

INSURER PRACTICES-UM, UIM AND PIP

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I. LEGAL ISSUES/TIPS THAT CUT ACROSS UM, UIM AND PIP

A. Are There Actionable Causes of Action in Oregon for Insurance “Bad Faith”?

Most insurers and defense counsel will tell you, “No”; there is no first-party bad faith in Oregon, or at least no law protecting claimants that are the victims of bad faith. UM, UIM and PIP claims are “first-party” claims. In the area of first-party bad faith, Oregon law remains undeveloped and is perceived as unfavorable to the insured, especially in the area of tort liability. 1 INSURANCE §10.1 (Oregon CLE 1996 &Supp 2003). However, Oregon bad faith law does exist in the PIP, UM and UIM context and the potential exists for clarification and expansion. Although Oregon law is sparse in the bad faith context, it should not be presumed that remedies do not exist. Oregon law does provide remedies, and black letter law and law from other jurisdictions should be used as persuasive authority if Oregon courts have not spoken as to the particular form of bad faith.

Recently, one class action judge and jury from Portland, Oregon, clarified that Oregon law and Oregon juries will hold insurers accountable for bad faith, unfair claims handling practices, and fraud. See *Strawn v. Farmers Insurance Company of Oregon*, Multnomah County Circuit Court; Case No. 99-08-09080 (See Oregonian article, attached hereto). In *Strawn*, the jury awarded \$9.5 million in compensatory and punitive damages (\$1.5 million compensatory and \$8 million in punitive damages) to thousands of Oregonians that had been defrauded by Farmers Insurance in the payment of PIP medical benefits. The jury found that Farmers had arbitrarily failed to pay for its insureds’ medical benefits to the extent the charge exceeded the 80th percentile of other similar procedures—regardless of whether the charge was reasonable. In effect, Farmers was shaving a percentage of the reimbursement for some charges, pocketing the reduction, and leaving the injured party with a balance due to their medical provider although Farmers had been paid premiums to cover the bill in its entirety. The case was brought by Portland attorney, Rick Yugler, on behalf of the class.

Any examination of insurance bad faith or extracontractual remedies in Oregon should begin with ORS 742.230, the Unfair Claim Settlement Practices Act. ORS 742.230 defines or provides examples of unfair claim settlement practices or “bad faith” conduct of insurers. While Oregon law is notoriously bad when it comes to protecting consumers of insurance, ORS 742.230 at least sets the standard as to what insurers are *not* supposed to

do in handling claims. Unfortunately, no private right of action exists in Oregon under ORS 742.230, and the state cannot afford or is unwilling to enforce the Act. However, these standards can be applied in support of traditional tort and breach of contract claims against insurers.

1. Are Consequential (Extra-Contractual) Damages Recoverable?

For the plaintiff attorney, the key issue is: what are the amount of damages recoverable in a PIP or UM claim? There have not been many recent cases clarifying Oregon first-party bad faith law. However, Oregon courts have recently awarded “consequential” or extracontractual damages in first-party breach of contract cases, including PIP cases. In *McKenzie v. Pacific Health & Life Ins. Co.*, 118 Or App 377, 380-381, 847 P2d 879, *rev allowed*, 317 Or 271 (1993), *rev. dismissed as improvidently allowed*, 318 Or 476 (1994), plaintiff sued under a health insurance contract for denial of benefits and bodily harm and emotional distress as a result of the breach, and the court held that plaintiff could recover for emotional distress caused by physical harm that results from the breach. *McKenzie*, 118 Or App at 381.

In *Eggiman v. Mid-Century Ins. Co.*, 134 Or App 381, 895 P2d 333 (1995), the court extended the *McKenzie* holding to the PIP context. Plaintiff sued for breach of the implied covenant of good faith and fair dealing. The court held:

“[S]o long as it is not inconsistent with the express terms of the contract, the duty of good faith is a contractual term that is implied by law into every contract * * *. See *Sheets v. Knight*, 308 Or. 220, 233 n 12, 779 P.2d 1000(1989). We conclude that, within defendant’s obligation to pay all covered claims was the duty to determine, in good faith, whether a claim is covered, and to refrain from arbitrarily refusing to preauthorize medical treatment.” 118 Or App at 381 (emphasis supplied).

The *Eggiman* court further held:

Here, as in *McKenzie*, the PIP insurer’s duty to preauthorize in good faith is a direct and natural corollary of the insured’s obligation to pay all covered claims. *McKenzie*, 118 Or App at 381, 847 P2d 879. Without such a duty, a PIP insurer could, in many instances, avoid its statutory obligation because, without preauthorization, many insureds will be unable or unwilling to obtain treatment and incur expenses, short-circuiting the insured’s duty to pay under ORS 742.524(1)(a). We conclude, therefore, that defendant had a

good faith duty to refrain from arbitrarily refusing to preauthorize covered treatment. *Id.* at 336-37.

In a separate PIP breach of contract case, *Anderson v. Farmers Ins. Co. of Oregon*, 188 Or App 179, 71 P3d 144 (2003), the court held that Farmers had breached its contract of insurance by refusing to pay full benefits on stacking insurance policies. Plaintiff was awarded \$26,000 in economic damages, or the full PIP limits to the extent of the surgical costs, and \$200,000 in noneconomic damages. *Anderson*, 188 Or App at 182.

Accordingly, consequential or extracontractual damages are recoverable in an insurance breach of contract action in Oregon when the breach causes physical harm and resulting emotional distress.

2. Tort Damages

In *Foltz v. State Farm Mutual Auto Ins. Co.*, 326 Or 294, 952 P2d 1012 (1998), the court responded to certain questions certified by the federal district court regarding arbitration of PIP denials. One of the legal theories of recovery was "fraud." The *Foltz* case involved the wrongful denial of PIP benefits wherein State Farm had conspired with Comprehensive Medical Review, a California company in the business of doing paper medical reviews, whereby false or forged medical reports were generated indicating that medical treatment was not necessary when in fact it was. *Foltz*, 326 Or 294. The *Foltz* plaintiffs alleged that State Farm profited from the wrongful denial of benefits. Although the limited questions did not include the propriety of the tort claims, the fraud claim was assumed to be viable in the federal district court in order to generate the questions posed to the Oregon Supreme Court. 1 *Insurance* §10-12A (Oregon CLE Supp 2003). Thus, tort claims such as fraud, under certain circumstances, are viable claims in the first-party insurance context, particularly in the current PIP climate where insurers are cutting off valid PIP claims as a matter of company policy.

3. Attorney Fees

Like extracontractual damages, attorney fees under ORS 742.061 used to be a substantial ally for insureds or consumers who were unfairly treated in the PIP and UIM context. Under ORS 742.061, before the legislative change, insureds were entitled to statutory attorney fees by complying with the statute and obtaining a recovery in excess of an amount tendered by the insured. ORS 742.061 was deemed necessary to hold first party insurers to the terms of their contract, particularly in the PIP context. Because the

disputed amounts in the PIP context are relatively small, insureds cannot litigate or arbitrate improper denials unless attorney fees are awarded to the insured that prevails. However, under the revised ORS 742.061, the insurer can cut off the injured person's right to attorney fees by accepting coverage and consenting to binding arbitration. Thus, insureds have lost a substantial incentive to litigate unfair and improper denials because the cost of litigating the issues generally outweighs the benefit obtained by prevailing against the insurer if an award of attorney fees is not available. Insurers understand that claimants generally cannot economically litigate improper denials of PIP because the costs outweigh the benefits if attorney fees are not recoverable.

B. Are the UM/UIM Required Statutory Provisions of ORS 742.504 Always the Law of the Case? What About PIP Provisions?

Attorneys must review the insurance policy in every case to determine whether UM policy provisions are more favorable to the insured than the required provisions of ORS 742.504. ORS 742.504 is a statute that provides certain minimums so that if an insurance company's policy language is less favorable to an insured, the policy language is unenforceable. However, if the policy language and terms are neutral or more favorable to the insured than ORS 742.504, the statute does not apply. *Erickson v. Farmers Insurance Company of Oregon*, 331 Or 681 (2001). The operative language that appears in the first paragraph of ORS 742.504 states that the policy "shall provide uninsured motorist coverage which in each instance is no less favorable in any respect to the insured or the beneficiary than if the following provisions were set forth in the policy. However, nothing contained in this section shall require the insured to reproduce in such policy the particular language of any of the following provisions."

Attorneys should apply the same analysis to PIP coverage (ORS 742.520, *et. seq.*). If an insurer provides benefits greater than provided in the statute, the insured is entitled to those greater benefits and the statute does not apply. Conversely, if the insurer attempts to provide less benefits than the statute or restricts the insured's rights under the statute by policy provisions or in the handling of the claim, then those policy provisions or claims handling practices are unenforceable.

QUERY: Is a PIP carrier permitted to force an insured to attend insurer sponsored physical examinations, IMEs or CMEs? Unlike the UM statutes, nowhere

in the PIP statutes does it state that the insurer is entitled to physical examinations. The UM statutes clearly lay out that insurers are entitled to physical examinations. See ORS 742.504(5)(b). If the legislature had intended for PIP insureds to be subject to physical examinations, then why didn't the legislature clearly state that PIP insurers are entitled to physical examinations as the legislature clearly stated in the UM statute? The public policy behind PIP coverage was and is to provide prompt no-fault benefits to injured victims without many of the restrictions that provide a delay or roadblock to quality care. The legislature did not envision PIP practices where biased insurance industry sponsored medical review companies, consultants, doctors and data entry personnel were used to overrule recommendations of treating physicians and cut off PIP benefits to insureds. Attorneys should weigh whether they should send their insureds to PIP examinations or whether these examinations are even permitted under Oregon law.

C. What Is the Statute of Limitations for UM Cases?

Plaintiff attorneys should assume the statute of limitations for UM claims is TWO YEARS from the date of injury. Attorneys cannot assume that UM claims are subject to the standard six (6) year statute of limitations for contract actions. ORS 742.504(12)(a), enacted by the legislature, is a "malpractice trap" for plaintiff lawyers. It is important to commence your UM/UIM case within two years, or alternatively, follow the statutory provisions of ORS 742.504(12)(a). Under ORS 742.504(12)(a), plaintiff attorneys must do one of the four options set forth in the statute within two years: (1) settle the UM case; (2) formally institute arbitration proceedings; (3) file a lawsuit against the insurer in court; or (4) file a lawsuit for bodily injury against the uninsured motorist and then, within two years from the date of settlement or final judgment against that motorist, formally institute arbitration proceedings or file suit against the insurer in court. However, the safe and prudent approach is to file the lawsuit (or formally get an agreement to arbitration) against the UM insurer within two years of the date of injury in the same manner as you would against the third-party. Many practitioners often file the third-party claim and the UM claim in the same lawsuit to alleviate concerns about the limitations period. Insurers may be entitled to bifurcate the claims, but at least the insured is protected against a statute of limitations defense.

It should be noted that the two year statute of limitation inserted into policies by insureds does not explicitly state that the statute of limitations is two years. Instead, the language usually states that the limitations period is the limitations period for bodily injury actions in your jurisdiction.

D. What Is the Date of “Proof of Loss” for Purposes of Triggering the Six Month Period and Attorney Fees under ORS 742.061?

At the request of the insurance industry lobby, the 1999 legislature modified ORS 742.061 regarding recovery of attorney fees in UM and PIP disputes. There is still a potential for injured persons to recover attorney fees from their insurers in UM and PIP disputes, but savvy insurance companies can avoid the risk of having to pay attorney fees by complying with ORS 742.061(2) and (3). If the insurer, within six months from the date proof of loss is filed with the insurer, states in writing that (1) it has unconditionally accepted coverage, and (2) the only issues are the liability of the uninsured or underinsured motorist and the damages due the insured, and (3) the insurer has consented to submit the case to arbitration and the arbitration is binding; then, the claimant is not entitled to attorney fees. The insurer must timely and clearly articulate the above three points in writing or the claim will remain subject to attorney fees.

The key issue often arises as to “when” proof of loss was filed with the insurer. This issue or question has been answered at least two times in plaintiff’s favor by Oregon courts. In *Dockins v. State Farm Ins. Co.*, 329 Or 20, 29, 985 P2d 796 (1999), the Oregon Supreme Court held an action on a homeowners policy, proof of loss was held to be any event or submission that would permit an insured to estimate its obligations, taking into consideration the insurers duty to investigate and to clarify uncertain claims. The court concluded that a **proof of loss** is “[a]ny event or submission that would permit an insurer to estimate its obligations taking into account the **insurer’s obligation to investigate** and clarify uncertain claims.” *Dockins*, 329 Or at 29 (emphasis added). In *Mosley v. Allstate*, 165 Or App 304, 996 P2d 513 (2000), the court of appeals again concluded, like in *Dockins*, that given the insurer’s obligation to investigate, it is not necessary that the insured provide all necessary information for insurer to compute final adjust the loss. The court confirmed that the terms “proof of loss” and “proof of claim” are synonymous. *Mosley*, 165 at 311. The proof of loss requirement is intended to trigger the insurer’s duty

to investigate. *Id.* It does not encompass every piece of information that the insurer may find useful in order to make a settlement offer. *Id.* It is incumbent on the insurer to act and investigate or it will face the prospect of attorney fees. It should be noted that in every PIP or UM case the carrier is provided with an application for benefits including a medical release that entitles the carrier to obtain all medical records to investigate the claim. This is typically the triggering event or the proof of loss that begins the running of the 6 month period under ORS 742.061.

As a practice tip, it is prudent for the injured person to give notice to the PIP carrier (which is also going to be the UM insurer) in early correspondence that there is or may be a UM claim. One paragraph you may wish to insert in your letter of representation to the PIP carrier is: "This is also our notice of claim and proof of claim/proof of loss for our client's uninsured/underinsured motorist claim arising out of this accident. If you have a form that you want Oregon insureds to complete as your proof of loss, notice of claim or proof of claim for UM or UIM claims, provide me your form within 15 days." Based upon the Oregon cases, it is clear that proof of loss occurs very early in the claims process and possibly as early as a written claim is made or at the time the PIP application or application for benefits is completed.

E. Do PIP Benefits on Multiple Policies "Stack"?

In 1982, in *Porter v. Utah Home Fire Ins. Co.*, 58 Or App 729 (1982), the Court of Appeals first wrote that "PIP stacks." Insurances occasionally argue that PIP does not stack different policies on two different vehicles, such as the common household in which multiple vehicles are owned by household members, insured with the same carrier, and for which a separate premium is charged for PIP under each vehicle's coverage. Insurers have generally agreed that PIP stacks for multiple vehicles owned and insured by members of the same household.

In the Winter 1999 issue of the magazine of Oregon Association of Defense Counsel (OADC), Bend attorney Chris Hatfield wrote an article entitled "Multiple Vehicles In One Household: Confusion On Stacking of PIP Benefits." The article assumed that an insurance company wrote two separate policies for two vehicles owned by a husband and wife living in the same household and assumed that each had the same PIP limits and anti-stacking language. When one spouse was injured, the question became whether the injured person was entitled to PIP benefits beyond the limits of the primary policy. Looking

to ORS 742.520(1), ORS 742.526 and the *Porter* case, the OADC article concluded that the anti-stacking language in the policy, being inconsistent with the requirement that every policy provided PIP benefits, would be interpreted by Oregon courts to provide the injured person PIP coverage from the primary policy and the second policy.

In 1999 the legislature amended ORS 742.520(2)(a)(A); insurance companies now maintain that insurers can avoid stacking of PIP benefits. Query? Does the statutory provision effectively halt the stacking of PIP benefits when the insured has paid for multiple PIP benefits under multiple policies?

F. Should Attorneys File a Lawsuit for PIP/UM Benefits or Go to Arbitration?

A simple approach is as follows: If the plaintiff is entitled to attorney fees, then file suit. If the plaintiff is not entitled to attorney fees, then attempt to go to arbitration. Of course, there are many other variables that must be considered, but the above is a starting point. At a minimum, the client should be consulted as to each approach after full disclosure. While there may be additional costs in filing suit and litigating a UM or PIP claim, if the plaintiff prevails, the attorney fees provision may substantially increase the plaintiff's net recovery. Furthermore, some insurers will agree to binding arbitration after suit is filed, with attorney fees to be determined by the arbitrator. Thus, for cases where attorney fees are potentially recoverable by the plaintiff, both plaintiff and defense counsel should explore the merits of arbitrating the claim.

G. Is Recovery of UM/UIM Benefits Based on a Comparison of Third-Party Policy and UM Policy or Comparison of "Amount Recovered" and UM Policy in Multi-party Cases?

In 1997, ORS 742.502(3) and (5) were amended to provide that reduction of UM limits or availability of UM coverage is based on the "recovery" from the third-party. In *Takano v. Farmers Ins. Co.*, 184 Or App 479, 56 P3d 491 (2002), the court confirmed that the amount of UM benefits available is based on the amount of recovery and not based on a simple matching of the policy limits provisions. For example, if 5 claimants are making demand against a tortfeasor's single limit policy of \$50,000 and against a separate UM policy of \$50,000, then the amount of the recovery from the tortfeasor for each claimant must be evaluated. If each claimant recovers \$10,000 from the tortfeasor, then potentially \$40,000 in UM benefits are available to a single UM claimant.

Thus, attorneys should be aware that a simple matching of policies is no longer appropriate for determining UIM benefits available in multi-party cases if damages exceed the tortfeasor's policy limits.

II. CONCLUSION

As has been the case for several years now, the law with respect to PIP, UM and UIM is in a constant state of flux. Attorneys practicing in this area must stay abreast of the constant legislative and statutory changes. While it has been proposed that a complete overhaul of the statutory scheme related to PIP and UM take place in order to "Sort out the Mess," it is unlikely that it will happen any time soon.

Farmers loses verdict, told to pay \$9.5 million. The insurance company illegally cut customers' claims in car crashes, a Multnomah County Circuit Court jury decided.

A Multnomah County Circuit Court jury handed down a verdict Friday that Farmers Insurance Co. of Oregon defrauded thousands of its customers by reducing the payments for their medical expenses after auto accidents. The jury awarded \$9.5 million to about 7,200 Oregonians who were represented in the class-action suit. In addition, more than 1,500 Oregon doctors, chiropractors, therapists, hospitals and other providers might be entitled to share in the verdict, attorneys for the plaintiffs said. The trial, which lasted five weeks, ended Friday afternoon after nearly two days of deliberations.

“Farmers broke its promise to me by not paying all my medical bills,” said Mark Strawn of Beaverton, the original plaintiff in the case. “We called them on it, and we won.” Farmers officials could not be reached for comment Friday evening. Farmers has since changed the reimbursement policy in question, an attorney for the plaintiffs said. Also named in the suit were two insurance companies affiliated with Farmers, Mid-Century Insurance and Truck Insurance Exchange.

The jury awarded \$8 million in punitive damages and \$1.5 million in compensatory damages and interest. Oregon insurance law requires that personal injury protection benefits cover “all reasonable and necessary expenses” for medical, hospital and other services incurred within a year of the injury. Portland attorney Richard Yugler and his partners contended that from 1998 to 1999, Farmers used a formula to reduce the reimbursement to doctors, claiming charges were higher than reasonable compared with the charges of other medical providers in the same geographic area. Yugler filed the lawsuit four years ago on behalf of Strawn, who suffered head injuries in a car wreck Nov. 20, 1997.

Physicians who treated Strawn submitted claims to Farmers that included \$35 for a chest X-ray, \$110 for diagnosis of a coma and \$1,387.50 for tests conducted by a neuropsychologist. Farmers paid a total of \$17,804 but reduced the payment for the X-ray by \$8.30, reduced the payment for the coma diagnosis by \$7 and reduced the neuropsychologist's payment by \$412.50. Strawn paid the difference for the neuropsychologist. OHSU Hospital was not reimbursed for the rest. When Strawn saw his bills, he wondered why all the expenses weren't paid and started investigating. The amounts that Farmers did not pay, Yugler said, were generally so small that it wasn't enough for a single policy-holder to pursue. About 70 percent of the reimbursements denied to the plaintiffs totaled less than \$10 each, he said. “The company was literally nickel-and-diming Oregon consumers,” Yugler said. The thousands of people represented in the suit will be asked to submit claims to be reimbursed for their medical expenses and to share the \$8 million in punitive damages. The average reimbursement would be about \$100 a policyholder and \$500 for each medical provider, Yugler said. He expects Farmers to appeal.

The Oregonian, by Steve Beaven The author of this article may be reached at stevebeaven@news.oregonian.com

ORS 746.230 Unfair claim settlement practices.

(1) No insurer or other person shall commit or perform any of the following unfair claim settlement practices:

- (a) Misrepresenting facts or policy provisions in settling claims;
- (b) Failing to acknowledge and act promptly upon communications relating to claims;
- (c) Failing to adopt and implement reasonable standards for the prompt investigation of claims;
- (d) Refusing to pay claims without conducting a reasonable investigation based on all available information;
- (e) Failing to affirm or deny coverage of claims within a reasonable time after completed proof of loss statements have been submitted;
- (f) Not attempting, in good faith, to promptly and equitably settle claims in which liability has become reasonably clear;
- (g) Compelling claimants to initiate litigation to recover amounts due by offering substantially less than amounts ultimately recovered in actions brought by such claimants;
- (h) Attempting to settle claims for less than the amount to which a reasonable person would believe a reasonable person was entitled after referring to written or printed advertising material accompanying or made part of an application;
- (i) Attempting to settle claims on the basis of an application altered without notice to or consent of the applicant;
- (j) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;
- (k) Delaying investigation or payment of claims by requiring a claimant or the physician of the claimant to submit a preliminary claim report and then requiring subsequent submission of loss forms when both require essentially the same information;

(l) Failing to promptly settle claims under one coverage of a policy where liability has become reasonably clear in order to influence settlements under other coverages of the policy; or

(m) Failing to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to the facts or applicable law for the denial of a claim.

(2) No insurer shall refuse, without just cause, to pay or settle claims arising under coverages provided by its policies with such frequency as to indicate a general business practice in this state, which general business practice is evidenced by:

(a) A substantial increase in the number of complaints against the insurer received by the Department of Consumer and Business Services;

(b) A substantial increase in the number of lawsuits filed against the insurer or its insureds by claimants; or

(c) Other relevant evidence.

(3) (a) No health maintenance organization, as defined in ORS 750.005, shall unreasonably withhold the granting of participating provider status from a class of statutorily authorized health care providers for services rendered within the lawful scope of practice if the health care providers are licensed as such and reimbursement is for services mandated by statute.

(b) Any health maintenance organization that fails to comply with paragraph (a) of this subsection shall be subject to discipline under ORS 746.015.

(c) This subsection does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act.

[1967 c.359 §588a; 1973 c.281 §1; 1989 c.594 §1]

McKENZIE v. PACIFIC HEALTH & LIFE
INS. CO.,

118 Or.App. 377 (1993); 847 P.2d 879

Max A. McKENZIE and Debra A. McKenzie,
Appellants v. PACIFIC HEALTH &

LIFE INSURANCE COMPANY, an Oregon
corporation, respondent.

CV90-188; CA A67100

Court of Appeals of Oregon

Argued and submitted January 6, 1992

Affirmed in part; otherwise reversed and
remanded for further proceedings

March 3, 1993

Reconsideration denied May 26, 1993

Petition for review allowed July 27, 1993 (317
Or. 271) [Page 378]

Appeal from Circuit Court, Umatilla County.

Jack F. Olsen, Judge.

Timothy J. O'Hanlon, Pendleton, argued the
cause for appellants. On the briefs were W.
Eugene Hallman and Mautz, Hallman,
Pendleton.

Ronald L. Marceau, Bend, argued the cause for
respondent. With him on the brief were Martin
E. Hansen and Marceau, Karnopp, Petersen,
Noteboom & Hubel, Bend.

Before Rossman, Presiding Judge, and De
Muniz and Leeson, [fn*] Judges, [fn*] Leeson,
J., vice Buttler, J., retired.

ROSSMAN, P.J.

Affirmed as to Debra A. McKenzie; otherwise
reversed and remanded for further proceedings
not inconsistent with this opinion. [Page 379]

ROSSMAN, P.J.

Plaintiffs, Max and Debra McKenzie, appeal
from a judgment dismissing Max's claim for
breach of a health insurance contract. They assign
error to the trial court's striking of allegations
relating to damages and to breach of the duty of
good faith and fair dealing. The trial court
dismissed all claims made by Debra, and that
ruling is not assigned as error. Accordingly, we

affirm as to Debra. Our reference to "plaintiff" is
to Max.

Defendant issued a policy to plaintiff that insured
him against major medical expenses up to \$1
million. The policy excluded coverage of expenses
relating to arthritis. Plaintiff developed "aseptic
necrosis" of both hips, a condition that, loosely
translated, is "dead, infected hip bones." After
defendant learned that plaintiff needed surgery, it
began to question the claim. Plaintiff's doctor sent
defendant a letter stating that plaintiff needed a
total hip replacement. He explained that plaintiff's
condition was not arthritis. Defendant denied
coverage.

Plaintiff's complaint alleged, in part:

"6.

"Defendant refused to authorize the
surgery for aseptic necrosis. Defendant
took this action without investigation of
any kind and specifically in contradiction
to the medical advice received by
plaintiff's physician, a copy of which is
attached as Ex. A. As a result of the
refusal to pay for the surgery for aseptic
necrosis, plaintiff was forced to delay
surgery and to attempt to obtain other
insurance.

"FIRST CLAIM – BREACH OF CONTRACT

"7.

"Plaintiffs have duly performed all
conditions required of them by said policy
of insurance.

"8.

"Defendant, in breach of the implied
covenant of good faith and fair dealing
and/or the terms of said policy of
insurance:

"(1) Failed and refused to pre-authorize or
pay for the insured Max A. McKenzie's
surgery for aseptic necrosis. [Page 380]

"(2) Acted in bad faith denying plaintiffs
the fruits of the insurance contract.

"9.

"Defendant's breach caused plaintiff Max
A. McKenzie bodily harm.

“10.

“Defendant’s breach was of such a kind that serious emotional disturbance was a particularly likely result.

“As a result of defendant’s breach, plaintiff Max A. McKenzie has suffered bodily harm and emotional distress, the amount of which will be proven at trial, and plaintiff has incurred medical expenses relating to surgery for aseptic necrosis in an amount in excess of \$10,000.

“ *****

“WHEREFORE, plaintiffs’ [sic] pray for judgment against defendant in an amount of economic and non-economic damages to be proven at trial, for an award of punitive damages in the amount of \$100,000.00, for reasonable attorney fees in an amount to be determined by the court and for costs and disbursements incurred herein.”

On defendant’s motion, the court struck paragraph 6, all of paragraph 8 except for the allegation claiming failure or refusal to pre-authorize surgery, paragraphs 9, 10 and 11 and the prayer. The court gave plaintiff leave to replead the damages allegation, but plaintiff declined. The court dismissed the complaint with prejudice. On appeal, plaintiff assigns error to the striking of the allegations.

Defendant argues that, because plaintiff could have repleaded the damages allegation and proceeded to trial on the express contract claim, but instead allowed judgment to be entered against him, the appeal is piecemeal and should be dismissed. Final judgment was entered dismissing plaintiff’s complaint in its entirety, with prejudice. Plaintiff apparently elected not to pursue the allegations relating to breach of the express terms of the contract that remained after the court had stricken the allegations related to breach of the duty of good faith and fair dealing. A party may violate its duty of good faith without also breaching the express provisions of the contract. *Elliot v. Tektronix, Inc.*, 102 Or.App. 388, [Page 381] 796 P.2d 361, rev den 311 Or. 13 (1990). Accordingly, we conclude that a claim for breach of the duty of good faith may be pursued independently of a

“11.

claim for breach of the express terms of the contract. Plaintiff is entitled to appeal the trial court’s ruling on that claim. We need not decide whether he is barred from litigating the allegations that he has chosen not to pursue related to breach of the express terms of the contract. The appeal is not piecemeal.

Defendant contends that the trial court correctly struck the allegations related to breach of the duty of good faith and fair dealing, because that duty is applicable only to contracts in which one of the parties has some discretion in the performance of its obligation. It is true that, in *Best v. U.S. National Bank*, 303 Or. 557, 739 P.2d 554 (1987), the court focused on contracts that give “discretion” to one party. 303 Or at 561. A contract that necessitates the exercise of discretion certainly implicates the duty of good faith. Yet, so long as it is not inconsistent with the express terms of the contract, the duty of good faith is a contractual term that is implied by law into every contract, not just those that necessitate the exercise of discretion. *See Sheets v. Knight*, 308 Or. 220, 233 n 12, 779 P.2d 1000 (1989). We conclude that, within defendant’s obligation to pay all covered claims was the duty to determine, in good faith, whether a claim is covered, and to refrain from arbitrarily refusing to pre-authorize medical treatment. The trial court erred in striking the allegations contained in paragraphs 6 and 8 related to the duty of good faith and fair dealing.

Plaintiff contends that the court erred in striking the allegations contained in paragraphs 9 and 10 that the breach of contract caused him bodily injury and emotional distress. Ordinarily, emotional distress caused by pecuniary loss resulting from a breach of contract is not recoverable. *Farris v. U.S. Fid. and Guar. Co.*, 284 Or. 453, 456, 587 P.2d 1015 (1978). When, however, the emotional distress is caused by physical harm that results from the breach of contract, the case is different. *Coffey v. Northwestern Hospital Assn.*, 96 Or. 100, 115, 183 P. 762 (1919), *reh’g denied* 189 P. 407 (1920); *see Keltner v. Washington County*, 310 Or. 499, 506, 800 P.2d 752 (1990). Plaintiff alleged that

defendant's breach caused both [Page 382] physical and emotional harm. The trial court erred in striking the allegations.

Finally, plaintiff assigns error to the trial court's striking of the damages allegation of paragraph 11 and the prayer. He concedes that the prayer for punitive damages is inappropriate. ORCP 18 provides that, when a pleading contains a demand for the recovery of money damages, "the amount thereof shall be stated." Plaintiff argues that he is forced to plead damages in an open-ended fashion, because his treatment is ongoing, and the full extent of his monetary damage is not yet ascertainable. We agree with the trial court that the allegations were not sufficiently specific. On remand the allegation of damages may be amended. We agree with plaintiff that he was not required to specify the amount of his non-economic damages. ORCP 18B.

Affirmed as to Debra A. McKenzie; otherwise reversed and remanded for further proceedings not inconsistent with this opinion. [Page 383]

Oregon Court of Appeals Reports
EGGIMAN v. MID-CENTURY INS. CO., 134
Or. App. 381 (1995)

895 P.2d 333

Linda EGGIMAN, Appellant, v.
MID-CENTURY INSURANCE COMPANY, a
foreign corporation, Respondent.

9304-02123; CA A81855

Court of Appeals of Oregon.

Argued and submitted June 16, 1994

Affirmed May 17, 1995

Appeal from Circuit Court, Multnomah County.

Lee Johnson, Judge.

Timothy W. Grabe argued the cause and filed the
brief for appellant. [Page 382]

Barbara L. Johnston argued the cause for
respondent. With her on the brief was Larry A.
Brisbee.

Before Deits, Presiding Judge, and Riggs and
Haselton, Judges.

HASELTON, J.

Affirmed. [Page 383]

HASELTON, J.

Plaintiff Eggiman appeals from a summary
judgment for defendant Mid-Century Insurance
Co. on her action for breach of contract. She
alleged that defendant breached its obligation
under an insurance policy, which provided for
personal injury protection (PIP) benefits, by
refusing to preauthorize physical rehabilitation
treatment after she sustained injuries in an
automobile accident. We affirm.

On November 3, 1990, plaintiff suffered a soft
tissue back injury in an automobile accident.[fn1]
At that time, she was insured under an automobile
liability policy issued by defendant, which
provided for statutorily mandated PIP benefits.
ORS 742.520(1) .

Following the accident, Keith Johns, a
chiropractor, treated plaintiff's back injuries. On
April 9, 1991, Johns wrote to defendant
recommending that plaintiff participate in a
"physical rehabilitation and educational program."
Such programs combine supervised aerobic and

strength exercises with counseling.[fn2] On May
16, 1991, defendant responded:

"Physical Therapy is covered under the policy.
However, 'rehabilitation', per se, is not.

"Our primary goal and responsibility to the
Insured, is to provide benefits to place them back
to the condition they were in prior to the accident.

"Rehabilitation goes beyond this process.
Although I agree it is to the benefit of the patient
to strengthen weak areas to avoid further injuries,
the purpose of the coverage is, as was stated
above, to place the patient back to the condition
they were in just prior to the accident."[fn3][Page
384]

Thereafter, a dispute arose over defendant's
refusal to pay. On December 3, 1991, defendant
wrote to Johns and Johns' services. Three days
later, plaintiff demanded arbitration, pursuant to
ORS 742.520 (6),[fn4] concerning defendant's
refusal to pay, but not its refusal to preauthorize
rehabilitation. Defendant eventually agreed to pay
all of Johns' submitted fees, and plaintiff canceled
arbitration in March 1992.

In January 1992, approximately nine months
after Johns requested preauthorization, plaintiff
enrolled in a physical rehabilitation program at
Portland Rehabilitation and Sports Medicine, a
rehabilitation program that accepts patients
without insurance preauthorization. Thereafter,
notwithstanding its refusal to preauthorize
physical rehabilitation, defendant paid all of
plaintiff's submitted costs for rehabilitation at
Portland Rehabilitation.

In April 1993, plaintiff brought this action
against defendant for breach of contract. She
alleged that defendant breached its insurance
contract by failing to preauthorize rehabilitation.
Plaintiff asserted that defendant's failure to timely
preauthorize rehabilitation prevented her from
recovering fully and left her 30 percent
permanently disabled.

Defendant moved for summary judgment,
arguing that it did not breach its insurance contract
and that, in any event, ORS 742.520(6) required
plaintiff to arbitrate her claim against defendant.
The trial court granted defendant's motion on the
ground that plaintiff should have arbitrated her
claim.[fn5]

Plaintiff contends that the trial court erred in granting summary judgment for defendant. In particular, plaintiff argues that: (1) genuine issues of material fact exist as to [Page 385] whether defendant breached its contract to provide PIP benefits; and (2) as a matter of law, she was not required to arbitrate her claim. The success of plaintiff's arguments depends ultimately on her assertion that, under *McKenzie v. Pacific Health & Life Ins. Co.*, 118 Or.App. 377, 847 P.2d 879 (1993), defendant had a duty to determine in good faith, whether her insurance policy covered physical rehabilitation, and to refrain from arbitrarily refusing to preauthorize that treatment. We conclude that defendant had such a duty, but that the determination as to whether defendant breached that duty is subject to mandatory arbitration under ORS 742.520(6).

We note, at the outset, that the summary judgment record does not include plaintiff's actual PIP policy with defendant. In moving for summary judgment, defendant did not attach excerpts of the policy, but, instead, assumed that the pertinent policy provisions conformed to, and did not exceed, the requirements of the PIP statutes, ORS 742.520 et seq. Plaintiff apparently made the same assumption, because she did not submit excerpts, of the policy in opposing summary judgment; nor did plaintiff ever argue, either before the trial court or on appeal, that defendant's failure to do so precluded summary judgment. Thus, any ostensible deficiency in defendant's summary judgment submission is not assigned as error and does not compel reversal. In reviewing the summary judgment, we shall assume that the policy terms pertinent to the issues on appeal parallel the statutory requirements.

1. Turning to the merits, we first consider plaintiff's argument that, under *McKenzie*, defendant had a duty to refrain from arbitrarily refusing to preauthorize covered treatments. In *McKenzie*, the plaintiff was insured under a health insurance policy, which expressly excluded coverage for expenses related to arthritis. The plaintiff subsequently developed "aseptic necrosis" in his hips, a condition that is not arthritis, but is "dead, infected hip bones." The plaintiff's doctor asked the defendant insurer to preauthorize hip replacement surgery, explaining that the condition was not arthritis. When the defendant nevertheless refused to preauthorize the

surgery, the plaintiff sued, alleging. Inter alia, that the defendant's refusal breached the implied covenant of [Page 386] good faith and fair dealing. The trial court struck the plaintiff's claim for breach of the duty of good faith, and we reversed:

"[S]o long as it is not inconsistent with the express terms of the contract, the duty of good faith is a contractual term that is implied by law into every contract * * *. See *Sheets v. Knight*, 308 Or. 220, 233 n 12, 779 P.2d 1000 (1989). We conclude that, within defendant's obligation to pay all covered claims was the duty to determine, in good faith, whether a claim is covered, *and to refrain from arbitrarily refusing to preauthorize medical treatment.*" 118 Or App at 381 (emphasis supplied).

Defendant argues that *McKenzie* is distinguishable in several material respects. Defendant contends that *McKenzie* holds that an insurer has a duty to preauthorize treatments in good faith only when it has an express contractual duty to preauthorize treatments. Because the PIP statutes do not refer to preauthorization, see *infra*, 134 Or App at 387, defendant reasons that there could be no good faith duty to preauthorize. As further support for its position, defendant cites *Uptown Heights Associates v. Sea-first Corp.*, 127 Or.App. 355, 873 P.2d 438 (1994), *aff'd. in part, rev'd. in part* 320 Or. 638, 891 P.2d 639 (1995).

Defendant misreads both *McKenzie* and *Uptown Heights*. In *McKenzie*, there is no suggestion that the duty to preauthorize in good faith arose from a duty to preauthorize expressly imposed by the health insurance policy at issue there. Indeed, our review of the briefs and oral arguments in *McKenzie* discloses no mention of such an express contractual duty. Rather, the duty to refrain from arbitrarily refusing to preauthorize treatments in *McKenzie* stems from defendant's general "obligation to pay all covered claims." 118 Or App at 381.

Similarly, *Uptown Heights* does not hold that an implied duty of good faith must precisely refer to a specific, express contractual duty. Instead, *Uptown Heights* validates the obverse proposition, *i.e.*, that a duty of good faith will not be implied and enforced in contravention of a parties' express

contractual rights (there, an express contractual entitlement to foreclose). 127 Or App at 360-61. [Page 387]

McKenzie's flexible and sensible analysis applies equally here. As in *McKenzie*, a duty to preauthorize in good faith is properly implied because, absent such a duty, a PIP insurer could avoid its contractual obligations altogether by arbitrarily withholding preauthorization. Without preauthorization – without assurance that the insurer will pay the cost of treatment – medical

“Personal injury protection benefits * * * shall consist of the following payments for the injury or death of each person:

“(a) All reasonable and necessary expenses of medical, hospital, dental, surgical, ambulance and prosthetic services incurred within one year after the date of the person’s injury[.]”

Defendant’s statutory arguments are, in some respect, an analytic non sequitur. It is true that the PIP statutes, including ORS 742.524 (1), do not expressly impose a duty to preauthorize. But neither did the health insurance statutes underlying the dispute in *McKenzie*. See ORS 743.402 et seq. Perhaps more pertinently, as in *McKenzie*, nothing in the statutory scheme precludes the recognition and enforcement of a duty to preauthorize in good faith. Nor does defendant point to any material differences between the PIP statutes and the health insurance statutes, or their predicate purposes, that dictate a different result. Although courts cannot imply and enforce a good faith duty in contravention of statutes, *see U.S. National Bank v. Boge*, 311 Or. 550, 567, 814 P.2d 1082 (1990), we are not so constrained by statutory neutrality. [Page 388]

Here, as in *McKenzie*, the PIP insurer’s duty to preauthorize in good faith is a direct and natural corollary of the insured’s “obligation to pay all covered claims.” *McKenzie*, 118 Or App at 381. Without such a duty, a PIP insurer could, in many instances, avoid its statutory obligation because, without preauthorization, many insureds will be unable or unwilling to obtain treatment and incur expenses, short-circuiting the insured’s duty to pay under ORS 742.524 (1) (a). We conclude, therefore, that defendant had a good faith duty to refrain from arbitrarily refusing to preauthorize covered treatment.

providers may refuse to provide the treatment, or PIP insureds may feel compelled not to obtain covered treatment, frustrating contractual expectations.[fn6]

For related reasons, defendant’s arguments pertaining to the particular requirements of the PIP statutes also fail. Defendant argues that, under the PIP statutes, an insurer’s only duty is to pay previously incurred, covered expenses. Defendant relies particularly on ORS 742.524 (1)(a):

2. Nonetheless, we conclude that the trial court properly granted defendant’s motion for summary judgment on the ground that plaintiff’s claim is subject to mandatory arbitration under ORS 742.520(6) (*since amended by Or Laws 1993, ch 282, §1*). That statute provided:

“Disputes between insurers and beneficiaries about the amount of personal injury protection benefits, or about *the denial of personal injury protection benefits*, shall be decided by arbitration.” (Emphasis supplied.)

Plaintiff argues that ORS 742.520(6) mandates arbitration only when an insurer refuses to pay already incurred costs, because ORS 742.524(1) (a) defines personal injury protection benefits as payments for incurred expenses. However, consistent with *McKenzie*, an insurer’s arbitrary withholding of preauthorization is a species of nonpayment because, absent preauthorization, insureds may be deterred or prevented from even incurring covered expenses. Thus, a PIP insurer’s arbitrary refusal to preauthorize a covered treatment constitutes a “denial of personal injury protection benefits” subject to mandatory arbitration under ORS 742.520(6).

3. We recognize that plaintiff’s claim is not that defendant is presently arbitrarily withholding preauthorization, but that defendant’s alleged prior arbitrary withholding of preauthorization caused her to suffer permanent personal injuries. Nonetheless, the success of that claim depends on a determination that defendant’s refusal to preauthorize physical rehabilitation was unreasonable. ORS 742.520(6) requires an arbitrator to make that determination in the first instance. Because no such determination was

made here, the [Page 389] trial court properly entered summary judgment for defendant.

Affirmed.

[fn1] We present the facts in the light most favorable to the plaintiff, as the non-moving party. *Seeborg v. General Motors Corporation*, 284 Or. 695, 699, 588 P.2d 1100 (1978).

[fn2] In a report to defendant, one of plaintiff's treating physicians described "rehabilitation":

"Rehabilitation is directed at physical functioning, more than at the pathology. Rehab[ilitation] incorporates counseling into the physical treatment program. Therefore, rehab[ilitation] can resolve the emotional and disability problems that

[fn5] Defendant did not move pursuant to ORS 36.310 to abate the action and compel arbitration. In opposing summary judgment, plaintiff did not assert that defendant's failure to so move precluded it from asserting an entitlement to summary judgment based on plaintiff's failure to arbitrate. Nor did plaintiff, in the alternative, apply for abatement of the action in the event that the court determined that an issue in dispute should have been arbitrated. ORS 36.315.

[fn6] In responding to defendant's motion for summary judgment, plaintiff presented affidavits stating that Portland Rehabilitation and Sports Medicine was the only local program that would accept patients without insurance preauthorization.[Page 390]

can occur with the chronic pain of physical injuries."

[fn3] In October 1991, Johns again requested that defendant approve plaintiff's admission to a rehabilitation program at East Side Athletic Club. The record does not contain defendant's response to that request.

[fn4] ORS 742.520(6) (since amended by Or Laws 1993, ch 282, §1) provided:

"Disputes between insurers and beneficiaries about the amount of personal injury protection benefits, or about the denial of personal injury protection benefits, shall be decided by arbitration."

ANDERSON v. FARMERS INS. CO. OF
OREGON, 188 Or.App. 179 (2003), 71 P.3d
144

FRANK ANDERSON, Respondent, v.
FARMERS INSURANCE COMPANY OF
OREGON, Appellant.

CV98-08-38946; A112325.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON.

Argued and submitted May 21, 2002, at La
Grande.

Filed: June 12, 2003.

Appeal from Circuit Court, Union County. Eric
W. Valentine, Judge (judgment), and Philip A.
Mendiguren, Judge (supplemental judgment).

Thomas M. Christ argued the cause for appellant.
With him on the briefs was Cosgrave, Vergeer &
Kester LLP.

W. Eugene Hallman argued the cause for
respondent. With him on the brief was Hallman &
Dretke.

Before EDMONDS, Presiding Judge, and
ARMSTRONG and KISTLER, Judges.

ARMSTRONG, J.

Affirmed. [Page 180]

[EDITORS' NOTE: THIS PAGE IS BLANK.]
[Page 181]

ARMSTRONG, J.

Defendant Farmers Insurance Company of
Oregon (Farmers) appeals from a judgment for
plaintiff, its insured, on plaintiff's claim for breach
of contract arising out of Farmers' failure to
preauthorize payment of personal injury protection
(PIP) benefits for the full cost of plaintiff's knee
replacement surgery after an automobile accident.
We affirm.

Most of the facts are not in dispute. Plaintiff
was injured while driving his own automobile,
which Farmers insured. At that time, plaintiff and
his wife had three separate but identical policies
insuring three different vehicles, each providing
\$25,000 in PIP coverage. The parties agree that
the PIP policy insuring the car that plaintiff was
driving at the time of the accident was the
"primary policy and that the policies covering the

two other family vehicles were "excess" policies.
ORS 742.526. Each PIP policy contained an
"other insurance" clause prohibiting the
"stacking"[fn1] of coverage:

"If any applicable insurance other than
this policy is issued to you or a *family
member* by us or any other member
company of the Farmers Insurance Group
of Companies, the total amount payable
among all such policies shall not exceed
the limits provided by the single policy
with the highest limits of liability."

(Emphasis in original.) The parties agree that, by
its terms, the clause restricts plaintiff's PIP
benefits to the limits of the highest policy, in this
case \$25,000. As Farmers acknowledges,
however, the clause is not enforceable "in full."
Because the policies are for equal amounts, the
clause would have the effect of completely
denying PIP coverage on the two excess policies,
when Oregon law requires some coverage. ORS
742.520 and 742.524 require every motor vehicle
insurance policy to provide \$10,000 in PIP
coverage for each [Page 182] insured for "all
reasonable and necessary expenses of medical,
hospital, dental, surgical, ambulance and
prosthetic services incurred within one year after
the date of the person's injury." Thus, Farmers
concedes that, despite the anti-stacking clause in
its policies, it was required to provide the
minimum statutory PIP coverage in each policy; it
calculates the amount due plaintiff as \$25,000
under the primary policy and \$10,000 under each
excess policy, for a total PIP benefit of \$45,000.
In plaintiff's view, he is entitled to the full limits
of his PIP policies on each policy for a total of
\$75,000 in PIP benefits.

Plaintiff's damages, including the proposed
surgery, were in excess of \$65,000. Farmers paid
\$32,000 toward plaintiff's medical expenses and
agreed to pay an additional \$13,000, which would
have covered half the cost of the surgery, for a
total PIP benefit of \$45,000. Because plaintiff
could not afford to pay the remaining \$13,000 for
the surgery, he chose not to have it and canceled
the surgery and a pre-operative medical
examination. He brought this action against
Farmers seeking damages for Farmers' failure to
agree to pay the full cost of the surgery. The trial
court concluded as a matter of law that plaintiff

was entitled to the full PIP limits on each policy, to the extent of his damages. A jury found that Farmers had breached its contract with plaintiff by refusing to pay the full cost of the knee

Farmers concedes that the challenged policy provision, if applied according to its terms, likely violates ORS 742.520. It asserts, nonetheless, that the anti-stacking provision can be applied with respect to policy limits in excess of the statutory minimum limits and, accordingly, that the trial court erred in denying its motion for summary judgment because, as a matter of law, plaintiff's PIP coverage under the three policies was only \$45,000. In support of its position, Farmers looks to case law dealing with a similar issue in the context of motor vehicle liability insurance.

In *Collins v. Farmers Ins.*, 312 Or. 337, 822 P.2d 1146 (1991), the plaintiff was an insured person under a motor [Page 183] vehicle liability insurance policy with limits of \$100,000 per person and \$300,000 per occurrence. The policy contained an exclusion for bodily injury to insured persons. The insurer offered to settle the plaintiff's claim for \$25,000, the minimum coverage required by the Financial Responsibility Law (FRL), and sought to enforce the exclusion for bodily injury to the insured as to coverage beyond the statutory minimum limits. The court agreed with the insurer that ORS 742.464 permits such a result. The statute provides:

"Any policy which grants the coverage required for a motor vehicle liability insurance policy under ORS 742.450, 806.080 and 806.270 may also grant any lawful coverage in excess of or in addition to the required coverage, and such excess or additional coverage shall not be subject to the provisions of ORS 742.031, 742.400 and 742.450 to 742.464. With respect to a policy which grants such excess or additional coverage only that part of the coverage which is required by ORS 806.080 and 806.270 is subject to the requirements of those sections."

(Emphasis added.) The court explained the statute:

"The manifest purpose of ORS 742.464 is to permit an insurer to write any other

replacement surgery and awarded plaintiff \$26,000 in economic damages and \$200,000 in noneconomic damages. Farmers appeals from the judgment that the court entered on the jury verdict.

lawful coverage that the insurer wishes to write, in addition to the required coverage. Such coverage may include higher limits than those required by ORS 742.450 and 806.080. But as to such higher limits, the mandatory requirements of ORS 742.450 and 806.080 do not apply. The insurer may limit such additional coverage by any exclusion not otherwise prohibited by law.

"To summarize, the law implies a provision in every motor vehicle liability insurance policy along these lines:

"THIS POLICY PROVIDES ALL THE COVERAGE REQUIRED BY OREGON LAW, INCLUDING ORS 742.450, 806.080, AND 806.270.

"Coverage other than that required by law may be limited by any lawful exclusion."

312 Or. at 342. The court held that the insurer could enforce the policy exclusion for bodily injury to its insureds with respect to limits in excess of \$25,000. The court's holding permits a motor vehicle liability insurer to enforce an exclusion [Page 184] for otherwise required coverage to the extent that the coverage exceeds the minimum coverage required by law.

In Farmers' view, a similar analysis applies in the context of PIP coverage: An insurer should be permitted to enforce its anti-stacking clause with respect to coverage in excess of the \$10,000 statutorily required PIP benefits. The first difficulty with Farmers' position is that the anti-stacking provision at issue here is different from the policy exclusion at issue in *Collins*. The court in *Collins* held that the exclusion could be given effect as to coverage in excess of the minimum required by law. Here, the anti-stacking clause provides that the PIP coverage available under all three insurance policies is limited to the highest limits provided by any single policy. Short of rewriting the clause, there is no tidy way of restricting its application to excess coverage. Additionally, we note that Farmers' policies otherwise *require* the stacking of PIP benefits in

determining Farmers' proportionate share. A "limits of liability" clause provides:

"If there is other applicable medical payments or Personal Injury Protection for medical and hospital benefits insurance that applies to a loss covered by this part, we will pay only our share. *Our share is the proportion that our limits of liability bear to the total of all applicable limits.*"

(Emphasis added) The italicized sentence requires that the applicable policy limits be stacked to "Nothing in ORS 742.520 to 742.542 is intended to prevent an insurer from providing more favorable benefits than the personal injury protection benefits described in ORS 742.520, 742.524 and 742.530."

Thus, as Farmers did here, an insurer may provide greater IP coverage than that required by ORS 742.524. However, [Page 185] no provision similar to ORS 742.464 exempts the additional benefits from the requirements of ORS 742.520 or ORS 742.524 to ORS 742.530. If provided, that greater coverage is subject to the provisions of ORS 742.520 and 742.524 to 742.530.

There are statutorily permitted limits on PIP payments. ORS 742.530 provides for three exclusions, none of which is applicable here. ORS 742.526(2) provides for the reduction or limitation of PIP benefits for workers' compensation benefits or other similar medical or disability benefits. ORS 742.542 further provides that payment of PIP benefits by an insured

"shall be applied in reduction of the amount of damages that the insured may be entitled to recover from the insurer under uninsured or underinsured motorist coverage for the same accident but may not be applied in reduction of the uninsured or underinsured motorist coverage policy limits."

Thus, the payment of PIP benefits reduces the damages due under uninsured motorist (UM) or underinsured motorist (UIM) coverage for the same accident. However, no statute permits an insurer to limit its PIP liability to the upper limits of one policy. We conclude that no statutory or policy provision authorizes the enforcement of the

determine the insurer's proportionate share of liability.

The second reason why we conclude that the Supreme Court's decision in *Collins* is not helpful to farmers is that the opinion hinged on the court's interpretation of ORS 742.464, which expressly exempts additionally liability coverage from the statutory coverage requirements. There is no similar provision with respect to PIP coverage. ORS 742.532 provides:

anti-stacking provision for coverage that exceeds the statutorily required minimum PIP coverage.

Our conclusion also finds support in a recent Supreme Court decision, *Erickson v. Farmers Ins. Co.*, 331 Or. 681, 21 P.3d 331 (2001). The plaintiff in *Enckson* was injured when the car in which she was a passenger collided with a car driven by an uninsured motorist. Both the plaintiff and the driver of the vehicle in which she was a passenger had identical UM coverage of \$100,000 with the same insurer. By arbitration, the plaintiff was awarded damages of \$150,000. The insurer paid the plaintiff \$100,000 in UM benefits toward satisfaction of the arbitration award without identifying the policy from which the benefit had been paid. The plaintiff brought an action against the insurer to recover the balance of her damages. The insurer asserted that two "other insurance" clauses in its policies limited the plaintiff's UM benefit to the highest limits of the two policies. The court [Page 186] held, first, that the two other insurance provisions denied the plaintiff coverage under her own policy in circumstances where UM statutes required some coverage and were therefore unenforceable. The court declined, however, to "amend" the policies by replacing the repugnant provisions with statutorily permitted "other insurance" limitations contained in ORS 742.504 (9)(a) and (b). The policies, as here, also contained a clause implicitly authorizing the stacking of coverage by requiring the insurer to pay as its share of the loss "the proportion that our limits of liability bear to the total of all applicable limits." The court said that when the repugnant provisions were disregarded, the remaining policy terms permitted stacking of UM coverage to the full amount of the arbitration award:

“Nothing more is required to conform the policy to Oregon law. Thus, there is no reason to replace the unenforceable provisions that denied plaintiff coverage with the statutory provisions.” 331 Or. at 687.

Here, the provisions of the policies prohibiting stacking violate Oregon law and must be disregarded. When the clauses are disregarded, each PIP policy provides coverage of \$25,000. And here, because each PIP policy also contains a clause limiting the insurer’s share to “the proportion that our limits of liability bear to the

Farmers also assigns error to the trial court’s denial of its motion for a directed verdict, in which it asserted that it had not breached the insurance contract by failing to preauthorize the full cost of plaintiff’s proposed knee surgery because the surgical expense was never incurred. Consistently with ORS 742.524,[fn2] Farmers’ three policies provided [Page 187] that it would pay all medical expenses “incurred” within one year from the date of the accident that caused the injury. Farmers contends that the statute and policies require a medical expense to be incurred before an insurance company can be required to pay it. Farmers contends that, because plaintiff never had the proposed surgery, the expense was not incurred and therefore was not a covered medical expense. Plaintiff responds that Farmers should not be able to avoid liability on the ground that the expense was not incurred because the surgery had been recommended by his physician and, but for Farmers’ refusal to preauthorize the full cost, the expense would have been incurred.

The trial court treated Farmers’ refusal to pay for the surgery as a repudiation of its obligation under the insurance contract to pay for medical expenses caused by the accident. We agree with the trial court that, in light of its refusal to preauthorize the surgery, Farmers cannot assert that the expense was not incurred during the prescribed period. The evidence in the record would support a finding that plaintiff chose not to have the knee replacement surgery because he could not afford to pay for the balance of the cost of the surgery in excess of the amount that Farmers had preauthorized. Plaintiff’s failure to incur the expense cannot provide an excuse for Farmers’ refusal to pay for the surgery. *Cf. Eggiman v. Mid-Century Ins. Co.*, 134 Or. App.

total of all applicable limits,” each policy implicitly permits stacking. As we held in *Porter v. Utah Home Fire Insurance Co.*, 58 Or.App. 729, 734, 650 P.2d 130 (1982), overruled, on other grounds by *Employers’ Fire Ins. v. Love It Ice Cream*, 64 Or.App. 784, 670 P.2d 160 (1983), no statutory provision precludes the stacking of PIP benefits when the damages exceed the limits of the primary coverage. We affirm the trial court’s ruling denying Farmers’ motion for summary judgment.

381, 387, 895 P.2d 333(1995) (applying related principle).

Citing *Aurora Aviation v. AAR Western Skyways*, 75 Or.App. 598, 603, 707 P.2d 631 (1985), Farmers contends that, if its failure to preauthorize the surgery was a repudiation of the contract, then plaintiff must establish that he was able to perform his part of the bargain, that is, that he was medically able to have the surgery. Farmers argues that, because plaintiff did not submit to a scheduled pre-operative medical examination to determine whether he was medically fit to have the surgery, it is not possible to determine whether he was able to have the proposed surgery, and, hence, plaintiff has failed to establish his ability to perform.

Farmers’ argument is based on the false premise that plaintiff’s duties under the contract included establishing his medical ability to have the surgery. By law, Farmers [Page 188] had an obligation to pay for all reasonable and necessary medical expenses. ORS 742.524. Farmers identifies no provision in its policy that requires an insured to establish a medical ability to withstand a recommended procedure.

There was evidence from which the jury could find that the recommended knee surgery was reasonable and necessary. Furthermore, Farmers’ willingness to pay for half the cost of the surgery is an indication that it considered the surgery to be a covered expense, even without proof of plaintiff’s ability to tolerate the surgery. We reject without further discussion Farmers’ contention that plaintiff could enforce Farmers’ obligation to provide coverage for his medical expenses only if he could establish that he was medically fit for the procedure. For the same reason, we conclude that

the trial court did not err in declining to give Farmers' requested jury instruction that, to prevail on his claim that Farmers had repudiated the insurance policy, plaintiff had to prove that he was medically able to have the surgery.

Farmers asserts that the trial court erred in refusing to allow Farmers to argue that plaintiff had suffered no damages as a result of Farmers' repudiation of its contractual obligation to pay for the surgery because plaintiff was medically unable to have the surgery. There was evidence that, two to three years after the surgery was recommended, plaintiff would not have been a good candidate for the surgery. However, at trial the only evidence concerning the reason that plaintiff did not have the surgery was that it was because Farmers had refused to preauthorize the full cost of the surgery as a result of its view that the PIP policy limits were \$45,000. Farmers' contention at trial that plaintiff would have been medically unable to tolerate the surgery at the time that it was requested was purely speculative and not based on any medical evidence in the record. The trial court did not abuse its discretion in forbidding Farmers to argue the point to the jury.

Farmers' final contention is that the trial court erred in allowing plaintiff to introduce his wife's testimony about advice that she had received from the Department of Consumer and Business Services Insurance Division about Farmers' Affirmed.

[fn1] "Stacking" becomes an issue when, as here, multiple policies cover the same loss and the amount available under the primary policy is inadequate to satisfy the damages alleged or awarded *Erickson v. Farmers Ins. Co.*, 331 OR. 681, 683 n 1, 21 P.3d 90 (2001).

[fn2] ORS 742.524 provides in part that PIP benefits shall be paid for all medical-services "incurred within one year after the date of the person's injury." [Page 190]

coverage position. When Farmers told plaintiff that [Page 189] his PIP coverage was only \$45,000, plaintiff's wife filed a complaint with the Insurance Division. Plaintiff's wife testified that a compliance officer with the division told her that the division "couldn't convince [Farmers' adjusters] to change their opinion" concerning plaintiff's PIP coverage and told her that the matter would have to go to arbitration and recommended that plaintiff hire an attorney. Farmers objected to the testimony on the ground that it was hearsay; the trial court overruled the objection, explaining that the testimony concerned "what this woman did." We agree with plaintiff that the testimony was not offered to prove the truth of the matter asserted, that is, that the Insurance Division had agreed with plaintiff's view as to the limits of PIP coverage and had been unable to persuade Farmers to change its position. Rather, the evidence was offered to explain the background of the dispute. In any event, even assuming that the evidence was hearsay, any error in admitting it was not prejudicial. ORS 19.415. The legal question of the PIP limits under the insurance policies was decided by the court. For that reason, whether the Insurance Division agreed or disagreed with plaintiff's position as to the scope of coverage is not likely to have affected the jury's decision on the issues that were submitted to it for decision.

Oregon Supreme Court Reports

DOCKINS v. STATE FARM INSURANCE COMPANY, 325 Or. 20 (1999), 585 P.2d 796

TROY DOCKINS AND DONNA DOCKINS,
Petitioners on Review, v. STATE FARM
INSURANCE COMPANY, a corporation.
Respondent on Review.

Nos. CC 9605-03556; CA A98608; SC S45747.

Supreme Court of Oregon.

Argued and submitted January 7, decision of Court of Appeals and judgment of circuit court reversed; case remanded to circuit court July 9, 1999, petitioners' petition for attorney fees allowed by opinion February 24, 2000 See 330 Or. 1 (2000) [Page 21]

On review from the Court of Appeals.[fn*]

Appeal from Multnomah County Circuit Court, Janice R. Wilson, Judge.

155 Or. App. 377, 963 P.2d 119 (1998) .

William A. Drew, Portland, argued the cause and filed the petition for petitioners on review. With him on the petition were Robert E. L. Bonaparte, and Bonaparte, Elliott, Ostrander & Preston, P.O., Portland.

Michael A. Lehner, of Lehner, Mitchell, Rodrigues & Sears, Portland, argued the cause and filed the brief for respondent on review.

Dean Heiling, Portland, filed a brief for amicus curiae Oregon Trial Lawyers Association.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Durham, Kulongoski, and Leeson, Justices.[fn**] Riggs, J., did not participate in the consideration or decision of this case.

GILLETTE, J.

The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed and the case is remanded to the circuit court for further proceedings. [Page 22]

GILLETTE, J.

As this insurance coverage dispute comes to this court, the sole issue concerns plaintiffs' right to collect attorney fees from defendant insurer. Before trial, the parties settled the substance of the action in plaintiffs' favor for \$15,000. The parties

left open the question of attorney fees to be resolved by the trial court if and when plaintiffs petitioned the court for such fees. After the parties had entered into a stipulated judgment reflecting their agreement, plaintiffs petitioned for attorney fees. Defendant objected. The trial court concluded that plaintiffs were not entitled to fees. The Court of Appeals affirmed. *Dockins v. State Farm Ins. Co.*, 155 Or. App. 377, 963 P.2d 119 (1998). Plaintiffs petitioned for review. We allowed the petition and now conclude that plaintiffs are entitled to attorney fees. Accordingly, we reverse the decision of the Court of Appeals and the judgment of the trial court, and remand the case to the trial court for further proceedings.

In January 1996, plaintiffs discovered oil seeping into their home through the basement floor. They immediately contacted their homeowner's insurance carrier, defendant State Farm Insurance Company. After examining the property, a State Farm adjuster informed plaintiffs that, although their policy included coverage for accidental, direct damage to their home, it did not cover contaminated soil or damage to their home arising from contamination or natural water seeping through the foundation. The notice explained that State Farm had decided to deny coverage with the understanding that the groundwater on the property had not been affected and concluded: "We ask that you notify us immediately if you discover the groundwater is involved with the clean-up operation." The notice did not explain how or why such a discovery would be relevant.

On February 27, 1996, the Oregon Department of Environmental Quality (DEQ) sent a letter to plaintiffs informing them that DEQ had received notice of a petroleum release from a tank on their property and that, as the parties responsible for the property, they were required to clean up [Page 23] the release. The letter made no specific reference to groundwater contamination, and nothing in the record indicates that plaintiffs contacted State Farm about the letter.

On May 9, 1996, plaintiffs filed the present action against State Farm for breach of contract and declaratory relief. The contract claim alleged that DEQ had brought an administrative action against plaintiffs, based on petroleum residue on

their property, that DEQ claimed that the petroleum had damaged the public groundwater, that plaintiffs would incur reasonable and necessary costs of not less than \$6,000 to clean up the property, that the homeowner's policy issued by State Farm provided both general liability and property coverage for the losses alleged, and that, "although demand was made upon [State Farm],

State Farm requested an extension of time to file its answer. In a letter to plaintiffs' lawyer. State Farm indicated that the complaint was its "first notice of there being a third party claim in this matter, as well as any ground water contamination." [fn] On July 30, 1996, plaintiffs provided State Farm with a copy of DEQ's cleanup letter, together with copies of a number of cleanup bids. On August 16, 1996, State Farm filed an answer denying most of plaintiff's allegations and raising seven affirmative defenses. Those defenses included that the policy excluded liability coverage to property owned by the insured, that plaintiffs had failed to comply with policy conditions, that plaintiffs had failed to state a claim for damage to covered property, and that the policy excluded property damage coverage for damage caused by contamination, corrosion, and the like.

Plaintiffs moved for summary judgment on the issue of State Farm's duty to defend the DEQ action against plaintiffs. In response. State Farm argued, among other things, [Page 24] that plaintiffs had failed to submit any evidence that they had tendered defense of the DEQ action to State Farm or that State Farm had denied coverage. In reply, plaintiffs submitted the affidavit of plaintiff Donna Dockins, which stated that she had advised State Farm by telephone in March or April of 1996 that there appeared to be groundwater contamination at the site. Plaintiffs also argued that the complaint itself constituted a tender of defense of the DEQ action. The trial court denied plaintiffs' motion for summary judgment, ruling that, "at a minimum, there is a question of fact as to whether plaintiffs have satisfied the conditions precedent to their claim." The next day, on November 14, 1996, plaintiffs formally tendered defense of the DEQ action to State Farm, enclosing DEQ's February 27, 1996, letter. Several months later, in February 1997, plaintiffs reiterated their formal tender of defense, this time including a letter from DEQ that clarified

no defense to the DEQ's claim was provided, and no part of the sums owing have been paid." Plaintiffs also sought attorney fees under ORS 742.061, set out post, their costs of remedial action "in an amount to be proved at trial," and a declaration that State Farm was liable for those costs.

that plaintiff's cleanup responsibilities extended to groundwater.

Shortly thereafter, the parties settled the action on the policy for \$15,000 and reserved the question of attorney fees. A stipulated order and judgment to that effect followed. More than six months had elapsed between the date that plaintiffs filed their complaint and the date of the settlement.

Plaintiffs then petitioned for \$18,725 in attorney fees under ORS 742.061, which provides:

"If settlement is not made within six months from the date proof of loss is filed with an insurer and an action is brought in any court of this state upon any policy of insurance of any kind or nature, and the plaintiff's recovery exceeds the amount of any tender made by the defendant in such action, a reasonable amount to be fixed by the court as attorney fees shall be taxed as part of the cost of the action and any appeal thereon."

State Farm opposed the petition, arguing that ORS 742.061 requires that an insurer be given six months to evaluate any claim before an action is commenced. State Farm contended that it was denied any opportunity to evaluate the claim in this case before plaintiffs filed their complaint, because plaintiffs never filed a proof of loss with respect to the DEQ action or otherwise gave sufficient notice of that [Page 25] claim (which State Farm styled as one for third-party liability coverage) until long after plaintiffs had filed their action. The trial court denied the petition for attorney fees for "failure to comply with ORS 742.061."

Plaintiffs appealed, arguing that they had complied with ORS 742.061 – in particular, that they had submitted the equivalent of a proof of loss (thereby triggering the six-month settlement

deadline in the statute) either by filing their action against State Farm on May 9, 1996, or by providing State Farm with cleanup bids on July 30, 1996. Plaintiffs also suggested that State Farm's argument that plaintiffs had failed properly to tender defense of DEQ's third-party claim was a "red herring," because their complaint contained both a first-party claim and a third-party claim. The Court of Appeals affirmed the trial court on the ground that the stipulated judgment for plaintiffs in the amount of \$15,000 did not exceed defendant's \$15,000 tender. The court held that "ORS 742.061 applies when a plaintiff obtains a

State Farm notes that ORS 742.061 requires that there be no settlement within six months after filing a proof of loss. State Farm maintains that, when the third-party liability provisions of a policy are at issue, the six-month settlement period is triggered only when the insured formally tenders defense of the third-party action to the insurer. *I.e.*, tender of defense of the third-party claim to the insurer *is* the "proof of loss." State Farm further contends that, because plaintiffs' action sought third-party coverage for DEQ's cleanup action against plaintiffs, it falls within that rule. State Farm contends that plaintiffs did not tender the defense of the DEQ action, *i.e.*, file their proof of loss, until [Page 26] November 14, 1996, long after they had filed their action against State Farm, and that State Farm had accepted the defense of the DEQ claim and settled plaintiffs' policy claims within six months of that tender of defense. Given those facts, State Farm concludes that plaintiffs did not fulfill the first requirement for collecting attorney fees under ORS 742.061 — failure to reach settlement within six months of a proof of loss.

Plaintiffs respond that, even if they failed formally to file a proof of loss by tendering defense of the DEQ cleanup action before they filed their complaint against State Farm, the complaint itself was sufficient to trigger the six-month settlement deadline on their third-party claim. Plaintiffs further contend that, in any event, defendant's "tender of defense" argument is beside the point, because the complaint contained both first- and third-party claims, and plaintiffs prevailed, by virtue of the stipulated judgment, on both. At the very least, plaintiffs argue, the complaint would serve as a proof of loss for their

money judgment in excess of an unaccepted tender * * *. Defendant offered \$15,000, plaintiff [s] accepted the tender, and judgment was entered for that amount." *Dockins*, 155 Or. App. at 379.

In petitioning this court for review of the Court of Appeals' decision, plaintiffs focus their attention on the issue decided by the Court of Appeals and give less attention to the proof-of-loss issue on which the trial court relied. We are persuaded, however, that the proof-of-loss issue requires analysis, and we turn to it now.

first-party claim, thereby triggering the six-month settlement period.

Having stated the contentions of the parties, we begin with the following question: Did plaintiffs submit a "proof of loss," within the meaning of ORS 742.061, more than six months before the parties settled? The answer to that question depends on what the legislature intended to convey in ORS 742.061 by its use of the term "proof of loss." To discern that intent, we employ the analytical framework summarized in *PGE v. Bureau, of Labor and Industries*, 317 Or. 606, 859 P.2d 1143 (1993), which begins, and in this case ends, with an examination of text and context.

The term "proof of loss," as it is used in ORS 742.061, is not self-defining. However, case law from this court establishes that the term encompasses more than the ordinary, policy-based meaning.[fn2] The statute, by its terms, applies to "any policy of insurance of any kind or nature," whether or not the policy includes a specific proof-of-loss requirement. It follows, then, that the term "proof of loss" in ORS 742.061 [Page 27] means something more than whatever is required by the policy at issue. *See Groce v. Fidelity General Insurance*, 252 Or. 296, 311, 448 P.2d 554 (1969) (court noted that, although the statute "no doubt was drawn in contemplation of the type of claim ordinarily made by means of a "proof of loss" form," it was broad enough to permit recovery in other circumstances).

At least one case from this court. *State v. Claypool*, 145 Or. 615, 28 P.2d 882 (1934), establishes that an insured can trigger the statutory six-month period for settlement by an act such as filing a complaint. *Claypool*, which was decided

under a substantively identical predecessor of ORS 742.061, involved an action by the state on a county official's bond. The state filed the action to recover on the bond when the official failed to safeguard funds that had been entrusted to her. More than a year after the complaint was filed, the trial court entered judgment for the state. The state then sought attorney fees under Oregon Code 1930, §46-134 (the predecessor statute). This court held that an award could be made:

“There was no tender made and there is no provision in the policy requiring proof of loss as in ordinary fire insurance cases. The commencement of the action is equivalent to demand for payment, whether previously made or not and this

What else, then, marks an event or submission as a “proof of loss” within the meaning of ORS 742.061? This court's cases that have considered the adequacy of a claimant's attempt to comply with a policy provision requiring proof of loss are instructive. Although those cases speak in [Page 28] terms of substantial compliance with the policy specifications, they ultimately conclude that an event or submission is adequate, both for purposes of collecting on the policy itself and for obtaining attorney fees under ORS 742.061, if it accomplishes the purpose of a proof of loss. That purpose is “to afford the insurer an adequate opportunity for investigation, to prevent fraud and imposition upon it, and to enable it to form an intelligent estimate of its rights and liabilities before it is obliged to pay.” *Sutton v. Fire Insurance Exch.*, 265 Or.322, 325, 509 P.2d 418 (1973) (quoting 14 Couch, *Cyclopedia of Insurance Law* §49:373, p 15 (2d ed)). *See also Heis v. Allstate Insurance Co.*, 248 Or. 636, 644, 436 P.2d 550 (1968)(“the insurer is entitled to enough information to form a reasonable estimate of its liability”).

Thus, the court's cases establish that that functional meaning of the term “proof of loss” described above fits ORS 742.061 and that the legislature intended for that standard to apply, despite different or more formal proof-of-loss requirements in the insurance policy itself.

Indeed, our cases suggest that, at least where ORS 742.061 is concerned, a plaintiff's burden, if anything, may be even lighter. In *Heis*, in particular, this court placed insurers under a duty

we think renders the [attorney fees] statute applicable and entitles the plaintiff to attorney's fees in this action. The complaint was filed on April 11, 1932, but the judgment was not entered until June 7, 1933, more than six months after the commencement of this action. This, we think, brought the case within the intentment of the statute under the doctrine followed and improved in [various cases awarding attorney fees under the statute].”

Claypool establishes that the statutory meaning of the term “proof of loss” encompasses a range of events or submissions, including a complaint that commences an action against the insurer.

of inquiry, holding that, even if a submission is insufficient to allow the insurer to estimate its obligations, it will be deemed sufficient if the insurer could accomplish that purpose through a reasonable investigation. 248 Or. at 644-45. [fn3] [Page 29]

From the foregoing discussion of the text of ORS 742.061 and the case law that surrounds it and its predecessor statutes, we conclude the meaning of the statutory term “proof of loss” is clear: Any event or submission that would permit an insurer to estimate its obligations (taking into account the insurer's obligation to investigate and clarify uncertain claims) qualifies as a “proof of loss” for purposes of the statute.

That leaves us with a question about timing. State Farm argues that, whatever “proof of loss” means in the statute, such proof must be filed at least six months before any legal action is filed. Certainly, the statute could be read that way. However, this is not the first time that we have addressed the issue of the scope of the statute. This court rejected the essential equivalent of State Farm's argument in *Murray v. Firemen's Ins. Co.*, 121 Or. 165, 254 P. 817 (1927). *Murray* held, under a substantively similar predecessor to ORS 742.061, that a proof of loss filed only two months before the commencement of an action was sufficient to trigger the period for settlement. The court explained that the statute “was not intended to postpone litigation or defer recovery by an insured but was intended to protect an insured who has suffered a loss from annoying and expensive litigation.” *Id.* at 172. In other words, the statute

seeks to protect insureds from the necessity of litigating their valid claims. It has no converse purpose of protecting insurers from litigation.

With the foregoing points in mind, we turn to the case at hand to determine whether any event that occurred more than six months before the settlement would qualify as a “proof of loss” under ORS 742.061. We begin with the complaint, which alleges that State Farm issued a policy to plaintiffs that provides both general liability and property coverage. The complaint then alleges:

“During the policy term, the Oregon Department of Environmental Quality made a claim against plaintiffs that damage had occurred as a result of petroleum residue on plaintiffs’ property. The claim of damage was a claim including injury to the public’s groundwater as a result of the condition of plaintiffs’ property. As a result, plaintiffs have incurred and will incur reasonable and necessary costs and expenses to remove and monitor the petroleum [Page 30] residue on plaintiffs’ property in an amount not less than \$6,000, including

As to its duty to indemnify under the liability provision of the policy. State Farm argues that the six-month settlement period does not begin to run until plaintiffs could calculate their remediation costs with enough specificity to enable State Farm to make a settlement offer. Again, in so arguing, State Farm ignores its duty of inquiry. There is no basis in this record to hold that, if it had undertaken an inquiry, State Farm could not have made that calculation.

We conclude that, at least with respect to the third-party liability claim that was at the center of plaintiffs’ action and that drove the settlement of the action, plaintiffs’ complaint was a “proof of loss” within the meaning of ORS 742.061. We further conclude that, because the parties failed to settle within six months of the filing of that complaint, the first element of ORS 742.061 is satisfied.

The foregoing brings us to the ground on which the Court of Appeals relied to conclude that ORS 742.061 was inapplicable to the present controversy – that the stipulated judgment in plaintiffs’ favor did not exceed defendant’s settlement offer of \$15,000. In so holding, the

tank removal and cleanup, restorative landscaping, and regulatory fees.”

Finally, the complaint prays for “remedial action costs in excess of \$6,000 in an amount to be proved at trial, including plaintiffs’ attorney fees herein.”

In our view, those allegations in plaintiffs’ complaint were sufficient to qualify as a proof of loss under ORS 742.061, at least with regard to the claim for third-party liability coverage that State Farm has identified as the “essence” of plaintiffs’ action. State Farm acknowledges that its duty to defend under those provisions would be triggered if there were a claim against plaintiffs based on groundwater contamination. The complaint alleges such a claim. Although it is true that the DEQ demand was not attached to the complaint and that State Farm was not required to accept plaintiffs’ characterization of the DEQ demand at face value, it also is true that State Farm easily could have

ascertained whether plaintiffs’ characterization was accurate.

Court of Appeals [Page 31] deemed defendant’s settlement offer, which was made some 10 months after the complaint was filed and more than six months after defendant had filed an answer to that complaint denying any liability under the insurance policy, to be a “tender” within the meaning of ORS 742.061:

“In this case, plaintiffs did not obtain a judgment in excess of defendant’s tender. Defendant offered \$15,000, plaintiffs accepted the tender, and judgment was entered for that amount. ORS 742.061 does not apply.”

Dockins, 155 Or. App. at 379.

Plaintiffs argue that defendant’s settlement offer was not a “tender” within the meaning of ORS 742.061. Plaintiffs contend that, in holding otherwise, the Court of Appeals ignored this court’s longstanding construction of that term as referring only to unconditional offers to pay made before the commencement of an action. In so arguing, plaintiffs rely primarily on their reading of *Dolan v. Continental Casualty Co.*, 133 Or. 252, 289 P. 1057 (1930).

Dolan was decided under the substantively identical predecessor to ORS 742.061, Oregon Laws, section 6355 (1920), as amended by General Laws of Oregon 1927, chapter 184. [fn4] In *Dolan*, the insured brought an action to collect on a life insurance policy and obtained a judgment for the full sum of the policy plus attorney fees. On appeal, the court granted the defendant insurer a new trial on the basis of an error at trial. However, when the action came on for retrial, the defendant answered by confessing its liability and tendering into court the full amount claimed on the policy. Over the plaintiff's objections, the trial court entered judgment on the [Page 32] pleadings and declined to award attorney fees on the apparent theory that the defendant had defeated the plaintiffs claim for attorney fees by tendering into court the amount claimed on the policy.

On the plaintiffs appeal of that decision, this court held that the plaintiff was entitled to her attorney fees. The court reasoned that, if the court were to allow the defendant's offer of settlement to preclude a recovery of attorney fees, "notwithstanding the expensive and prolonged litigation, the benefit of the statute [would be] largely destroyed" *Id.* at 256. The court indicated, moreover, that the defendant and the trial court on remand had misapprehended the meaning of the statutory term "tender." The court noted:

"The meaning of the word 'tender,' when said statute was enacted, was defined by

Although they do not read *Dolan* accurately, plaintiffs nonetheless prevail because, although there have been modest revisions to the statute since *Dolan*, none of those [Page 33] revisions has affected its theoretical approach. Unless and until the legislature decides to provide otherwise, only a timely tender (which State Farm's was not) can defeat a prevailing insured's right to attorney fees. In the context of the present case, in which the filing of the insured's complaint is deemed to be the "proof of loss," that means that State Farm had six months from the date of service of the complaint in which to make a tender, *i.e.* an unconditional offer to pay money. As noted, it did not meet that deadline.[fn5]

In the companion case to this one, *Grijalva v. Safeco Ins. Co.*, 153 Or App 144, 956 P.2d 995 (1998), *rev'd and rem'd* 329 Or. 36, 958 P.2d 784 (1999)—the Court of Appeals, apparently also

our statute, Or. L., §574. The general laws of the state having defined the word 'tender,' it will be presumed, on the enactment of a new statute using the word 'tender,' that the word as defined by the statute is intended. * * * [Section 6355] does not attempt to define 'tender' and that word as therein used must be taken to be the word 'tender' used in said section 574."

Id. at 254-55. Section 574, which is substantially equivalent to present day ORS 20.180, provided that a prevailing plaintiffs bid for attorney fees would be defeated if the defendant had made a prelitigation tender in excess of the amount ultimately recovered and then had deposited that same amount into the court.

Plaintiffs contend that, because ORS 742.061 is substantially the same statute as the one at issue in *Dolan*, the interpretation set out in that case is binding here. Thus, plaintiffs conclude. State Farm's offer of settlement was not a "tender" within the meaning of ORS 742 061 because it came after the litigation had commenced. That argument, however, reads too much into *Dolan*. The point of that case was not that only a prelitigation tender would suffice. The point was that the tender had to be timely (and, in that context, the tender was not timely).

misreading *Dolan* to require prelitigation tenders, concluded that *Dolan* implicitly was overruled by *Gore v. Prudential Ins. Co. of Amer.*, 265 Or 12, 507 P 2d 20 (1973). The Court of Appeals stated:

"We conclude that in light of later case law, *Dolan* is no longer controlling. In *Gore*, for example, * * * the plaintiff commenced litigation on an insurance policy and the insurer, facing multiple claims on the policy, interpleaded the proceeds of the policy. *Gore*, 265 Or. at 14. The insurer made no tender before the commencement of litigation. Nevertheless, the court concluded that the plaintiff was not entitled to recover attorney fees under [the identically-worded predecessor to ORS 742.061] because the statute was intended to provide attorney fees in situations

where “the insurer is contending it has no liability under the policy” and did not provide for attorney fees where the insurer was “willing to pay policy proceeds to whomever they might belong.” *Gore*, 265 Or. at 16. In the light of *Gore*, we must conclude that, notwithstanding *Dolan*, ORS 742.061 does not require that tenders be made before the commencement of litigation.”

Grijalva, 153 Or. App. at 155.

Whatever vitality that analysis might continue to have in light of our reading of *Dolan*, we disagree with the Court of Appeals’ assessment of the import of *Gore*. *Gore* involved competing claims to the proceeds of a life insurance [Page 34] policy. The insurer did not know whom to pay. When the claimants filed independent actions on the policy, the insurer responded that it was willing to deliver the entire proceeds of the policy to whomever the court might direct. The insurer asked the court to consolidate the two actions and to require the claimants to litigate the issue of who was entitled to the proceeds.

In considering whether the victorious claimant was entitled to attorney fees under ORS 743.144 (the predecessor to ORS 742.061), this court first noted that, under the circumstances, the course of action that the insurer chose to follow – allowing the claimants to sue and then seeking to proceed in interpleader – was not substantially different from preempting the claimants and filing its own interpleader action. The court then stated:

“It is our belief that the legislature did not intend, by the passage of the statute, to place the insurance company in a position where it either had to pay one claimant or the other, running the risk of double recovery, or was compelled to pay attorney fees. * * *.

“[T]he adequacy of plaintiff’s proof of loss can be explained in even broader terms. There are no provisions in the statutes or in the insurance contract relating to the specificity with which the insured must set forth his proof of loss. The insurer is entitled to sufficient information to form a reasonable estimate of its liability. This does not mean that the

“It appears to us that the circumstances envisaged by the statute are those where the insurer is contending it has no liability under the policy. We believe that the statute was not intended to apply to any situation where an insurance company, as an innocent stakeholder, is willing to pay policy proceeds to whomever they might belong.”

Gore, 265 Or. at 16. *Gore* thus identified a single circumstance to which the statute does not apply – “where an insurance company, as an innocent stakeholder, is willing to pay policy proceeds to whomever they might belong.” *Id.* It says nothing about the overall meaning of the statute in more ordinary circumstances, *i.e.*, when the claimant has a quarrel with the insurer about his or her right to payment under a policy.

As construed by this court, ORS 742.061 provides that plaintiffs are entitled to attorney fees if their recovery exceeds the amount of any timely tender made by defendant. State Farm did not make a timely tender in this case. Its offer of settlement, made more than six months after service of the complaint, does not defeat plaintiffs’ claim for attorney fees under ORS 742.061. [Page 35]

The decision of the Court of Appeals is reversed. The judgment of the circuit court is reversed and the case is remanded to the circuit court for further proceedings.

[fn1] In State Farm’s view, plaintiffs’ policy applied only to a claim for remediation of groundwater contamination.

[fn2] Case law construing a statute is considered at our first level of analysis under the *PGE* framework. *State v. Toevs*, 327 Or. 525, 532, 964 P.2d 1007 (1998).

[fn3] In *Heis*, this court stated:

insured’s claim is barred if the proof of loss originally filed does not contain sufficient information to make this estimate. If the proof of

loss is ambiguous, the insurer should make a reasonable effort to resolve the ambiguity. Defendant’s own policy indicates that it may be necessary for it to

investigate a claim for purpose of testing its validity.”

248 Or. at 644. Later in the opinion, the court shifted the burden of clarifying a proof of loss even more decisively onto the insurer:

“If defendant’s contention is that plaintiff’s proof of loss was so uncertain that defendant was unable to determine the character of plaintiff’s claim, then defendant should have requested plaintiff to make her claim more definite and certain.”

Id. at 645.

[fn4] Oregon Laws, section 6355 (1920), as amended by General Laws of Oregon 1927, chapter 184, provided:

“Whenever any suit or action is brought in any court of this state upon any policy of insurance of any kind or nature whatsoever, the plaintiff, in addition to the amount which he may recover, shall also be allowed and shall recover as part of said judgment such sum as the court or jury may adjudge to be reasonable as attorney’s fees in said suit or action; provided, that settlement is not made within six months from date proof of loss is filed with the company; provided further; that if a tender be made by a defendant in any such suit or action and the plaintiff’s recovery shall not exceed the amount thereof, then no sum shall be recoverable as attorney’s fees.”

[fn5] Because State Farm’s offer was not timely, we need not address the question whether it was unconditional, and we express no opinion on that question. [Page 36]