PERSPECTIVES ON THE LAW

Lachenmeier Enloe Rall & Heinson
Attorneys at Law

UM and UIM Claims, Litigation and Arbitration

Where we are and how we got here

— *by* **Jay D. Enloe**

Historical Perspective

Way back in the last Century, in fact in the year the State of Oregon was celebrating its 100th anniversary as a state, the Oregon Legislature established the first chapter of what is now known as compulsory uninsured motorist (UM) coverage. In the 44 years that has transpired since its adoption, this coverage has grown to include underinsured motorist (UIM) coverage, a claims and litigation system involving insurers, insureds, arbitrators, attorneys (with attorney fees being awarded or not depending on a multitude of factors), and quite possibly a compensation system not foreseen by our pioneering UM legislators in 1959.

In the beginning, UM coverage was a simple concept. If an insured had the misfortune of having been injured as a result of the negligence of an uninsured motorist, the insured's own insurer would step up and pay the damages that the insured would have recovered against the other driver if he or she had been insured. UM coverage was statutorily required to provide $5,000 in benefits. UM coverage expanded and came to include coverage for damages caused by drivers who were not only uninsured but also socially irresponsible, in that they left the scene without even stopping to identify themselves ("hit and run" drivers), as well as those who did not actually collide with the insured but whose actions caused the insured's collision anyway ("phantom" drivers).

Recognizing that allowing claims caused by drivers who could not be identified (or cross-examined by counsel for the insurer) could open the door to fraudulent claims, these claims were made dependent upon solid evidence of negligent driving by the unidentified driver. "Hit and run" claims required damage to the insured vehicle. "Phantom" claims required corroborative testimony, by someone not making a claim, establishing that the phantom driver did what the insured said he or she did. Phantom claims have since evolved, by case law, to allow corroboration from a passenger in the insured vehicle who once had a claim but has already settled it.

Of late, one of the biggest problems (now mostly remedied by further legislation) has been that of the attorney fees "tail" wagging the damages claim "dog". In other words, when attorney fees are available to the insured (the Legislature has never made attorney fees reciprocal in this setting), the fact that the insured's attorney has run up large amounts of attorney fees can cause a claim to settle for well more than its actual value, so as to keep the risk of an inflated attorney claim from continuing to grow exponentially. One of the most problematic features of these attorney fee claims has been the tendency of some judges to allow extraordinarily high attorney fee hourly rates or to factor in a contingency type percentage of the verdict as attorney fees. Fortunately, if current statutes are followed, attorney fees are far less of a risk these days under ORS

742.061 and most claims can be resolved for their fair value.

What is it Worth?

What the claim is worth is, of course, the ultimate question. If you and the insured or the insured's attorney can agree on that (or if you have done what you need to do to avoid attorney fee exposure), there is no need to be concerned about owing fees.

What a UM or UIM claim should be worth is not necessarily the same as what it is worth. The reason for UM coverage in the first place was to provide for compensation to the insured when the at fault driver was uninsured and could not respond to a damages judgment. Analyzing what an at fault driver in a third party setting owes is generally a pretty straight forward analysis. By considering the seriousness of the accident, the relative appearances of the parties, the nature and extent of a person's injuries, and the person's prior medical history, a fair value range for the claim (if it were taken to trial to a jury in the county where the accident occurred), is fairly easy to come up with. Granted, there are claims in which the medical issues are disputed and the verdict will vary significantly depending upon how the causation issue is decided, and occasionally juries do return unexpected verdicts, but usually verdicts can be forecast that will stand the test of time.

With UM claims, and now UIM claims, "what the claim is worth" is a function of many more factors. Not that it should be, but in the real world it is. For example, if the insured makes a very nice appearance and has a surgeon who will go to bat for him or her, juries may want to award the cost of the surgery in a case in which the defendant is the plaintiff's insurer, whether or not medical science seems to support the need for the surgery or the relationship between the surgery and the accident. That is not always the result, but it does happen, even with careful Jury Instructions from the judge, telling the jury to base their verdict on the evidence.

The pendulum may be swinging back in favor of fair resolution of these claims. Attorney fees are often not an issue these days, because insurers are consenting to binding arbitration pursuant to ORS 742.061. Although insureds and their attorneys are able to choose their forum, they often choose arbitration. If they want to ask a jury to evaluate the case, they may do so. What keeps this from happening more often is the increased cost and trouble of a jury trial in contrast to that of an arbitration. Arbitration is easier and cheaper for the insured's attorney than trial, especially since by statute the insured is only responsible for $100 of the arbitrator fees. Arbitrators generally do not evaluate these claims the same as if the claim were against an individual defendant and was being considered by a jury, but they can come a lot closer than when a jury evaluates a claim against an insurer. There are many arbitrators who try to do exactly what he or she thinks a jury would do. After all, that is why we have this coverage in the first place. Other arbitrators are quite up front about not doing what a jury would do and say that the insured is entitled to an award based on what the arbitrator thinks.

Proof of Loss

The magic words that determine whether attorney fees will be available to the insured's attorney, and from which so many other aspects of the claim will flow, are "proof of loss." ORS 742.061 provides that if the insurer provides the insured, in writing, consent to have the claim decided in binding arbitration, and agrees that the only issues are liability and damages, and provides this written consent within six months of the insured's "proof of loss", then attorney fees will not be available to the insured. The trick is in figuring out when the insured gave a proof of loss.

If the insurer uses a Proof of Loss form, the

analysis of the proof of loss date is fairly easy. It should be the date the insured provides the insurer with a fully completed Proof of Loss form. Unfortunately, many insurers do not use such a form. Please feel free to use the Proof of Loss form that the writer's law firm has developed, which can be found at www.lerlaw.com/publications.htm.

The problem comes when such forms are not used. At least one Oregon Court of Appeals case has held that a mere letter from the insured's counsel, that provides some supporting documentation but ignores repeated requests for a recorded statement, suffices as the "proof of loss" contemplated by ORS 742.061. This is true whether or not the insurer has received adequate information with which to evaluate the claim.

Our recommendation is that insurers use a formal Proof of Loss form, so there will be no question when the six month period to provide written consent to binding arbitration begins. Also, the information in the Proof of Loss will assist considerably with the evaluation of the claim. Under ORS 742.504(5)(a), forms are to be provided to the insured within 15 days of when the insurer receives notice of the claim. If a Proof of Loss form is not used, we recommend that written consent to binding arbitration be provided to the insured, or the insured's attorney if there is one, no later than six months after the insurer first suspects a UM or UIM claim will be brought. The letter should contain language similar to the following: "We hereby consent to binding arbitration of this UM (or UIM if appropriate) claim. The only issues to be determined are liability and damages".

Please note that if there are coverage questions, and therefore issues beyond liability and damages, sending such a letter may result in a waiver of the insurer's coverage position. As a result, if an insurer wishes to contest coverage, there is an attorney fee risk that attaches to taking that position. In that event, the insurer would be well advised to consult with defense counsel early on. There may be an opportunity to have the coverage issue resolved within six months. Even if not, a reasoned decision about retaining the right to contest coverage can be made.

There are many other issues relating to the handling of UM and UIM claims that will be the subject of later articles. In the meantime, the writer welcomes any questions on either the subject of this article or any other aspect of UM and UIM claims. The writer can either be reached by phone at 503-768-9600 or by email at jay@lerlaw.com.