No. 96516-1

SUPREME COURT
OF THE STATE OF WASHINGTON

No. 76365-2-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

GROUP HEALTH COOPERATIVE,
a Washington nonprofit corporation,

Petitioner,

v.

NATHANIEL COON and LORI COON,
husband and wife,

Respondents.

ANSWER TO PETITION FOR REVIEW

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A. Introduction.

The Court of Appeals reversed summary judgment and remanded for determination of fact questions. It held that the Coons presented non-speculative evidence supporting inferences that there was a settlement of a disputed claim of liability against The Everett Clinic (herein "the Clinic") and that Group Health had not met its burden of establishing that the Coons were made whole. Alternatively, it held that if no third party was responsible for the injuries, Group Health had no right of subrogation to amounts received by the Coons.

B. Statement of the Case.

The Coons settled a disputed claim of liability for injuries and damages sustained because a perioperative fungal infection resulted in an above-knee amputation. (CP 120) A claim was submitted to the Clinic, based largely on a theory of *res ipsa loquitur*, and the Clinic denied the claim. (CP120) The parties then agreed to engage in a pre-litigation mediation, and this resulted in a settlement for $2,000,000. (CP 254)

The Group Health contract provides that it has "subrogation and reimbursement rights." The relevant provisions of the contract are attached as Exhibit A. Group Health contends that the subrogation provisions do not apply because there was no third party responsible for the damages suffered by the Coons. (Pet. p. 7) It contends that Group

Health can assert a "contractual right of reimbursement" rather than a subrogation claim and can thus avoid both the "made whole" provision in the contract and the "made whole" doctrine found in *Thiringer v. American Motors Ins. Co.*, 91 Wn.2d 215, 588 P.2d 191 (1970). (Pet. p. 7)

The Court of Appeals reversed the summary judgment because the Group Health contract made its recovery dependent on the existence of a third-party tortfeasor. (App. A ¶ 37) It further held that there were fact issues regarding whether the Coons were made whole. (App. A ¶ 43)

C. Argument Why Review Should be Denied.

1. Group Health's interpretation of its contract of insurance is nonsensical and would lead to absurd results. There are fact issues regarding the liability of the Clinic for the injuries and summary judgment was inappropriate.

Group Health contends that it has a "contractual right of reimbursement" that applies to any funds received by the Coons as a result of Mr. Coon's injuries regardless of the source of the funds. (Pet. p. 7) If Group Health's interpretation of its contract were adopted, it would mean that if Mr. Coon received money from a disability policy to compensate him for the amputation and consequent disability, Group Health would have a claim to be reimbursed for the medical expenses it has paid. It

would also mean that if friends of the Coon family started a Go-Fund-Me site to raise money to help the Coons through their ordeal, Group Health would have a right to reimbursement from those funds. It would even have a claim on any money provided to the Coons by family or church members to assist them through the financial and personal problems resulting from the infection and amputation.

In a motion for summary judgment, all facts and inferences are to be construed in favor of the non-moving party. "In ruling on a motion for summary judgment, the court must consider the material evidence and all reasonable inferences therefrom most favorably for the non-moving party and, when so considered, if reasonable people might reach difference conclusions, the motion should be denied." *Jacobsen v. State*, 89 Wn.2d 101, 108 (1977), 569 P.2d 1153.

There is a strong inference that the Clinic felt it had potential liability for the injuries, proposed a mediation to resolve the claim, and required the Coons to sign a settlement agreement releasing all claims against the Clinic. (CP 254)

Group Health's strained reading of the contract would lead to absurd results. See *Morgan v. Prudential Ins. Co.*, 86 Wn.2d, 549 P.2d 1193 (1970): "[t]he contract should be given a practical and reasonable rather than a literal interpretation; it should not be given a strained or

forced construction which would lead to an extension or restriction of the policy beyond what is fairly within its terms, or which would lead to an absurd conclusion, or render the policy nonsensical or ineffective."

Read as a whole, it is clear that the subrogation provisions in the contract relate to recoveries from third parties resulting from a claim that the third party was a cause of the injury. This view is buttressed by the fact that the last portion of the cited contract provision parallels the *Thiringer* made whole doctrine. The clear intent of Group Health was to include the made whole concept in its contract.

If there are conflicting or ambiguous provisions in the Group Health contract, it must be construed in favor of the insured, not the insurance company that drafted the contract. "When a clause in an insurance policy is ambiguous, it will be construed in a manner most favorable to the insured regardless of the insurer's intent. . . . In construing the language of an insurance contract, we will examine the contract as a whole and if, on the face of the contract, two reasonable and fair interpretations are possible, an ambiguity exist." *State Farm Insurance v. Emerson*, 102 Wn.2d 477, 484, 687 P.2d 1139 (1084).

The *Emerson* court cited *Morgan v. Prudential Ins Co.*, 86 Wn.2d, 549 P.2d 1193 (1970), which held that "[t]he contract should be given a practical and reasonable rather than a literal interpretation; it should not be

given a strained or forced construction which would lead to an extension or restriction of the policy beyond what is fairly within its terms, or which would lead to an absurd conclusion, or render the policy nonsensical or ineffective." Citing *Philadelphia Fire & Marine Ins. Co. v. Grandview*, 42 Wn.2d 357, 255 P.2d 540 (1953); 44 C.J.S. Insurance § 296 (1945).

2. The Court of Appeals applied well-established legal principles in determining that the "made whole" doctrine applied.

The Court of Appeals correctly held that Group Health must meet both the requirements of its insurance contact as well as the common law made-whole doctrine before it can share in the Coon's settlement. The following portion of the decision succinctly summarizes the basis for the Court's ruling:

> "The posture of the Coons, the Clinic, and Group Health is similar to that of an injured party, an alleged tortfeasor, and the injured party's insurance company in many personal injury settlements involving contest liability. In the absence of a judicial decision absolving the Clinic of liability, it is not clear that the weakness of the Coons' claims provides a basis for refusing to apply the Thiringer "made whole" rule." An insurance company that is pursuing its right of subrogation after settlement of a contested liability case should not be permitted to avoid application of the equities advanced by Thiringer merely by asserting that the alleged tortfeasor had no tort liability . . ." (App. A ¶ 42)

The ruling by the Court of Appeals is entirely consistent with the underlying principles enunciated in *Maher v. Szucs*, 135 Wn.2d 598, 957 P.2d 632 (1998), *Thiringer v. American Motors Ins. Co.*, 91 Wn.2d 215,

588 P.2d 191 (1978), and *Cook v. USAA Cas. Ins. Co.*, 121 Wn.App., 844, 90 Pac.2d 1154 (2004): the made-whole doctrine broadly applies whenever an insurer seeks to share in a recovery made by a policy holder from a third party. It is possible to cite factual details and differences in the many cases applying the made-whole doctrine, as Group Health does in its Petition for Review, but the decision by the Court of Appeals in the instant case applies the widely-accepted made whole doctrine mandated by *Thiringer*.

D. Any Violation of the Insurance Contact Did Not Prejudice or Cause Damages to Group Health.

Group Health contends that the Coons violated the insurance contract by not notifying it of the proposed settlement. (Pet. p. 15) It offers no explanation for how this has prejudiced Group Health and, indeed, it has not prejudiced it. The Court of Appeals correctly held that for Group Health to establish prejudice under a claim for breach of contract, it must show causation and damages. That ruling is consistent with the rationale expressed in *Liberty Mut. Ins. Co. v. Tripp*, 144 Wn.2d, 25 P.3d 997 (2001). That case required the insurer to prove some prejudice resulting from the narrow breach of a notice provision. The Court of Appeals in the instant case upheld fundamental contract principles requiring a claimant to prove causation and damages resulting

from a breach.

E. Conclusion.

The decision by the Court of Appeals is not in conflict with any Supreme Court decision or published Court of Appeals decision. It does not raise a significant question of law under the Constitutions of the United States or the State of Washington. It does not involve an issue of substantial public interest that should be determined by the Supreme Court.

The decision simply applied the well-established principles underlying the "made whole" doctrine and held that there were issues of fact that precluded summary judgment from being granted by the trial court. This Court should not accept review of the decision by the Court of Appeals.

RESPECTFULLY SUBMITTED this 10th day of December, 2018.

CHEMNICK MOEN GREENSTREET

By _____
Eugene M. Moen, WSBA #1145
Attorney for Respondents

CERTIFICATE OF SERVICE

I declare that on this date, I forwarded a copy of this *Answer to Petition for Review* to the parties of record in the manner described below:

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I certify under penalty of perjury that the foregoing is true and correct.

EXECUTED this 10th day of December, 2018 at Seattle, Washington.

Patricia A. Freeman, Paralegal to
Eugene M. Moen

B. Subrogation and Reimbursement Rights

The benefits under this Agreement will be available to a Member for injury or illness caused by another party, subject to the exclusions and limitations of this Agreement. If GHO provides benefits under this Agreement for the treatment of the injury or illness, GHO will be subrogated to any rights that the Member may have to recover compensation or damages related to the injury or illness and the Member shall reimburse GHO for all benefits provided, from any amounts the Member received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise. This section VII.B. more fully describes GHO's subrogation and reimbursement rights.

"Injured Person" under this section means a Member covered by the Agreement who sustains an injury or illness and any spouse, dependent or other person or entity that may recover on behalf of such Member, including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this section, "GHO's Medical Expenses" means the expenses incurred and the value of the benefits provided by GHO under this Agreement for the care or treatment of the injury or illness sustained by the Injured Person.

If the Injured Person's injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, GHO shall have the right to recover GHO's Medical Expenses from any source available to the Injured Person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorist coverage. This right is commonly referred to as "subrogation." GHO shall be subrogated to and may enforce all rights of the Injured Person to the full extent of GHO's Medical Expenses.

GHO's subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages.

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury or illness, including but not limited to any liability insurance or uninsured/underinsured motorist funds, GHO's Medical Expenses are secondary, not primary.

The Injured Person and his/her agents shall cooperate fully with GHO in its efforts to collect GHO's Medical Expenses. This cooperation includes, but is not limited to, supplying GHO with information about the cause of injury or illness, any potentially liable third parties, defendants and/or insurers related to the Injured Person's claim and informing GHO of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit GHO, at GHO's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow GHO to initiate its own direct action for reimbursement or subrogation.

The Injured Person and his/her agents shall do nothing to prejudice GHO's subrogation and reimbursement rights. The Injured Person shall promptly notify GHO of any tentative settlement with a third party and shall not settle a claim without protecting GHO's interest. If the Injured Person fails to cooperate fully with GHO in recovery of GHO's Medical Expenses, the Injured Person shall be responsible for directly reimbursing GHO for 100% of GHO's Medical Expenses.

To the extent that the Injured Person recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Injured Person agrees to hold such monies in trust or in a separate identifiable account until GHO's subrogation and reimbursement rights are fully determined and that GHO has an equitable lien over such monies to the full extent of GHO's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of GHO's Medical Expenses.

If reasonable collections costs have been incurred by an attorney for the Injured Person in connection with obtaining recovery under certain conditions GHO will reduce the amount of reimbursement to GHO by the amount of an equitable apportionment of such collection costs between GHO and the Injured Person. This reduction will be made only if each of the following conditions has been met: (i) GHO receives a list of the fees and associated costs before settlement and (ii) the Injured Person's attorney's actions were reasonable and necessary to secure recovery.

Implementation of this section shall be deemed a part of claims administration under the Agreement and GHO shall therefore have discretion to interpret its terms.

CHEMNICK MOEN GREENSTREET

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Transmittal Information

Filed with Court:	Supreme Court
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