wn.2d at 433, 38 P.3d 322.
Because an action for bad faith is based in tort law, harm is an essential element. Safeco Ins. Co. v. Butler, 118 Wn.2d 383, 823 P.2d 499 (1992). Third party claimants have no cause of action against an insurance company for breach of duty of good faith. Tank, 105 Wn.2d at 393, 715 P.2d 1133. However, an insured’s bad faith cause of action against an insurer can be assigned to the third-party claimant after judgment or settlement of the main case. Safeco, 118 Wn.2d 383, 389, 823 P.2d 499 (1992).

B. Negligence

An insurer also has a duty to exercise reasonable care with respect to the interests of its insured. See Murray v. Mossman, 56 Wn.2d 909, 912-13, 355 P.2d 985 (1960) (recognizing a distinction between a claim for negligence and a claim for bad faith). In order to prove a negligence claim against an insurer, an insured must establish the insurer was at fault as defined in RCW 4.22.015. Harm is also an element for an action for an insurer's negligent handling of its defense of an insurance claim. Burnham, 10 Wn.2d at 627.

In proving negligence, an insured may show noncompliance with WAC § 284-30-300. However, a violation of those standards does not constitute negligence per se. See RCW 5.40.050.

C. Fraud

In Washington, the nine elements of fraud are: (1) representation of an existing fact; (2) its materiality; (3) its falsity; (4) the speaker’s knowledge of its falsity, (5) the speaker’s intent that it shall be acted upon by the plaintiff (6) plaintiff’s ignorance of its falsity; (7) plaintiff’s reliance on the truth of the representation; (8) plaintiff’s right to rely upon it; and (9) consequent damages suffered by plaintiff. Stiley v. Block, 130 Wn.2d 486, 505, 925 P.2d 194 (1996). The burden is upon the claimant to prove the existence of all the essential and necessary elements of fraud. Beckendorf v. Beckendorf, 76 Wn.2d 457, 462, 457 P.2d 603 (1969).

D. Intentional and Negligent Infliction of Emotional Distress

Washington recognizes the tort of outrage, also known as intentional infliction of emotional distress, as a cause of action. Snyder v. Med. Serv. Corp. of E. Wash., 145 Wn.2d 233, 250, 35 P.3d 1158 (2001) (applying elements of outrage to claim for intentional infliction of emotional distress). The tort of outrage requires the proof of three elements: (1) extreme and outrageous conduct, (2) intentional or reckless infliction of emotional distress, and (3) actual result to plaintiff of severe emotional distress. Kloepfel v. Bokor, 149 Wn.2d 192, 195, 66 P.3d 630 (citing Reid v. Pierce County, 136 Wn.2d 195, 202, 961 P.2d 333 (1998)). These elements were adopted from the Restatement (Second) of Torts § 46 (1965) by the Washington Supreme Court in Grimsby v. Samson, 85 Wn.2d 52, 59-60, 530 P.2d 291 (1975).

As to the first element, extreme and outrageous conduct is conduct “so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community.” Grimsby, 85 Wn.2d at 59, 530 P.2d 291 (1975). As to the second element, conduct is reckless when one knows of and disregards a substantial risk that a wrongful act may occur and that disregard of such substantial risk is a gross deviation from conduct that a reasonable man would exercise in the same situation. RCW 9A.08.010(1)(c).
As to the third element, emotional distress includes “all highly unpleasant mental reactions, such as fright, horror, grief, shame, humiliation, embarrassment, anger, chagrin, disappointment, worry, and nausea.” Kloepfel, 149 Wn.2d at 203, 66 P.3d 630 (citing Restatement (Second) of Torts, supra cmt. J at 77). Severe emotional distress is such that “no reasonable man could be expected to endure it.” Id. Objective symptomology (physical injury or bodily harm) is not required to establish intentional infliction of emotional distress. Grimsby, 85 Wn.2d at 59, 530 P.2d 291 (1975) (a “showing of bodily harm is not necessary” to prove outrage).

Washington also recognizes a cause of action for negligent infliction of emotional distress. A plaintiff claiming negligent infliction of emotional distress must demonstrate objective symptoms evidencing and resulting from the emotional injury. Hunsley v. Giard, 87 Wn.2d 424, 436, 553 P.2d 1096 (1976). To satisfy this “objective symptomology” requirement, a plaintiff’s emotional distress must be susceptible to medical diagnosis and proved through medical evidence. Hegel v. McMahon, 136 Wn.2d 122, 135, 960 P.2d 424 (1998). This requires objective evidence regarding both the severity of the distress and the causal link between the observation and the subsequent emotional reaction. Id.

E. State Consumer Protection Act

The Washington Consumer Protection Act (RCW 19.86.010 et seq.) prohibits “[u]nfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce.” RCW 19.86.020. The Consumer Protection Act provides a private cause of action for persons injured by violations of its terms. RCW 19.86.090. Damages may be trebled in an amount not to exceed $10,000, and the plaintiff may recover reasonable attorney fees and costs incurred in prosecuting the Consumer Protection Act claim. RCW 19.86.090. A private action under the Consumer Protection Act may be brought within four years after a cause of action accrues. RCW 19.86.120.

Violations of the insurance regulations are subject to the Consumer Protection Act. Industrial Indem. Co. of Northwest, Inc. v. Kallevig, 114 Wn.2d 907, 922, 792 P.2d 520 (1990); RCW 19.85.170. In order to prove a claim under this Act, an insured must prove (1) an unfair or deceptive act or practice (2) in trade or commerce (3) that impacts the public interest (4) causing injury to the party in his business or property, and (5) which injury is casually linked to the unfair or deceptive act. Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co., 105 Wn.2d 778, 784-85, 719 P.2d 531 (1986).

A violation of WAC 284-30-330, which defines specific unfair claims practices applicable to the settlement of insurance claims, constitutes a per se unfair deceptive act or practice under the Consumer Protection Act. Kallevig, 114 Wn.2d 907, 925, 719 P.2d 531. Failure to act in good faith is not a per se violation of the Consumer Protection Act. See Hangman Ridge, 105 Wn.2d 778, 719 P.2d 531; but see Gingrich v. Unigard Security Ins. Co., 57 Wn. App. 424,433, 788 P.2d 1096 (Div. 3 1990). However, frequently, acts that constitute bad faith by an insurer will also be violations of the Consumer Protection Act. A denial of coverage does not constitute an unfair or deceptive act or practice as long as it is based on reasonable conduct of the insurer, even if the denial is ultimately proved incorrect. Overton v. Consolidated Ins. Co., 145 Wn.2d 417, 434, 38 P.3d 322 (2002) (citing
Third party claimants do not have a cause of action for per se violations of the Consumer Protection Act. Tank v. State Farm, 105 Wn.2d at 393-94, 715 P.2d 133 (1986). The Court has not yet decided whether a third-party claimant has a potential cause of action against an insurer for non per se violations of the Consumer Protection Act. Id.

F. Insurance Fair Conduct Act

The Washington Insurance Fair Conduct Act (“IFCA”) went into effect in December 2007 and allows a first party claimant who is unreasonably denied a claim for coverage or for payment of benefits to sue for actual damages, costs, and attorneys’ fees. RCW 48.30.015(1).

Under IFCA after a trial court finds that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated one of several enumerated sections of WAC 284-30, the trial court may increase the total award of damages to an amount that is up to three times the actual damages. RCW 48.30.015(2).

V. DEFENSES IN ACTIONS AGAINST INSURERS

A. Misrepresentations/Omissions: During Underwriting or During Claim

The Revised Code of Washington provides as follows with respect to misrepresentations made by insurance applicants:

(1) Except as provided in subsection (2) of this section, no oral or written misrepresentation or warranty made in the negotiation of an insurance contract, by the insured or on his behalf, shall be deemed material or defeat or avoid the contract or prevent it attaching, unless the misrepresentation or warranty is made with the intent to deceive.

(2) In any application for life or disability insurance made in writing by the insured, all statements therein made by the insured shall, in the absence of fraud, be deemed representations and not warranties. The falsity of any such statement shall not bar the right to recovery under the contract unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

RCW 48.18.090. In Washington:

Liability on an insurance policy cannot be avoided unless it appears that untrue representations were knowingly made in the application for the policy and that, in making those representations, the applicant had an intent to deceive the company.


Absent an insurer’s request for health information, or a statement of good health, a prospective insured is under no duty to volunteer information,
and the mere fact that an insured has failed to disclose health related information, where such information was not requested, is not grounds for avoiding the policy. See, e.g., UsLife Credit Life v. McAfee, 29 Wn. App. 574, 577, 630 P.2d 450 (1981).

Likewise, Washington’s Administrative Code provides the following:

If an insurer, including a health care service contractor or a health maintenance organization intends to rely on an applicant’s or enrollee’s answers to health questions in an application to determine eligibility for coverage or the existence of a preexisting condition, such questions must be clear and precise. Simply asking whether the applicant has been under the care of a physician during the preceding year, for example, is not sufficient to require a “yes” answer where the applicant has been using medications that were prescribed prior to the start of the preceding year and the applicant has not seen a physician for more than a year.

WAC 284-30-630.

B. Preexisting Illness or Disease Clauses

The applicability of “preexisting illness or disease” clauses are limited by Washington statutory law. RCW 48.43.012, which pertains to individual health benefit plans, provides as follows:

No carrier may deny, exclude, or otherwise limit coverage for an individual’s preexisting health conditions except as provided in this section.

For an individual health benefit plan originally issued on or after March 23, 2000, preexisting condition waiting periods imposed upon a person enrolling in an individual health benefit plan shall be no more than nine months for a preexisting condition for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months prior to the effective date of the plan.

RCW 48.43.012(2)-(3). Similarly, RCW 48.43.025, which pertains to group health benefit plans, provides similar limitations:

(1) For group health benefit plans for groups other than small groups, no carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual’s preexisting health conditions; except that a carrier may impose a three-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before the effective date of coverage . . . .

(2) For group health benefit plans for small groups, no carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual’s preexisting health conditions. Except that a carrier may impose a nine-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider
recommended or provided treatment within six months before the effective date of coverage . . . .

RCW 48.43.025 (1) - (2).

C. Statutes of Limitation

Washington law provides a six year statute of limitations for any action upon a contract in writing, or liability express or implied arising out of a written agreement. RCW 4.16.040. Actions sounding in tort, or arising from an unwritten agreement, are subject to a three year statute of limitation. RCW 4.16.080.

VI. INTERPLEADER ACTIONS

a. Availability of Fee Recovery

It is within the discretion of the Federal District Court to award attorney fees and costs to a disinterested stakeholder in an interpleader action. Abex Corp. v. Ski’s Enters., Inc., 748 F.2d 513, 516 (9th Cir. 1984). And courts will routinely grant that request absent a showing of bad faith. Schirmer Stevedoring Co. Ltd. v. Seaboard Stevedoring Corp., 306 F.2d 188, 194-95 (9th Cir. 1962).

Washington Statute allows for a party to use an interpleader to avoid being subjected to an adverse award of fees and costs. Koncicky v. Sekac, 103 Wn. App. 292, 12 P.3d 645 (2000). However, the plain language of the supporting statute only permits the interpleading party to recover costs for that action. RCW 4.08.170. There is case law alluding to the possibility that costs may include attorney fees under the statute. Osawa v. Onishi, 33 Wn.2d 546, 206 P.2d 498 (1949). Even so, Washington Courts have been loath to award fees when the statutory language is not clear that fees are to be included.