68226-1 68226-1

No. ~~68266-1~~ 68226-1

COURT OF APPEALS, DIVISION ONE
OF THE STATE OF WASHINGTON

JOHN J. JONES AND MARY ANN MORBLEY JONES,

Appellants,

v.

KING COUNTY, a municipal corporation,

Respondent.

BRIEF OF RESPONDENT

Medora A. Marisseau, WSBA # 23114
Johanna M. Coolbaugh, WSBA # 39518
KARR TUTTLE CAMPBELL
1201 Third Ave., Suite 2900
Seattle, WA 98101
Telephone: (206) 223-1313

Attorneys for Respondent King County

Table of Contents

Page

I. **INTRODUCTION** 1

II. **STATEMENT OF THE CASE** 1

III. **ASSIGNMENTS OF ERROR** 8

IV. **ARGUMENT** 9

A. Standards of Review 9

1. Summary Judgment 9

2. Motion to Amend Answer 10

B. King County is Entitled to Reimbursement 11

C. No Evidence That Mr. Jones was Made Whole 13

D. There is No Admissible Evidence of Comparative Fault 21

E. The Made Whole Doctrine Does Not Apply to the Self-Funded KingCare Program 22

1. Historical Context and Application of Made Whole Rule 22

2. King County is Not an Insurer and Therefore Not Subject to the Insurance Made Whole Rule 31

3. The Contract is Enforceable 32

4. The Made Whole Rule Does Not Need to be Reached 34

F. ERISA Does Not Apply 35

G. Denial of Motion to Amend was Proper 35

1. The Counterclaims Were Factually Deficient 36

2. The Third-Party Claims were Improper Under CR 14 38

3. Amendment Would be Futile Because Summary Judgment was Proper 39

V. **CONCLUSION** 39

Table of Authorities

Page

Cases

Admin. Comm. v. Salazar, 525 F. Supp. 2d 1103 (D. Ariz. 2007) 35

Averill v. Farmers Ins. Co. of Wash. 155 Wn. App. 106, 229 P.3d 830 (2010)............12

Baldwin v. Silver, 165 Wn. App. 463, 269 P.3d 284 (2011) 19

Barnes v. Indep. Auto Dealers Ass'n Health & Benefit Plan, 64 F.3d 1389 (9th Cir. 1995) 34, 35

Berge v. Gorton, 88 Wn.2d 756, 567 P.2d 187 (1977)............36

Bordeaux, Inc. v. American Safety Insurance Co., 145 Wn. App. 687, 186 P.3d 1188 (2008) 32

Brown v. Snohomish County Physicians, 120 Wn.2d 747, 845 P.2d 334 (1993)............19, 24, 25, 26, 27, 30

Cann v. King County, 86 Wn. App. 162, 937 P.2d 610 (1997)............31, 32

Fisher v. Aldi Tire Inc., 78 Wn. App. 902, 902 P.2d 166 (1995)............12, 33

Gersema v. Allstate Ins. Co., 127 Wn. App. 687, 693, 112 P.3d 552 (2005)............30

Greenhalgh v. Dep't of Corr., 160 Wn. App. 706, 248 P.3d 150 (2011)............19

Indoor Billboard/Washington, Inc. v. Integra Telecom of Wash., Inc., 162 Wn.2d 59, 170 P.3d 10 (2007) 9, 10

Kirby v. City of Tacoma, 124 Wn. App. 454, 98 P.3d 827 (2004) 36

Leingang v. Pierce County Medical Bureau, 131 Wn.3d 133 (1996)............28

Mahler v. Szucs, 135 Wn.2d 398, 957 P.2d 632 (1998) 23, 30, 33

Meas v. State Farm Fire & Cas. Co., 130 Wn. App. 527 (2005)............33

Mendoza v. Rivera-Chavez, 140 Wn.2d 659, 999 P.2d 29 (2000) 28

Myers v. Kitsap Physicians Serv., Inc., 78 Wn.2d 286, 474 P.2d 109, 66 A.L.R.3d 1196 (1970)............26

Northwest Independent Forest Mfrs. v. Dept. of Labor & Indus., 78 Wn. App. 707, 899 P.2d 6 (1995)....37

Peterson v. Safeco Ins. Co. of Illinois, 95 Wn. App. 254, 976 P.2d 632 (1999)....14

Redford v. Seattle, 94 Wn.2d 198, 615 P.2d 1285 (1980)....11, 12, 32, 33

Rodriguez v. Loudeye Corp., 144 Wn. App. 709, 189 P.3d 168 (2008)....10, 35

Seven Gables Corp. v. MGM/UA Ent. Co., 106 Wn.2d 1, 721 P.2d 1 (1986)....19

Sherry v. Fin. Indem. Co., 132 Wn. App. 355, 131 P.3d 922 (2006)....12

Stamp v. Dept. of Labor and Indus., 122 Wn.2d 536, 859 P.2d 597 (1993)....30

Thiringer v. Am. Motors, Ins. Co., 91 Wn.2d 215, 588 P.2d 191 (1978)....13, 23, 24, 25, 26, 30, 33

Truong v. Allstate Prop. & Cas. Ins. Co., 151 Wn. App. 195, 211 P.3d 430 (2009)....14, 15, 16, 17, 19, 21

Vacova v. Farrell, 62 Wn. App. 386, 814 P.2d 255 (1991)....21

Watson v. Ingram, 124 Wn.2d 845, 881 P.2d 247 (1994)....12, 33

Statutes

RCW 41.04.180....31

RCW 48.01.050....31

RCW 48.22.030....25, 31

RCW 48.22.085....24

RCW 48.43.005(21)(j)....31

RCW 48.43.005(23)....26

RCW 48.43.005(24)....26

RCW 48.43.005(26)(j)....26

RCW 48.44.010(9)....26

RCW 48.62....2, 31

RCW 48.62.011....22

RCW 48.62.031....4, 30

RCW 48.62.061 5
RCW 51.24.050-.060 29

Other Authorities

3 Moore's Federal Practice, § 14.02[2] (Matthew Bender 3d ed.) 38
Subrogation Clauses, What is Acceptable, Washington Office of Insurance Bulletin 79-4 (August 8, 1979) 33

Rules

CR 14 .... 6, 37, 38
CR 14(a) 6, 37
CR 15 35
CR 15(a) 10
CR 56 9
CR 8 37
CR 8(a) 36
RAP 10.3(a)(3) 9
RAP 10.3(g) 9
RAP 2.5(a) 9
Rule 56(f) 6
WAC 200-110 5

I.

INTRODUCTION

This case involves the simple question of whether Mr. Jones produced sufficient evidence to create a material issue of fact on whether he had been fully compensated for his injuries so as to defeat King County's Motion for Summary Judgment. Mr. Jones, even after being given additional time by the Superior Court to produce evidence in support of his opposition to the summary judgment motion, failed to submit a single supporting document or affidavit that would prevent summary judgment from being entered in King County's favor.

Because the only evidence in the record showed that Mr. Jones had been made whole by his recovery of $610,000 from a third-party liability carrier (whose policy limits were $1,000,000), King County was entitled to reimbursement under the provisions of its self-funded government medical benefits program.

II.

STATEMENT OF THE CASE

On or about April 3, 2008, Mr. Jones injured his ankle while on a Hendrickx Construction worksite. CP 24-27. After filing suit against Hendrickx Construction, through counsel Mr. Jones negotiated an arms-length settlement with Hendrickx's liability carrier, Contractors Bonding

and Insurance Company ("CBIC"). CP 43. Hendrickx held a policy with CBIC with coverage limits of $1,000,000. *Id.*

Mr. Jones, while represented by counsel, settled with CBIC for the amount of $610,000, out of which $152,000 was apportioned to Mrs. Jones for her loss of consortium, wage loss, and other claims. *Id.* Mr. Jones received $458,000 for his personal injury claim, which was not further apportioned. *Id.*

As a result of his ankle injury, Mr. Jones incurred medical costs in the undisputed amount of $46,315.98, which were paid by King County (medical benefits are paid directly out of King County's general assets). CP 31. Mr. Jones received these benefits because his wife worked for King County and enrolled in KingCare, one of the two medical benefits plans available to employees of King County.[1] The KingCare plan, a self-funded government medical benefits program, is governed by RCW 48.62 *et seq.*, which regulates self-funded government risk management programs.

---

[1] The other plan being an insured plan by Group Health. CP 35-39 (distinguishing between Group Health plan and KingCare plan, where under Group Health plan the reimbursement is limited to the excess required to fully compensate the injured party).

A provision in the KingCare plan provides that, when a recovery is had from a third party, such as CBIC, for an injury caused by a third party, then King County is entitled to reimbursement of the amounts it has paid:

> When you or your covered dependent is injured or becomes ill because of the actions or inactions of a third party, KingCare[SM] may cover your eligible medical and prescription drug expenses. However, to receive coverage, you must notify the plan that your illness or injury was caused by a third party, and you must follow special plan rules.
>
> . . . .
>
> By accepting plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that KingCare[SM]
>
> - Has an equitable lien on any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the plan paid benefits for such illness or injury; [and]
>
> - May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the plan paid benefits for such illness or injury;
>
> . . . .
>
> If you (or your attorney or other representative) receive any payment from the sources listed below—through a judgment, settlement or otherwise—when an illness or injury is the result of a third party, you agree to place the funds in a separate, identifiable account and that KingCare[SM] has an equitable lien on the funds, and/or you agree to serve as constructive trustee over the funds to the extent the plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.
>
> You must repay KingCare[SM] first, in full, out of such funds for any health care expenses the plan has paid related to such illness or injury. You must repay KingCare[SM] up to the full

> amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment say that the money you received (all or part of it) is for health care expenses.
>
> Furthermore, you must repay KingCare[SM] whether the third party admits liability and whether you've been made whole or fully compensated for your injury. If any money is left over, you may keep it.
>
> Additionally, KingCare[SM] isn't required to participate in or contribute to any expenses or fees (including attorneys' fees and costs) you incur in obtaining the funds.

CP 35-41. After King County's subrogation agent, the Rawlings Company LLC, was informed that Mr. Jones had recovered $610,000, it sought reimbursement from Mr. Jones under the above provision. CP 22. Mr. Jones refused to reimburse King County, which then filed a complaint on April 12, 2011, in King County Superior Court asserting a cause of action for an equitable lien on the settlement proceeds and seeking $46,315.98 in reimbursement. *Id.*; CP 1-5.

Mr. Jones' attorney accepted service on June 3, 2011. No discovery was conducted by either side, and on September 28, 2011, King County filed a Motion for Summary Judgment. CP 6-21. King County asserted that summary judgment was proper because under the plain terms of the KingCare program it was entitled to reimbursement. Moreover, King County is not an insurer and is not subject to insurance rules, such as the made whole rule. Rather, it is subject to RCW 48.62.031, under which

the Washington legislature provides authority for local governments to establish self-funded risk management programs. *See also* RCW 48.62.061; WAC 200-110 *et seq*.

In the Jones' response to the Motion for Summary Judgment, the Joneses made the same arguments, word for word, that they are making on appeal to this Court. CP 44-55. They asked for more time to conduct discovery under CR 56(f), although they did not specify exactly what discovery they needed before responding to the summary judgment motion. *Id.* at CP 47-48.

The Joneses at the same time filed a Motion to Amend Answer and Assert Counterclaims and Third-party Claim ("Motion to Amend"), wherein they sought to add counterclaims against King County for bad faith, breach of contract, negligence, and violations of the Consumer Protection Act and of the Unfair Debt Collection Practices Act. CP 150-155. The only "facts" alleged in the Jones' proposed Amended Answer to Plaintiff's Complaint for Damages, Counterclaims and Third Party Claims ("Amended Answer") was that "actions of plaintiff have proximately caused defendants injury damages as will be proved at the time of trial." *Id.*[2]

---

[2] Mr. Smith, the attorney for Mr. and Mrs. Jones, appears to have failed to file the proposed Defendant's Amended Answer to Plaintiff's Complaint for Damages, Counterclaims and Third Party Claims

The Jones also proposed to assert third-party claims against "Aetna Insurance Company" (King County's third party administrator) and "The Rawlings Company" (subrogation agent), seeking declaratory and injunctive relief, breach of contract, bad faith, violation of Consumer Protection Act, negligence, outrage, and punitive damages. CP 150-155. The Joneses, however, did not allege, as is required under CR 14, that Rawlings or Aetna are or may be liable to the Joneses "for all or part of the plaintiff's claim" against them. CR 14(a).

At the summary judgment hearing held on October 28, 2011, the Court inquired into whether the parties needed to get into the issue of whether King County was an insurer, because if Mr. Jones had been made whole then King County was entitled to reimbursement regardless of whether or not insurance laws applied to King County. The Court partially granted the Jones' Rule 56(f) motion and ordered King County to provide copies of all the KingCare plans for the years 2006-2008, along with notices to employees about any changes to the KingCare plan

---

("Amended Answer") as an exhibit to Mr. Smith's Declaration in Support of Defendants' Motion to Amend Answer and Assert Counter-Claims and Third-Party Claims (CP 143-145). The proposed Amended Answer is attached in Appendix A.

between those years.[3] CP 175. The Court set a new hearing date for the summary judgment motion, and allowed the Joneses and King County to submit supplemental briefing on the motion. *Id.*

King County produced the documents it was ordered to produce and timely filed a supplemental brief. RP 4:8-24; CP 177-184. Mr. and Mrs. Jones did not file a supplemental brief, nor did they seek additional discovery. RP 4:8-24.

After the second hearing on Plaintiff's Motion for Summary Judgment and Defendants' Motion to Amend, held December 16, 2012, the Court issued an Order on Motion for Summary Judgment, granting King County's motion. The Court made the following relevant findings:

> 1. Defendants John Jones and Mary Ann Morbley Jones received a settlement in the amount of $610,000 as payment for injury received by John Jones from a third party. There is no evidence that Mr. Jones was not "made whole" by this settlement.
>
> 2. Pursuant to the terms of the KingCare plan, King County is entitled to a contractual and equitable lien and reimbursement from said settlement.

CP 186-88. Based on those findings, the Superior Court ordered that "King County is entitled to be reimbursed $46,315.98, minus an

---

[3] Mr. and Mrs. Jones had not propounded any discovery requests upon King County. These documents were requested at the hearing by the Jones' counsel.

equitable share of the expenses and fees incurred in recovering those funds," plus its fees and costs for bringing the action. *Id.*

III.

ASSIGNMENTS OF ERROR

King County disagrees with the Jones' statement of errors on their appeal. The issues properly before this Court on appeal are as follows:

1. Whether the Superior Court correctly granted King County's motion for summary judgment because there was no evidence that Mr. Jones had not been made whole.

2. Whether the Superior Court correctly declined to grant the Jones' Motion to Amend.

In making assignments of error, the Joneses incorrectly characterize the Superior Court's findings and conclusions. The Superior Court never reached the question of whether King County was an insurer (nor was such a determination necessary to the Court's holding). Contrary to the Jones' assertion, the Superior Court did not implicitly rule that King County is subject to the laws and precedents used to regulate the insurance industry. Nor did the Superior Court address whether King County could be reimbursed regardless of whether Mr. Jones had been made whole. The Superior Court found that it was unnecessary to reach these issues given that there was no genuine issue of material fact regarding Mr. Jones' full compensation from the settlement.

The Joneses do not assign error to the trial court's award of attorneys' fees to King County, nor do they assign error to the trial court's pro rata apportionment of fees on the underlying claim. King County's cross-appeal on the pro rata apportionment issue has been voluntarily dismissed. Therefore, these issues are not before this Court on appeal. Wash. RAP 2.5(a); 10.3(a)(3), (g) (the appellate court is not required to review alleged errors that are not preserved, nor is the appellate court required to review unassigned errors).

IV.

ARGUMENT

A. **Standards of Review**

1. Summary Judgment

An appellate court reviews a summary judgment de novo, applying the standard of CR 56 and viewing the facts submitted in the light most favorable to the nonmoving party. *Indoor Billboard/Washington, Inc. v. Integra Telecom of Wash., Inc.*, 162 Wn.2d 59, 70, 170 P.3d 10 (2007). The moving party has the burden of showing that there is no genuine issue as to any material fact. *Id.* The moving party may allege that the nonmoving party failed to present sufficient evidence to support its case, and must identify those portions of the record, together with affidavits, that demonstrate the absence of a genuine issue of material fact. *Id.* If the

moving party meets its burden, the burden shifts to the nonmoving party to demonstrate the existence of a genuine issue of material fact. *Id.*

Here, King County presented evidence that Mr. Jones was made whole. Mr. Jones was given an opportunity to supplement the record on this issue, and failed to produce any evidence creating a genuine issue of material fact that he had not been made whole.

2. Motion to Amend Answer

A trial court's denial of a motion to amend a pleading is reviewed for abuse of discretion. *Rodriguez v. Loudeye Corp.*, 144 Wn. App. 709, 729, 189 P.3d 168 (2008). A party may amend an answer more than 20 days after it is served only by leave of court, and leave shall be freely given when justice so requires. CR 15(a). A denial of leave to amend may be made without an explanation if there is an apparent reason for denial, such as futility. *Rodriguez*, 144 Wn. App. at 730. For example, when a court dismisses a complaint for failure to state a claim and the plaintiff cannot show that it can successfully plead a claim, an amendment is futile and a denial of a motion for leave to amend is within the trial court's discretion. *Id.*

Here, any leave to amend would have been futile because all of the Jones' proposed counterclaims and third-party claims were contingent on a finding that King County was not entitled to reimbursement. Moreover,

the Joneses did not actually plead any facts that would support their claims.

B. **King County is Entitled to Reimbursement**

Under the plain terms of the KingCare program, when an employee (or dependent) of King County is injured by a third party and recovers a settlement from that third party (or his insurers), then the employee must repay King County, in full, for any health care expenses the County has paid related to such injury. CP 37-39. The reimbursement provision of the KingCare plan is unambiguous:

> If you . . . receive any payment . . . through a judgment, settlement or otherwise . . . when an illness or injury is the result of a third party . . . . You must repay KingCare^{SM} first, in full, out of such funds for any health care expenses the plan has paid related to such illness or injury.

Id.

The plain terms of the contract provide that Mr. Jones must reimburse King County for the amounts King County has paid on his behalf. As a general rule, the courts "will uphold whatever lawful agreement the parties made with each other." *Redford v. Seattle,* 94 Wn.2d 198, 206, 615 P.2d 1285 (1980). Unless "the contract is illegal or violates public policy, the court will not interfere in the agreement of competent parties." *Id.*

Under Washington law, an employer or insurer may contract for the right to be reimbursed for payments made to an employer or the insured when that person recovers money from a tortfeasor for his injury. *Sherry v. Fin. Indem. Co.*, 132 Wn. App. 355, 363, 131 P.3d 922 (2006) (an insurer may contract for the right to be reimbursed for payments made when the insured recovers money from a tortfeasor); *Fisher v. Aldi Tire Inc.*, 78 Wn. App. 902, 908-09, 902 P.2d 166 (1995) (finding that the right to subrogation as it would otherwise arise from the equities existing between the parties may be modified or extinguished by agreement).

A Court is "not at liberty" to rewrite the terms of the contract. *Averill v. Farmers Ins. Co. of Wash.* 155 Wn. App. 106, 114, 229 P.3d 830 (2010). "Parties often contract so that they, and not the common law, control the legal effect that will flow from an anticipated set of circumstances and thus the result will differ from that under the common law." *Redford*, 94 Wn.2d at 207; *Watson v. Ingram*, 124 Wn.2d 845, 852, 881 P.2d 247 (1994) (courts "are loathe to interfere with the rights of parties to contract as they please . . . . It is not the role of the court to enforce contracts so as to produce the most equitable result.").

Mr. Jones, in violation of the contract and the law, has refused to reimburse King County for the amounts that King County paid out of its general assets for his medical care and that he has subsequently also

received under a settlement agreement with a third party. The terms of the KingCare contract should enforced as plainly stated.

In refusing to reimburse King County, Mr. Jones has argued that he is not required to do so because the contract is unenforceable under the "made whole" doctrine set forth in *Thiringer v. Am. Motors, Ins. Co.*, 91 Wn.2d 215, 219, 588 P.2d 191 (1978). The made whole doctrine is a common law rule adopted by Washington courts in insurance coverage cases. *Id.*

As discussed below, Mr. Jones' arguments fail on two fronts. First, even if the made whole doctrine applies, the Superior Court found that Mr. Jones produced no evidence showing that he had not been made whole. Thus, King County is entitled to reimbursement, regardless of whether the contract provision requiring reimbursement before the employee is made whole, is upheld. Second, the made whole doctrine does not apply to self-funded risk management government programs like KingCare, and therefore King County is entitled to reimbursement.

C. **No Evidence That Mr. Jones was Made Whole**

In support of King County's Motion for Summary Judgment, King County submitted evidence that Mr. Jones received less than full policy limits from CBIC, the third-party insurer. This created sufficient evidence that Mr. Jones had been made whole and shifted the burden on summary

judgment for Mr. Jones to produce some evidence that he had been made whole. However, Mr. Jones failed to produce one piece of admissible evidence that he had not been made whole by the settlement.

The fact that Mr. Jones accepted less than full policy limits is evidence that Mr. Jones was made whole. *Peterson v. Safeco Ins. Co. of Illinois*, 95 Wn. App. 254, 259-60, 976 P.2d 632 (1999) (finding that party accepting $25,000 when insurer had $250,000 available was fully compensated); *Truong v. Allstate Prop. & Cas. Ins. Co.*, 151 Wn. App. 195, 205, 211 P.3d 430 (2009) (party that accepted $9,347.54 when insurer's liability limits were $25,000 was fully compensated). The insurer, CBIC, had a $1,000,000 liability policy, yet Mr. Jones accepted $610,000 in an arms-length settlement negotiation in full satisfaction of his claims. CP 43. Because there were additional funds available with which to pay his claim, Washington courts have held that Mr. Jones' acceptance of less than full policy limits is evidence that Mr. Jones was made whole by this settlement. *Peterson*, 95 Wn. App. at 259-60; *Truong*, 151 Wn. App. at 201 (such a settlement "is some evidence, even if not irrefutable evidence, that the settlement fully compensated" the insured).

In response to King County's motion, the Joneses submitted no evidence that Mr. Jones had not been made whole. CP 146-149; CP 56-142. Even after the Court gave Mr. Jones more time to file supplemental

briefing, the Joneses submitted no evidence that Mr. Jones had not been made whole.

In *Truong*, Division 1 of the Washington Court of Appeals found, in a case similar to the one at hand, that where evidence is presented that the injured party was fully compensated by the settlement, the person claiming not to have been made whole must produce some admissible evidence creating an issue of fact to avoid summary judgment. 151 Wn. App. at 195. In *Truong*, Mr. Truong was involved in a car accident and his insurer, Allstate, paid his medical bills in the amount of $4,172 under the personal injury protection ("PIP") provisions of their insurance contract. *Id.* at 199. Truong made a claim against the other driver for $34,000; the other driver was insured by Pemco, with limits of $25,000. *Id.* After Truong served a summons and complaint, Pemco settled with Truong for the sum of $9,347.54. *Id.*

Taking the position that the settlement did not fully compensate him, Truong asked Allstate to waive any claim for reimbursement of the PIP payments. *Id.* Allstate declined to do so, and Truong sued for bad faith, breach of contract, and CPA violations. *Id.*

Allstate moved for partial summary judgment, requesting that Truong's suit be dismissed and Allstate receive a judgment for $4,172. The trial court granted Allstate's summary judgment, finding that Allstate

was entitled to seek reimbursement because Truong had failed to show that he was not fully compensated for his loss. *Id.* at 200.

In determining whether the settlement was full compensation for the actual losses suffered, the Court found that "Truong freely accepted an arms-length settlement from [the tortfeasor] in an amount less than the limits of [the tortfeasor's] liability insurance." *Id.* at 201. Such a settlement "is some evidence, even if not irrefutable evidence, that the settlement fully compensated Truong." *Id.* Because Truong accepted less than policy limits, "Truong had the burden [on summary judgment] of rebutting that evidence by showing that his damages were greater than the amount he settled for." *Id.* at 202. Truong, like Mr. Jones in this case, failed to meet that burden. *Id.*

Truong cited evidence in the record documenting his injuries and argued that a jury must decide the extent of his actual losses. *Id.* In response to that argument, the Court found that "this is not a personal injury suit against an alleged tortfeasor . . . . It is a declaratory judgment action brought for the purpose of determining whether the PIP insurer is entitled to reimbursement from compensation the claimant has already obtained. The issue being litigated is whether Truong suffered from any damages for which the settlement did not fully compensate him." *Id.* at 203-04. Just like in this case, the issue before the *Truong* Court was <u>not</u>

whether and to what extent Mr. Truong was injured, but whether he was fully compensated for those injuries.

To try and create a material issue of fact on whether he had been fully compensated, Truong's attorney submitted a two paragraph opinion stating that, based on his experience, the settlement value of Truong's case was higher than the amount Truong recovered and, "on a more probable than not basis," the settlement of $9,347.54 represented a compromise claim wherein the plaintiff was not made whole but less than full value was accepted in order to avoid a difficult and costly trial. *Id.* at 204. The Court found that the attorney's opinion was "entirely conclusory and unsupported by reference to specific facts and must be disregarded." *Id.*

Here, Mr. Jones provided no evidence to support his claim that he was not made whole by the settlement. The only declarations he submitted were from Mr. Jones' attorney, J.D. Smith, and from Mrs. Jones. Neither declaration provides evidence that Mr. Jones was not made whole.

Mr. Smith's declaration did not even rise to the level of the attorney's declaration (that was found inadequate) in *Truong*. Mr. Smith did not offer any evidence in his declaration as to why Mr. Jones accepted less than policy limits or any evidence showing that the settlement did not fully compensate him. Mr. Jones, even though given extra time to

supplement the record, did not submit a doctor's opinion or a damages expert's opinion as to the adequacy of the recovery. Nor did he attempt to present any evidence of what damages he had incurred for which he was not compensated.

The documents submitted with Mr. Smith's declaration also do not provide evidence that Mr. Jones was not made whole when he accepted less than policy limits. The attached documents (photographs of Mr. Jones' injuries and Mr. Jones' demand letter in the underlying litigation) simply support Mr. Jones' underlying claim that he was injured. CP 109-138. Because the issue being litigated now is not whether Mr. Jones was injured, but rather whether Mr. Jones suffered from any damages for which settlement did not fully compensate him, documents supporting the fact of injury do not create a factual dispute on the material issue.

Mrs. Jones' declaration cites to no facts. Instead, she simply states her conclusory opinion, without support, that Mr. Jones has been injured and that he not been made whole. CP 146-149. Mrs. Jones is neither qualified as a witness to testify to such a statement, nor does she offer any facts for the Court to consider as evidence in support of her conclusory statement. The Joneses are required to set forth "specific facts" rebutting King County's evidence that Mr. Jones was made whole in order to create a genuine issue of material fact. *Seven Gables Corp. v. MGM/UA Ent.*

Co., 106 Wn.2d 1, 13, 721 P.2d 1 (1986); *Baldwin v. Silver*, 165 Wn. App. 463, 471, 269 P.3d 284 (2011); *Greenhalgh v. Dep't of Corr.*, 160 Wn. App. 706, 714, 248 P.3d 150 (2011) ("Mere allegations, argumentative assertions, conclusory statements, and speculation do not raise issues of material facts that preclude a grant of summary judgment."). Mr. and Mrs. Jones failed to produce any admissible evidence to overcome King County's evidence that Mr. Jones had been made whole.[4]

When the trial court specifically asked at the second hearing on summary judgment whether there was any evidence that Mr. Jones had not been made whole, Mr. Smith could not point to any admissible evidence:

> **Mr. Smith**: . . . . [Ms. Marisseau] identifies that Mr. Jones has not come forward with any admissible evidence on whether he was made whole. The reason is we haven't had that case yet. We're here on their motion on the contract principles alone. There's no case over the made whole. When you have those cases, that's an entirely different case where you do conduct a trial or discovery over that issue.

---

[4] While King County has the burden to show that Mr. Jones had been made whole, *Brown v. Snohomish County Physicians*, 120 Wn.2d 747, 758-59, 845 P.2d 334 (1993), King County met that burden by producing evidence that Mr. Jones had accepted less than full policy limits. Once King County met its burden on summary judgment, Mr. Jones was required to produce evidence showing a genuine issue of material fact, which he failed to do. *Truong*, 151Wn. App. at 202 ("Truong had the burden of rebutting that evidence by showing that his damages were greater than the amount he settled for."); *see also Seven Gables Corp. v. Mgm/Ua Entm't Co.*, 406 Wn. 2d 1, 13, 721 P.2d 1 (1986) (in order to avoid summary judgment, the nonmoving party must provide admissions, affidavits, declarations, or other sworn testimony presenting specific facts).

The Court: But – but isn't – isn't it – I mean isn't this the time to come forward with and create a genuine issue of material fact on whether or not he's been made whole?
Mr. Smith: No, because there's – there's no cause of action related to that. The only cause of action is their cause – is their action against Mr. Jones saying that this contract applies.
The Court: Right. And you're saying it doesn't apply. You're not – you shouldn't get reimbursed, because he hasn't been made whole. I mean the – they're saying the contract applies . . . . But nobody's telling me that the contract, read literally, would not have him reimbursing [King County] . . . I don't understand there to be any question but that the contract, read literally, would require him to reimburse King County for all of the medical bills, right?
Mr. Smith: Right.
The Court: Okay . . . . So your argument is that no, he shouldn't be required to, because he hasn't been made whole.
Mr. Smith: Right.
The Court: Okay. And so Ms. Marisseau is saying where is there any evidence that he hasn't been made whole.
Mr. Smith: Well, this is what – this is what I was attempting to do in the motion to amend.
. . . . .
The Court: . . . . So isn't, I mean isn't this your time to come forward? And I've got my notes from before. We got – and let me make sure. We've got a million dollar limit, a $610,000 settlement of which $152,000 we paid to Mrs. Jones for loss of consortium. The County paid $46,315.98; right? I'm close enough. And so isn't this the time to say not just there are these insurance cases that say you don't get reimbursed if the plaintiff in the underlying action hasn't been made whole, but and Mr. Jones hasn't been made whole. Because, otherwise, why do I care what the insurance cases say on that?

RP 19:6-22:8.

There is no admissible evidence in the record that Mr. Jones was not made whole.

D. **There is No Admissible Evidence of Comparative Fault**

Mr. Smith, in his brief, argues that Mr. Jones accepted less than full policy limits because of comparative fault issues without citing to any evidence. Brief of Appellants, p. 4. This argument is not evidence sufficient to defeat summary judgment. "Unsupported argumentative assertions are not sufficient to defeat summary judgment." *Vacova v. Farrell*, 62 Wn. App. 386, 395, 814 P.2d 255 (1991).

The issue of how comparative fault affects the made whole analysis was addressed by the *Truong* court. The *Truong* court found that because Mr. Truong asserted in the underlying tort case that there was no comparative fault, there was no evidence that the amount of compensation he accepted reflected a reduction in the actual losses for his own comparative fault. *Truong*, 151 Wn. App. at 204.

Similarly, here, there is no evidence that Mr. Jones admitted comparative fault in the underlying case against CBIC. To the contrary, in the underlying case, Mr. Jones affirmatively asserted that he was not comparatively at fault. CP 28.

In sum, Mr. Jones points to no facts showing that his settlement reflected any admission of comparative at fault (no expert opinion, no

court rulings) or that he admitted in the underlying case that he was comparatively at fault. There is no evidence in the record sufficient to show a genuine issue of material fact that comparative fault affected the amount of recovery by Mr. Jones. The trial court's decision should be upheld.

E. **The Made Whole Doctrine Does Not Apply to the Self-Funded KingCare Program**

Even if this Court were to find an issue of material fact as to whether Mr. Jones was fully compensated by the $610,000, the trial court's ruling on summary judgment would be harmless error and King County would still be entitled to summary judgment because the contract provides that King County is entitled to full reimbursement, whether or not Mr. Jones has been made whole. The Washington Supreme Court has very clearly and carefully traced the history and effect of the made whole rule as being rooted in and based upon the insured/insurer relationship. Because the KingCare plan is a self-funded government program, it is regulated by RCW 48.62.011 and it is not an insured plan subject to insurance regulations.

1. Historical Context and Application of Made Whole Rule

The made whole doctrine is a common law rule adopted by Washington courts in insurance cases involving subrogation or third party recoveries. Under the rule, an insurer is entitled to be reimbursed to the

extent that its insured recovers payment for the same loss from a tortfeasor responsible for the damage, but the insurer can recover only the excess which the insured has received from the wrongdoer remaining after the insured is fully compensated for his loss.

As the Washington Supreme Court explained in *Mahler v. Szucs*, 135 Wn.2d 398, 412, 957 P.2d 632 (1998), the made whole rule arises in the insurance context because of the unique principles applicable to insurance companies:

> The potential for conflict of interest abounds in such circumstances. Both insurer and insured, having entered into an insurance contract, are bound by the common law duty of good faith and fair dealing, as well as the statutory duty 'to practice honesty and equity in all insurance matters.' RCW 48.01.030. We have said the statute creates a fiduciary duty for insurers running to their insureds. *Industrial Indem. Co. of the Northwest, Inc. v. Kallevig*, 114 Wn.2d 907, 916-17, 792 P.2d 520 (1990). Yet the injured insured seeks recovery from the tortfeasor, the same source to which the insurer may look to recover its payments to its insured.

Id. at 414-15. The Washington Supreme Court went on to explain that the courts have dealt with these difficulties "as they have arisen since the advent of subrogation in insurance contracts involving personal injury claims" by adopting certain "principles of subrogation in the insurance setting," including the "made whole" rule set forth in *Thiringer v. Am. Motors, Ins. Co.*, 91 Wn.2d 215, 219, 588 P.2d 191 (1978). *Id.* at 415

The policies supporting this common law rule are unique to the insurance context. In *Thiringer*, the Washington Supreme Court "addressed the question of priorities *between an insurer and the insured* to proceeds of a settlement which the insured entered with the party responsible for the insured's injuries." *Brown v. Snohomish County Physicians*, 120 Wn.2d 747, 754, 845 P.2d 334 (1993) (emphasis added). In *Thiringer*, the insured was injured in an accident by a third-party tortfeasor and reported the accident to his insurer. *Thiringer*, 91 Wn.2d at 216. Because the third-party tortfeasor had insurance, the PIP[5] carrier told the insured to pursue his remedy against the tortfeasor first. *Id.* The insured did so and recovered a settlement of $15,000, this being the limit of the tortfeasor's liability insurance. *Id.* at 217. The recovery was not apportioned between general and special damages. *Id.* After securing the settlement, the insured demanded benefits payable to him under his PIP coverage, which the carrier refused to pay. *Id.* In an action seeking a declaratory judgment requiring the insurer to submit to arbitration the question of the amount of general damages and the amount of the PIP payable, the Washington Supreme Court held that the proceeds of the

---

[5] Personal Injury Protection ("PIP") is a mandatory insurance coverage required to be offered with any new automobile liability insurance policy or renewal. RCW 48.22.085.

settlement should be allocated first to the insured's general damages and then to the special damages covered by the PIP provision. *Id.* at 219.

In so holding, the court cited the rule that "while an insurer is entitled to be reimbursed to the extent that its insured recovers payment for the same loss from a tort-feasor responsible for the damage, it can recover only the excess which the insured has received from the wrongdoer remaining after the insured is fully compensated for his loss." *Id.* (emphasis added).

In the case of *Brown v. Snohomish County Physicians Corp.*, 120 Wn.2d 747, 845 P.2d 334 (1993), the Court found support for the *Thiringer* rule in the statutorily expressed public policy reasons behind PIP and uninsured or underinsured motorist coverage ("UIM")[6]. Mr. Brown was struck by an automobile and suffered medical and wage losses. *Id.* at 749-50. He recovered liability and no fault insurance from the tortfeasor's automobile insurer, and underinsured and PIP coverage from his own automobile insurer. *Id.* His medical expenses were excluded by his health care services contractor under an exclusion prohibiting coverage where UIM payments were made on behalf of the insured. *Id.* The issue was whether this UIM exclusion was enforceable. *Id.*

---

[6] *See* RCW 48.22.030, mandating UIM insurance coverage for any auto liability policy.

Before determining whether to apply the made whole rule to override the UIM exclusion, the Court first questioned whether the made whole rule could be applied to a health care service contractor.[7] The Court found that there was "some question about the extent to which insurance law applies to the contracts at issue here." *Id.* at 752.

After noting that a health care service contractor is specifically treated as an insurer under the law, the Court agreed that, for the purposes of the case, the "general rules respecting insurance policies should be applied in resolving the public policy issue here." *Id.* (citing *Myers v. Kitsap Physicians Serv., Inc.*, 78 Wn.2d 286, 288, 474 P.2d 109, 66 A.L.R.3d 1196 (1970) (holding that rules of interpretation generally applicable to insurance contracts apply to health care service contracts).

The Supreme Court in *Brown* expressly recognized the common law made whole rule as "insurance law." *Id.* at 753. The Court explained

---

[7] A health care service contractor is defined as "[a]ny corporation, *cooperative* group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services." RCW 48.44.010(9). A health care service contractor and any health plan issued thereby is regulated by the Insurance Commissioner. RCW 48.43.005(23), and (24). In contrast, a self funded plan is expressly not regulated by the Insurance Commissioner. See RCW 48.43.005(26)(j).

that the public policy basis in the "made whole" doctrine was grounded in the insurance statutes. "The policy expressed in *Thiringer* favoring full compensation of innocent automobile accident victims is reflected in the UIM statute . . . . In protecting the innocent victim of an auto accident, UIM insurance provides a source of indemnification when the tortfeasor does not provide adequate protection." *Id.* at 756. The purpose of UIM coverage is to provide the insured with a second layer of protection which "floats" on top of the recovery from other sources. *Id.* at 757. To the extent the challenged provisions operated to exclude coverage for medical expenses before the injured party was fully compensated for general damages and other special damages, the "floating" layer of UIM coverage would be, in effect, negated. *Id.*

Based on the way the policy was written, the court in *Brown* concluded that if the challenged provision was applicable, the petitioners "would be worse off by having to rely on [their] UIM coverage instead of liability coverage of the tortfeasor." *Id.* at 756. That result would be contrary to public policy because the statutory purpose of UIM coverage is to allow an injured party to recover those damages which the injured party would have received had the responsible party been insured with liability limits as broad as the injured party's statutorily mandated underinsured motorist coverage limits. *Id.* at 756-57. Thus, the Washington Supreme

Court has repeatedly recognized the public policy rationale for the "made whole" rule is squarely based on statutory insurance law.

The Washington Supreme Court "has been careful to look to a particular statute to guide it in defining public policy" and it "will not make public policy from whole cloth." *Mendoza v. Rivera-Chavez*, 140 Wn.2d 659, 663, 999 P.2d 29 (2000). As the Supreme Court has stated, when it was discussing the made whole rule in *Brown*, it was "considering whether the use of the [made whole] exclusion violated public policy, given the intent of the UIM statute." *Leingang v. Pierce County Medical Bureau*, 131 Wn.3d 133, 154, (1996).

The public policy reasons behind the made whole rule in the insurance context (and specifically in the UIM context) do not apply in this case because King County is not an insurer and thus is not subject to insurance rules and regulations.[8]

Moreover, there is a strong public policy of allowing self-funded government medical programs maximum flexibility to allow for full reimbursement and other cost controls:

> Legislative intent — Construction.
>
> This chapter is intended to provide the exclusive source of local government entity authority to individually or jointly self-insure risks, jointly

[8] See Section 2, *infra*.

> purchase insurance or reinsurance, and to contract for risk management, claims, and administrative services. <u>This chapter shall be liberally construed to grant local government entities maximum flexibility in self-insuring</u> to the extent the self-insurance programs are operated in a safe and sound manner.
>
> RCW 48.62.011 (emphasis added).

The taxpayers of King County have paid for Mr. Jones' medical treatment and are now entitled to be reimbursed by the third-party who caused the injury. CP 31-39. Because King County is not an insurer, there is no risk of negation of the public policy purposes of insurance coverage if King County is reimbursed for the amounts that it has paid to Mr. Jones. Public policy, if any, requires enforcement of the contract.

The equities of this situation also support King County's position. The provision in the KingCare plan requiring reimbursement serves an important public interest of keeping costs to the taxpayers to a minimum while also ensuring that participants' medical benefits are covered until they are able to recover payment from a third-party tortfeasor.

This public interest has been previously articulated by the legislature in regards to reimbursement of expenses from third party recoveries when government funds are at play. For example, the Workers Compensation statute allows a self-insured employer and the state to recover from the insured employee amounts recovered by the employee from third-party tortfeasors. RCW 51.24.050-.060. The statute also

allows self-insured employers and the state to assert a lien against any proceeds. *Id.* The purpose of the statute is to protect the state fund by providing reimbursement. *Gersema v. Allstate Ins. Co.*, 127 Wn. App. 687, 693, 112 P.3d 552 (2005); *Stamp v. Dept. of Labor and Indus.*, 122 Wn.2d 536, 859 P.2d 597 (1993).

The insurance-related public policy reasons expressed by the courts in *Thiringer, Mahler* and *Brown* center around the unique insurer/insured relationship, the policies expressed by the legislature in mandating PIP and UIM coverage, the potential for conflicts of interest in insurance reimbursement situations, and payment of premium in exchange for insurance coverage. None of those policies apply here. Moreover, the Court in those cases, when faced with competing public policy concerns, chose to elevate the insured over the insurer because of the peculiar relationship between the insured and the insurer. There is no basis to elevate Mr. Jones' interests over that of King County's taxpayers.

King County has a legitimate interest in protecting its general assets and has been given the authority by the Washington legislature to form self-funded risk management programs and to do so in a manner that is conscious of costs. RCW 48.62.031. Public policy does not support extending the made whole rule beyond its limited insurance context.

2. King County is Not an Insurer and Therefore Not Subject to the Insurance Made Whole Rule

Under Washington law, a local government, like King County, is not considered an insurer, even if it has its own risk management programs, like KingCare. It is clear that self-funded government health programs are not considered insurance by the legislature. RCW 41.04.180 (distinguishing "regularly constituted insurance carriers" from "self-insurers as provided for in chapter 48.62 RCW"); RCW 48.01.050 (an "insurer" is defined as "every person engaged in the business of making contracts of insurance, other than a fraternal benefit society . . . . Two or more local government entities, under any provision of law, that join together and organize to form an organization for the purpose of jointly self-insuring or self-funding are not an 'insurer' under this code."). Nor are self-funded plans treated as insurance. RCW 48.43.005(21)(j) (defining "health plan" subject to insurance regulations as specifically excepting "employer-sponsored self-funded health plans").

King County has specifically been found to be exempt from insurance regulations. In *Cann v. King County*, 86 Wn. App. 162, 163, 937 P.2d 610 (1997), King County self-insured its automobile liability coverage. The plaintiff asserted King County's failure to provide UIM coverage violated Washington insurance law. The court disagreed.

The plaintiff, Cann, was injured while riding a bus operated by King County. *Id.* at 163. Cann sued King County, arguing that it had a duty to provide her with UIM protection under the insurance code, RCW 48.22.030. *Id.* She argued that because King County as a self-insurer, in effect, has a liability policy, King County is required to provide UIM coverage as required under the insurance code governing insurance companies. *Id.* at 164. The court unequivocally held that self-insurance plans like the King County plan are not subject to Washington's UIM statute or other insurance laws. *Id.*

This treatment of the County as operating outside of insurance regulations is reinforced under other Washington case law, where the court has found that a self-insured retention provision did not convert a plaintiff into an "insurer" subject to insurance subrogation provisions. *Bordeaux, Inc. v. American Safety Insurance Co.*, 145 Wn. App. 687, 695, 186 P.3d 1188 (2008).

3. <u>The Contract is Enforceable</u>

As a general rule, the courts "will uphold whatever lawful agreement the parties made with each other." *Redford,* 94 Wn.2d at 206. KingCare participants are required to reimburse King County regardless of whether they have been made whole. Even if the equitable insurance rule applies to this self-funded government health plan, it is a common law rule

that can be modified by contract.[9] Any common law rule was unambiguously modified by the self-funded KingCare plan at issue here.

"Parties often contract so that they, and not the common law, control the legal effect that will flow from an anticipated set of circumstances and thus the result will differ from that under the common law." *Redford*, 94 at 207; *Watson v. Ingram*, 124 Wn.2d 845, 852, 881 P.2d 247 (1994) (courts "are loathe to interfere with the rights of parties to contract as they please . . . . It is not the role of the court to enforce contracts so as to produce the most equitable result.").

In *Fisher v. Aldi Tire Inc.*, the court addressed "the crucial question of whether parties to an insurance contract may agree to subrogation standards that deviate from, and thereby supplant, those developed at common law. We find that they may." 78 Wn. App. 902, 908 (1995), 128 Wn.2d 128 (1996), *amended by Mahler*, *supra, following remand*, 138 Wn.2d at 421-26 (finding policy language required payment of fees by State Farm). Consistent with this principle, the Court in *Thiringer* only applied the equitable made whole rule after finding that the parties had not

[9] In contrast, insured plans cannot avoid the rule by contract because they are subject to the jurisdiction of the Office of the Insurance Commissioner, which has determined that all insurance policies must comply with the common law rule. *Subrogation Clauses, What is Acceptable*, Washington Office of Insurance Bulletin 79-4 (August 8, 1979). Attached in Appendix B.

agreed to a different rule in their contract. *Thiringer*, 91 Wn.2d at 220. *See also Meas v. State Farm Fire & Cas. Co.*, 130 Wn. App. 527 (2005) ("The *Thiringer* court held that the insured was entitled to be 'made whole' and that where an insurance policy is silent on the matter, the insured may recoup his or her general damages from settlement proceeds before allowing subrogation") (emphasis added); *Barnes v. Indep. Auto Dealers Ass'n Health & Benefit Plan*, 64 F.3d 1389 (9th Cir. 1995) ("It is a general equitable principle of insurance law that, absent an agreement to the contrary, an insurance company may not enforce a right to subrogation until the insured has been fully compensated. . . . No one doubts that the beneficiary of an insurance policy or (as here) an employee welfare or benefits plan can if he wants sign away his make-whole right. The right exists only when the parties are silent. It is a gap filler.") (emphasis added).

Here, King County's Plan permissibly and unambiguously supplanted the made-whole rule. Summary judgment should be granted.

4. The Made Whole Rule Does Not Need to be Reached

This Court, however, does not have to reach this issue, since as the Superior Court recognized below, the issue can be decided upon summary judgment because Mr. Jones failed to produce any admissible evidence that he was not made whole. Therefore, regardless of whether the made

whole rule applies to King County, the County is entitled to summary judgment in its favor.

F. **ERISA Does Not Apply**

Appellants spend a significant portion of their cut and pasted brief discussing ERISA cases. Both parties agree that ERISA does not control here, and thus all of the authority cited by appellants in Sections C and D of their brief is inapplicable. RP 17:20-18:16; RP 34:2-10. ERISA cases are useful only in the sense that they are potentially analogous to the case at hand. Given that ERISA is a statutory-based regulatory scheme, federal courts have held that, where a plan specifically provides that the plan is entitled to reimbursement regardless of whether the participant has been made whole, such a provision is enforceable. *See, e.g., Admin. Comm. v. Salazar*, 525 F. Supp. 2d 1103, 1112 (D. Ariz. 2007) (in the Ninth Circuit, "an employee may sign away his or her make-whole right"); *Barnes*, 64 F. 3d at 1395 (adopting federal common law that parties can contract around the made whole rule).

G. **Denial of Motion to Amend was Proper**

Appellants assign error to the Superior Court declining to allow their CR 15 Motion to Amend. Brief of Appellant, p. 2. Appellants proposed Amended Answer asserted counterclaims against King County and third-party claims against "Aetna Insurance Company" and "The

Rawlings Company." The Superior Court's order granting summary judgment did not directly address the Jones' Motion to Amend. However, a denial of leave to amend may be made without an explanation if there is an apparent reason for denial, such as futility. *Rodriguez*, 144 Wn. App. at 730. In this case, amendment clearly would have been futile because the Joneses failed to assert any facts supporting the counterclaims and third party claims and because the Joneses failed to allege how the third-party defendants would be liable for a judgment against the Joneses.

1. The Counterclaims Were Factually Deficient

First, the proposed Amended Answer asserting counterclaims was so deficient on its face that it did not comply with CR 8(a). CR 8(a) requires a counterclaim to contain a short and plain statement that apprises the other party of the factual nature of the claims and the legal grounds upon which the claim rests. *Kirby v. City of Tacoma*, 124 Wn. App. 454, 469-70, 98 P.3d 827 (2004). However, "[e]ven our liberal rules of pleading require a complaint to contain direct allegations sufficient to give notice to the court and the opponent of the nature of the plaintiff's claim" *Berge v. Gorton*, 88 Wn.2d 756, 762, 567 P.2d 187 (1977).

The Jones' counterclaim against King County contained no factual allegations, let alone any allegations that would support their claims for declaratory and injunctive relief, breach of contract, bad faith, violation of

Consumer Protection Act and Unfair Debt Collecting Act, Negligence, Outrage, and punitive damages. Appendix A, p. 3. The only statements set forth in the proposed counterclaim were that "Plaintiff's complaint is contrary to Washington law . . ." and that the "actions of plaintiff have proximately caused defendants injury damages as will be proved at the time of trial." *Id.* These statements are not factual allegations upon which a claim can be made.

The Joneses plead no facts, and did not allege anything that would support any of the claims set forth. For example, in making their counterclaim for bad faith, the appellants did not set forth what duty, if any, was owed by King County or whether King County breached that duty. It is not even clear what type of "bad faith" claim was being asserted. *See, e.g., Northwest Independent Forest Mfrs. v. Dept. of Labor & Indus.*, 78 Wn. App. 707, 712-13, 899 P.2d 6 (1995) (bad faith requires duty, breach, and damages proximately caused by that breach).

Because the proposed counterclaims were insufficient on their face to pass the basic requirements of CR 8, amendment would have been futile and the Superior Court did not err when it declined to grant leave to amend.

2. <u>The Third-Party Claims were Improper Under CR 14</u>

In addition, the proposed third-party claims asserted against Aetna and Rawlings are insufficient under CR 14. Under CR 14(a), a defendant may implead a third-party when that third-party is or may be liable to the defendant "for all or a part of the plaintiff's claim against him." CR 14(a). That is, Mr. and Mrs. Jones could add a third party if that third party would be liable to Mr. and Mrs. Jones for all or a part of King County's claims against Mr. and Mrs. Jones.

Mr. and Mrs. Jones, however, do not allege any facts that would allow a Court to conclude that Rawlings and Aetna were properly added as third-party defendants. Appendix A, pp. 3-9. And CR 14 does not permit a defendant to join third parties by asserting entirely independent claims, which is exactly what appellants were attempting to do.

The liability of the third-party defendant to the party that impleads it must be "for losses sustained by that party as a *result of plaintiffs' claims*; unrelated liability to the defendant is not a basis for impleader." *3 Moore's Federal Practice*, § 14.02[2] (Matthew Bender 3d ed.) (original emphasis). The Joneses never alleged in the proposed third-party complaint that Rawlings or Aetna were liable to the Joneses as a result of King County's claim against the appellants. Appendix A, pp. 3-6.

Therefore, any amendment to allow third-party claims would have been futile.

3. Amendment Would be Futile Because Summary Judgment was Proper

Amendment of the Joneses' Answer to allow the assertion of counterclaims and third-party claims would have been futile because summary judgment in favor of King County was proper. All of the Joneses' counterclaims and third-party claims were based on the premise that King County was not entitled to reimbursement or was not allowed to seek reimbursement in the first place. The Joneses cite no law showing that King County is not entitled to seek reimbursement. Nor did the Joneses make any allegation that would have risen to the level of creating a material issue of fact that Mr. Jones was not fully compensated.

V.

CONCLUSION

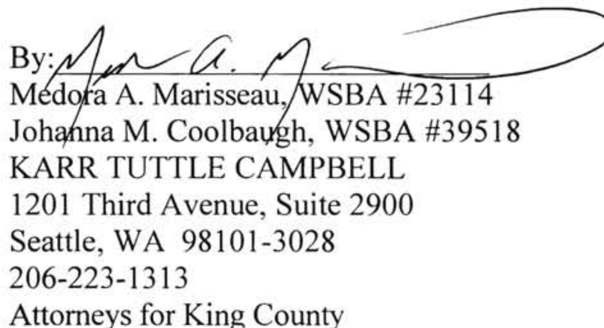
The Superior Court's order of summary judgment should be upheld. Appellants have failed to show any error. By showing that Mr. and Mrs. Jones accepted less than full policy limits in settling their arms-length negotiations with a third-party, and thus were fully compensated, the burden shifted to the Joneses to produce evidence that Mr. Jones was not made whole. Mr. and Mrs. Jones failed to produce any such evidence.

Further, even if they could have met that burden, summary judgment is still proper because the KingCare plan clearly provides that King County is entitled to reimbursement whether or not Mr. Jones was made whole. Because the KingCare program is a self-funded government program and King County is not an insurer, reimbursement provisions that circumvent the made whole rule are allowed.

Last, the Superior Court did not err in failing to grant the Jones' Motion to Amend. The amendment would have been futile, since they failed to allege a single fact that would support a counterclaim or third-party claim against King County, Aetna, or Rawlings.

RESPECTFULLY SUBMITTED, this 25th day of October, 2012.

KARR TUTTLE CAMPBELL



By:

Medora A. Marisseau, WSBA #23114
Johanna M. Coolbaugh, WSBA #39518
KARR TUTTLE CAMPBELL
1201 Third Avenue, Suite 2900
Seattle, WA 98101-3028
206-223-1313
Attorneys for King County

No. 68226-1

COURT OF APPEALS, DIVISION I,
OF THE STATE OF WASHINGTON

(King County Superior Court Cause No. 11-2-13470-9 SEA)

JOHN J. JONES and MARY ANN MORBLEY JONES,,

Defendant/Appellant,

v.

KING COUNTY,

Plaintiff/Respondent.

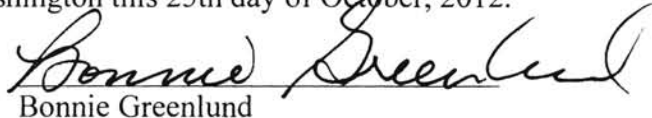
CERTIFICATE OF SERVICE

I hereby certify that on the 25th day of October, 2012, I caused to be served a copy of *King County's Brief of Respondent* by electronic mail and messenger on the following:

J.D. Smith	X Email
1000 2nd Ave Suite 4050	X Messenger
Seattle, WA 98104	___ U.S. Mail
Attorney for Jones	___ Overnight Mail

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

Dated at Seattle, Washington this 25th day of October, 2012.



Bonnie Greenlund

1
2
3
4
5
6
7 IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
FOR KING COUNTY
8
9

KING COUNTY, a municipal corporation Plaintiffs, v. JOHN J. JONES and MARY ANN MORBLEY JONES Defendants. JOHN J. JONES and MARY ANN MORBLEY JONES Third Party Plaintiffs v. THE RAWLINGS COMPANY, AETNA INSURANCE COMPANY, Third Party Defendants	NO. 11-2-13470-9 SEA **DEFENDANT'S AMENDED ANSWER TO PLAINTIFF'S COMPLAINT FOR DAMAGES, COUNTERCLAIMS AND THIRD PARTY CLAIMS** **[PROPOSED]**

10
11
12
13
14
15
16
17
18
19
20
21
22
23 COMES NOW the defendant, John Jones and Mary Ann Morbley Jones (Jones) and in
24

WARD SMITH PLLC
1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

1 answer to plaintiffs' Complaint, admit, deny and allege as follows:

2 **I. ANSWER**

3 Defendants admit Mary Ann Morbley Jones works for King County and is insured under
4 a health care plan she believed was Aetna (See Attachment#1, copy of Aetna insurance card).
5 Defendants also admit John Jones (husband of Mary Ann Morbley Jones) was involved in a
6 serious accident causing permanent injuries. Due to the weaknesses of the case and significant
7 risks and costs of trial, the Jones' elected to settle their case for an amount significantly below
8 the real value. As to the remaining averments, defendant lacks sufficient information to admit or
9 deny, therefore deny.

10 **II. AFFIRMATIVE DEFENSES**

11 BY WAY OF FURTHER ANSWER AND AS AFFIRMATIVE DEFENSES,
12 defendants states and alleges as follows:

13 1. Action prematurely brought;

14

2. Circuity of Action (two actions necessary in order to effect the adjustment of
15 rights between all parties concerned;

16

3. Defendants reserves the right to add further defenses, claims or parties as may be
17 deemed necessary.

18

19 WHEREFORE, having fully answered plaintiffs' Complaint and having alleged
20 affirmative defenses, defendant prays as follows:

21 1. That plaintiffs' Complaint be dismissed with prejudice and without costs.

22

2. That defendant be awarded costs, disbursements and reasonable attorneys fees
23 herein;

24

WARD SMITH PLLC

1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

1 3. For such other and further relief as the Court may deem just and equitable

2

3

III. COUNTERCLAIMS FOR DAMAGES, DECLARATORY AND INJUNCTIVE RELIEF

4

5 WHEREFORE, Jones defendants alleges by way of counterclaim as follows:

6 1. Plaintiffs' complaint is contrary to Washington law and taken in bad faith,

7 breach of contract, negligent, violation of the Consumer Protection Act and the Unfair Debt

8 Collection Practices Act.

9 2. The actions of plaintiff have proximately caused defendants injury damages as

10 will be proved at the time of trial.

11 WHEREFORE, defendants pray for the following relief:

12 1. For an Order dismissing this matter.

13 2. Declaratory and Injunctive Relief

14 3. For costs, disbursements, and fees incurred herein, as provided by statue, court

15 rule or court decision;

16 4. For such special and general damages as are allowed at law; and

17 5. For such other and further relief as the Court deems just and equitable in the

18 premises.

19

THIRD PARTY CLAIMS

20 Third Party Plaintiffs, JOHN AND MARY ANN MORBLEY JONES by and through

21 their undersigned counsel, files this COMPLAINT against defendants AETNA INSURANCE

22 COMPANY and the THE RAWLINGS COMPANY, and alleges the following:

23 ///

24

1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

WARD SMITH PLLC

1 I. **PARTIES**

2 1.1 Third Party Plaintiffs are and at all relevant times herein, was receiving healthcare
3 benefits through an ERISA exempt and/or non-ERISA health care plan offered through AETNA
4 INSURANCE COMPNAY. On information and belief AETNA contracted with The Rawlings
5 Company. The Rawlings Company has been acting as agents of AETNA.

6 1.2 Defendant AETNA INSURANCE COMPANY's and THE RAWLINGS
7 COMPANY claim handling practices, including demands for reimbursement of the health
8 benefits following resolution of a personal injury claim, constitutes breach of contract, bad faith,
9 unjust enrichment, and violates the consumer protection laws of the State of Washington. As a
10 result of Defendant AETNA INSURANCE COMPANY's and THE RAWLINGS COMPANY
11 claim handling practices, the Jones' have suffered and/or will continue to suffer damages.

12 II. **VENUE**

13 2.1 Third Party Plaintiffs are residents of King County, Washington.

14 2.2 Upon and information and belief, Defendant AETNA INSURANCE
15 COMPANY's and THE RAWLINGS COMPANY negotiated and entered into a contract in
16 Seattle, Washington.

17 2.3 Upon information and belief, Defendants, AETNA INSURANCE COMPANY's
18 and THE RAWLINGS COMPANY ("Aetna" and "Rawlings") are foreign companies authorized
19 to do business in King County, Washington. Aetna was formed in Connecticut.

20 2.4 All acts giving rise to this complaint occurred in King County, Washington.

21 2.5 Venue is proper in King County, Washington.

22 ///

23 ///

24

WARD SMITH PLLC
1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

1 **III. FIRST CAUSE OF ACTION: DECLARATORY RELIEF**

2 5.1 Third Party Plaintiff seeks a judicial declaration that Aetna's Plan language is
3 contrary to Washington law, unenforceable, and against public policy. As such, Defendant
4 Aetna's Benefit Plan language should be severed from the Benefit Plan. Plaintiff seeks an order
5 from the Court enjoining Aetna and Rawlings from attempting to enforce the Plan language on
6 other Washington residents and Third Party Plaintiffs seeks an order from the Court enjoining
7 Aetna from adopting, allowing, and/or permitting such terms as part of its health insurance
8 benefit plan.

9 **VI. SECOND CAUSE OF ACTION: BREACH OF CONTRACT**

10 6.1 Third Party Plaintiff re-alleges and incorporates herein the allegations contained
11 above.

12 6.2 Defendant Aetna contractually promised to provide Plaintiff health care benefits.

13 6.3 Aetna, breached its promise to Plaintiff by requiring full reimbursement of health
14 care expenses made by the plan, regardless of whether a plan member has been fully
15 compensated or made whole.

16 6.4 Defendant Aetna and Rawling are in breach of the Health Care Plan
17 Agreement by demanding repayment of health care expenses that are clearly provided for by the
18 Plan.

19 6.5 By requiring the Third Party Plaintiffs to fully reimburse health care expenses
20 made by the plan, regardless of whether a plan member has been fully compensated or made
21 whole, Defendants in essence are taking back coverage that it is contractually obligated to
22 provide under the Health Care Plan.

23

24

WARD SMITH PLLC
1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

1 6.6 Third Party Plaintiffs have been damaged by Aetna's and Rawling's failure to
2 provide health care benefits as alleged herein.
3 6.7 Aetna's and Rawlings breach of contract entitles Plaintiff to an award of legal and
4 equitable relief, including actual damages, reformation, and specific performance.

5 **VII. <u>THIRD CAUSE OF ACTION: BAD FAITH</u>**

6 7.1 Third Party Plaintiff re-alleges and incorporates herein the allegations contained
7 above.
8 7.2 The business of insurance is one affected by the public interest, requiring that all
9 persons be actuated by good faith, abstain from deception, and practice honesty and equity in all
10 insurance matters. RCW 48.01.030.
11 7.3 Defendant Aetna and Rawlings, by virtue of its position and authority to conduct
12 insurance business in the State of Washington, owed and continues to owe the Plaintiffs
13 fiduciary and quasi-fiduciary duties and an enhanced obligation of fairness in transactions
14 involving insurance.
15 7.4 Defendant Aetna's and Rawlings actions as described herein and which will be
16 further developed in discovery were in violation of its duties. Defendant Aetna's and Rawlings
17 actions as described herein and which will be further developed in discovery were vexatious and
18 unreasonable. Defendant Aetna and Rawlings, through its actions, failed to give plaintiffs equal
19 consideration and elevated its own interests above the Plaintiff's and Defendant Aetna's and
20 Rawlings actions were without reasonable justification.
21 7.5 The acts and omissions of Aetna and its agent, including Rawlings, as described
22 herein and as will be further developed in discovery are in direct violation of RCW 48.30.010,
23 imposing upon the Defendant the duty to fairly and properly investigate claims made plaintiffs
24

WARD SMITH PLLC
1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

1 and to make claim determinations and evaluation of such claims in good faith. By ignoring
2 Washington law and Washington State's public policy of full compensation for injured persons,
3 and asserting a lien and demanding reimbursement of health care expenses made by the plan,
4 regardless of whether Mr. Jones was fully compensated or made whole, Defendant Aetna and
5 Rawlings have acted and continues to act in bad faith and has breached the implied covenant of
6 fair dealing in insurance contracts.

7 7.6 Third Party Plaintiffs have suffered extra-contractual damages such as mental
8 anguish, emotional distress, attorney fees, court costs, and foreseeable economic losses as a
9 result of Aetna's and Rawlings actions.

10 **VIII. <u>FOURTH CAUSE OF ACTION: CONSUMER PROTECTION ACT</u>**

11 8.1 Third Party Plaintiffs re-alleges and incorporates herein the allegations contained
12 above.

13 8.2 Plaintiffs contracted for health care benefits from Aetna. In instances, Aetna has
14 engaged in the same pattern of unfair and deceptive conduct pursuant to a common policy. Upon
15 information and belief, Aetna has acted unfairly and deceptively in:

16 a. Requiring full reimbursement of health care expenses made by the plan, regardless of whether a plan member has been fully compensated or made
17 whole.

18 b. Requiring full reimbursement of health care expenses made by the plan without deduction for attorney fees and/or costs.
19

8.3 The acts and omissions of defendant Aetna and its agent, Rawlings, as described
20
herein and as will be further developed in discovery were and are unfair and deceptive acts or
21
practices in trade and commerce and affect the public interest. As such, The acts and omissions
22
of defendant Aetna and its agent, Rawlings, as described herein and as will be further developed
23
in discovery are in direct violation of the Consumer Protection Act, RCW 19.86 *et seq*, entitling
24

1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

WARD SMITH PLLC

1 Plaintiff s to treble damages, reasonable attorney fees, costs of suit, and such other relief as may
2 be permitted by statute.
3 8.4 Defendant Aetna's and Rawlings unlawful collection practices have directly and
4 proximately caused injury to Plaintiff s property interest in health plan benefits and coverage.

5 **IX. FIFTH CAUSE OF ACTION: NEGLIGENCE**

6 9.1 Plaintiff re-alleges and incorporates herein the allegations contained above.
7 9.2 The acts and omissions of defendant Aetna and its agent, Rawlings, as described
8 herein and as will be further developed in discovery, were negligent and in violation of its duty
9 to exercise reasonable care towards Plaintiffs.

10 **X. SIXTH CAUSE OF ACTION: TORT OF OUTRAGE**

11 10.1 Plaintiff re-alleges and incorporates herein the allegations contained above.
12 10.2 As a matter of Washington State public policy and law, it is well known and
13 clearly established that the enforcement of subrogation rights is precluded until the injured
14 person has been made whole.
15 10.3 Defendant Aetna and Rawlings are well aware that its collection practices are
16 contrary to Washington law and public policy, yet, despite this knowledge, continues to pursue
17 recovery of health expenses from Plaintiffs who have been injured and not made whole.
18 10.4 Defendant Aetna's actions, including the actions of its agent, Rawlings, were so
19 outrageous in character, and so extreme in degree, as to go beyond all possible bounds of
20 decency and to be regarded as atrocious, and utterly intolerable in a civilized community.
21 10.5 Defendant Aetna's actions, including the actions of its agent, Rawlings, actions
22 caused extreme emotional distress to the Plaintiffs.
23 ///
24

WARD SMITH PLLC
1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

1 **XI. SEVENTH CAUSE OF ACTION: PUNITIVE DAMAGES**

2 11.1 Plaintiff re-alleges the paragraphs set forth above.

3 11.2 Defendant Aetna's acts and omissions, including the acts and omissions of its
4 agent Rawlings, have been motivated by its own financial interests and done with indifference to
5 the rights and interests of the Plaintiffs, or conducted with reckless, willful or wanton disregard
6 under the law of Connecticut where the decisions, policies or acts, complained of herein were
7 decided, entitling Plaintiffs to exemplary or punitive damages under the law of the State of
8 Connecticut and that Connecticut's punitive damages law under these circumstances is
9 enforceable in this jurisdiction.

10 **XII. EIGHTH CAUSE OF ACTION: INJUNCTIVE RELIEF**

11 12.1 Plaintiff re-alleges the paragraphs set forth above.

12 12.2 Aetna's and Rawlings conduct is causing irreparable harm to Plaintiffs. As a
13 result, the Court should impose an injunction restraining Aetna and Rawlings from further
14 wrongful conduct.

15 **XIII. RESERVATION OF RIGHTS**

16 13.1 Plaintiffs reserve the right to assert additional claims and additional parties including
17 possibly seeking Class Action Status as may be appropriate following further investigation and
18 discovery in this action.

19 **XIV. PRAYER FOR RELIEF**

20 WHEREFORE, the Plaintiffs pray for the following relief against the Defendants:

21 1. Declaratory Relief. A judicial declaration Aetna's Plan language is contrary to
22 Washington law, unenforceable, and against public policy; and Defendant Aetna's Benefit Plan
23 language should be severed from the Benefit Plan;

24

1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

WARD SMITH PLLC

2. Injunctive Relief. Appropriate injunctive relief including an order enjoining the Defendants from:

a. requiring full reimbursement of health care expenses made by the plan, regardless of whether a plan member has been fully compensated or made whole, and

b. requiring the plan to pay its proportionate share of attorney fees and costs when it is reimbursed health care expenses after the plan member is made whole.

3. Equitable Relief. Equitable relief in the form of rescission, reformation, specific performance, restitution, and/or disgorgement of all money received by the Aetna and/or Rawlings, as a result of the deceptive conduct alleged herein.

4. Damages. Damages in an amount to be proven at trial.

5. Exemplary Damages. Damages and such other relief, including treble and punitive damages, as provided by the statutes cited herein.

6. Fees and Costs. The costs of bring this suit, including but not limited to reasonable attorneys' fees and costs under *Olympic S.S. Co. v. Centennial Ins. Co.*, 117 Wn.2d 37, 811 P.2d 673 (1991);

7. For such further and other relief as this Court deems just and proper.

DATED this ____ day of October, 2011

WARD SMITH PLLC

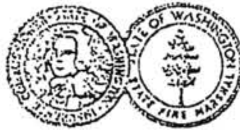
____

J.D. SMITH, WSBA #28246

WARD SMITH PLLC
1000 2ND Ave., Ste. 4050
Seattle, WA 98104-1023
Tel: 206-588-8529

STATE OF WASHINGTON

DICK MARQUARDT
STATE INSURANCE COMMISSIONER
AND STATE FIRE MARSHAL



REPLY TO:
OLYMPIA OFFICE
INSURANCE BUILDING
OLYMPIA, WASHINGTON 98504
753-7300, AREA CODE 206

OFFICE OF

INSURANCE COMMISSIONER

B U L L E T I N

No. 79-4 August 8, 1979

Subject: SUBROGATION CLAUSES, WHAT IS ACCEPTABLE.

A recent Washington State Supreme Court decision, Thiringer v. American Motors Ins. Co., 91 Wn.2d 215, has caused us to review subrogation clauses that are being used in insurance policies and in health care service contractor and health maintenance organization contracts.

In that case, the supreme court considered the allocation of the proceeds of a tort settlment, as between an insured and an insurer, upon the contention of the insurer that the proceeds should be allocated first to the special damages covered by the insurance policy or, in the alternative, prorated between the general damages and the covered damages. The court stated the general rule to be that, while an insurer is entitled to be reimbursed to the extent that its insured recovers payment for the same loss from a tort-feasor responsible for the damage, it can recover only the excess which the insured has received from the wrongdoer, after the insured is fully compensated for his loss.

The supreme court found, and we agree, that the more equitable approach, where a subrogation provision is utilized, is to permit the insured to recoup his general damages from the tort-feasor before allowing subrogation, provided, of course, that in so doing he does not prejudice the rights of his insurer. As stated by the court:

> Such a rule, we believe, accords more with the undertaking of the insurer and the reasonable expectations of the insured, than does a rule requiring proration of the recovery.

RCW 48.01.030 imposes the requirement of equity in all insurance matters It follows that my office will not approve or allow subrogation provisions that deny full recovery to an insured. It should be emphasized, however, that this need not result in duplicate payments to an insured. There is a difference between being "made whole" and receiving a double recovery.

Obviously, modification of existing subrogation clauses in conflict with the intent of this Bulletin will result in some loss of subrogation monies. We have concluded, however, that such loss is relatively insignificant when measured against premiums received. In any event, to paraphrase the supreme court, we prefer to follow a rule embodying the socially desirable policy of fostering adequate indemnification of innocent accident victims.

Each carrier--insurance companies, health care service contractors and health maintenance organizations--should review its subrogation clauses and make such changes as are necessary to conform to the rationale herein expressed.

DICK MARQUARDT
Insurance Commissioner