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No. 96516-1

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

GROUP HEALTH COOPERATIVE,
a Washington non-profit corporation,

Plaintiff/Petitioner,

vs.

NATHANIEL COON and LORI COON,
husband and wife,

Defendants/Respondents.

BRIEF OF AMICUS CURIAE
WASHINGTON STATE ASSOCIATION FOR JUSTICE FOUNDATION

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I. IDENTITY AND INTEREST OF AMICUS CURIAE

The Washington State Association for Justice Foundation (WSAJ Foundation) is a not-for-profit corporation organized under Washington law, and a supporting organization to Washington State Association for Justice. WSAJ Foundation operates an amicus curiae program and has an interest in the rights of persons seeking redress under the civil justice system, including an interest in the equitable rule in Washington that insureds must be made whole before insurers may seek subrogation or reimbursement rights.

II. INTRODUCTION AND STATEMENT OF THE CASE

This case presents the Court with the opportunity to reaffirm the principles underlying the “made whole” rule adopted in *Thiringer v. American Motors Ins. Co.*, 91 Wn.2d 215, 588 P.2d 191 (1978), and to clarify the scope of its application under Washington law. The facts are drawn from the Court of Appeals’ opinion and the parties’ briefs. *See Group Health Cooperative v. Coon*, 4 Wn. App. 2d 737, 423 P.3d 906 (2018), *review granted*, 192 Wn.2d 1017 (2019); Coon Op. Br. at 3-12; Group Health Resp. Br. at 3-6; Group Health Pet. for Rev. at 2-5; Ans. to Pet. for Rev. at 1-2.

For purposes of this amicus brief, the following facts are relevant. Nathaniel Coon underwent knee surgery at Everett Clinic (the Clinic). After the surgery, Coon developed a rare and aggressive fungal infection that ultimately resulted in the amputation of his leg above the knee.

The Clinic voluntarily paid Coon over \$300,000 to help with expenses, and requested a pre-lawsuit mediation. Coon’s attorney consulted

with liability experts, but advised the mediator that “without extensive discovery,” they had been unable “to pinpoint a specific explanation” of how Coon acquired the infection. *Coon*, 4 Wn. App. 2d at 740. The best theory they had been able to develop was a “*res ipsa loquitor*” argument. *Id.* Coon’s attorney also consulted with damages experts, who opined that full compensation for Coon would total between \$5 million and \$15 million.

Coon had health insurance coverage with Group Health (GHO), which paid approximately \$372,000 in medical expenses. The policy provided that GHO had subrogation and reimbursement rights “for all benefits provided, from any amounts the [insured] received or is entitled to receive from any source ... whether by suit, settlement or otherwise.” *Coon*, 4 Wn. App. 2d at 742-43 (brackets added). It further stated that “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.” *Id.*, 4 Wn. App. 2d at 743. The policy required the insured to do nothing to prejudice GHO’s subrogation and reimbursement rights, to promptly notify GHO of any tentative settlement with a third party, not to settle without protecting GHO’s interest, and to hold in trust any funds the insured recovers “from any source that may serve to compensate for medical injuries or medical expenses” “until GHO’s subrogation and reimbursement rights are fully determined.” *Coon* Ans. to Pet. for Rev., Ex. A. The policy provided that if the insured failed “to cooperate fully with GHO in recovery of GHO’s Medical Expenses, the

[insured] shall be responsible for directly reimbursing GHO for 100% of GHO's Medical Expenses." *Coon*, 4 Wn. App. 2d at 743 (brackets added).

Coon's attorney advised GHO that he was pursuing a claim against the Clinic where the original knee surgery was performed, and GHO responded with a list of paid medical expenses and a request to be kept informed regarding settlement negotiations and to be contacted before final settlement to confirm GHO's subrogation interests.

Coon settled for \$2 million, which was less than the Clinic's insurance policy limits. The settlement was reached on a Friday, and Coon notified GHO of the settlement the following Monday. Coon advised GHO that he settled for an amount far less than his damages due to the low likelihood of proving liability. He asked GHO to waive any subrogation claim. It declined, and instead sued Coon for declaratory relief, contending that it had an enforceable reimbursement claim for the full amount of the benefits paid under the policy. Both parties filed motions for summary judgment. GHO argued Coon's settlement necessarily determined his total losses and that he had been made whole. It urged that Coon had breached the contract by not strictly complying with its notice of settlement provision and by disbursing the settlement funds before the matter was resolved, and that the contractual remedy of full reimbursement for the breach should be enforced. The trial court granted GHO's summary judgment motion.

Coon appealed, and the Court of Appeals reversed, holding: 1) GHO could not seek reimbursement based on Coon's alleged breach of the notice

provision unless, and to the extent that, it proved it had been prejudiced; 2) GHO's asserted rights of subrogation or reimbursement require proof by GHO of a negligent third-party; 3) Coon need not establish the presence of a liable third-party to invoke the made whole doctrine. GHO petitioned for review, which this Court granted.

III. ISSUES PRESENTED

- 1) What is the scope and proper application of the "made whole" doctrine in light of the public policies underlying *Thiringer* and its progeny? Sub-issues include:
 - a) Should insureds under health insurance policies be excluded from the protection of the made whole rule?
 - b) Should insureds who receive funds from a third-party not conclusively determined to be "liable in tort," *see* GHO Supp. Br. at 9, be excluded from the protection of the made whole rule?
- 2) Must a health insurer prove it has been prejudiced in order to enforce a contractual provision that purports to entitle the insurer to full reimbursement for benefits paid based on an insured's breach of a notice of settlement provision?

IV. SUMMARY OF ARGUMENT

Under this Court's decision in *Thiringer* and its progeny, an insurer may not seek reimbursement or subrogation rights until its insured has been made whole. This fundamental tenet of Washington law reflects the recognized public policy that an insured suffering compensable injury is entitled to be made whole but is not entitled to a double recovery.

While application of this rule has frequently arisen in the context of automobile insurance, it has also been applied to claims involving other types of coverage, including health insurance policies. Application of the doctrine

in that context is consistent with the Legislature's declaration that access to health insurance is a "paramount concern" in Washington. There is no basis for excluding health insureds from the protection of this equitable rule.

Nor should the Court hold that an insured's entitlement to be made whole requires him to prove that a third-party is liable in tort for his injury. Such a rule would be both unworkable and inconsistent with this Court's jurisprudence. It is commonplace for insureds to settle with potentially liable third-parties for a variety of reasons, including issues of proof regarding liability. The applicability of the made whole doctrine should simply function alongside asserted rights of subrogation or reimbursement, operating as a guiding principle ensuring that the insurer obtains only the excess beyond what is necessary to make the insured whole.

An insurer should not be permitted to enforce a reimbursement clause for an insured's breach of a notice of settlement provision unless, and to the extent that, the insurer proves it has been prejudiced by the breach. To hold otherwise would be to allow insurers to strictly enforce contract clauses that unfairly penalize insureds for technical breaches, and effectuate a windfall for insurers. This Court should reaffirm that an insurer's remedy for breach of such provisions is limited to the extent to which it can prove prejudice.

V. ARGUMENT

In its Petition for Review, GHO frames the issues as follows: 1) does the made whole rule apply in the absence of a third-party tortfeasor, and 2) must an insurer show prejudice in order to enforce a right of reimbursement

based on breach of a notice of settlement provision? In its supplemental brief, GHO suggests that an additional basis for removing this case from the reach of *Thiringer* is that it concerns a health insurance policy. It includes this fact in a list of circumstances which it asserts, taken together, operate to deny Coon the benefit of the make whole rule. *See* GHO Supp. Br. at 10-11.

In fact, this case bears no legally relevant distinction to the vast body of this Court's insurance jurisprudence regarding subrogation and reimbursement, which has determined that entitlement to such rights is "guided by the principle that a party suffering compensable injury is entitled to be made whole." *Thiringer*, 91 Wn.2d at 220. The Court should reaffirm this fundamental tenet that grounds Washington insurance law.

A. Overview Of Washington Law Regarding Subrogation And Reimbursement Rights Of Insurers, And The Ameliorative "Made Whole" Doctrine Adopted To Ensure Equitable Application Of These Rights.

An insurer may be entitled to recover amounts paid to its insured for policy benefits either: 1) through a reimbursement claim against its insured who recovered damages from a tortfeasor; or 2) through a subrogation claim against a tortfeasor who caused the loss. *See* Thomas V. Harris, WASHINGTON INSURANCE LAW, § 52.01, at 52-1 (3rd ed., 2010). "Reimbursement" allows an insurer to seek to recover the amount of benefits paid from proceeds its insured collects directly from a third party. *See Winters v. State Farm Mut. Auto. Ins. Co.*, 144 Wn.2d 869, 876, 31 P.3d 1164 (2001). Subrogation is a three-party transaction, "permitting one who has paid benefits to one party to collect from another." *Id.*, 144 Wn.2d at 875.

Historically, subrogation rights were limited to the area of property insurance, and courts resisted extension of these rights to coverage for medical expenses and other non-property claims. *See* Roger M. Baron, *Subrogation on Medical Expense Claims: The “Double Recovery” Myth and the Feasibility of Anti-Subrogation Laws*, 96 Dick. L. Rev. 581, 583 (1992). However, subrogation clauses have become more prevalent outside the property insurance context, including in medical policies:

[S]ubrogation clauses have been inserted in first party medical payments coverage in automobile policies, uninsured and underinsured motorist coverage, and medical and hospitalization coverage. Initially, this expansion was resisted by the common law. . . . The continued efforts of the insurance industry, however, eventually led many jurisdictions to either allow subrogation directly on medical expense claims or to permit the same result by upholding insurers’ revised policy language purporting to give the insurer the right to reimbursement.

Baron, 96 Dick. L. Rev. at 583 (brackets added).

The purpose of subrogation is to impose liability on the party responsible in law for the loss. *See Mahler v. Szucs*, 135 Wn.2d 398, 411-12, 957 P.2d 632 (1998). Subrogation may arise as a matter of law or a matter of contract. *See Mut. of Enumclaw Ins. Co. v. USF Ins. Co.*, 164 Wn.2d 411, 423, 191 P.3d 866 (2008). In either case, it is an equitable remedy subject to equitable principles. *See Transamerica Title Ins. Co. v. Johnson*, 103 Wn.2d 409, 417, 693 P.2d 697 (1985). This Court has expressed disagreement with courts in other jurisdictions holding that equitable principles cannot be applied to change the terms of contractual subrogation, noting “the better rule is that regardless of the source of the right of subrogation, the right will

only be enforced in favor of a meritorious claim and after a balancing of the equities.” *Transamerica Title Ins. Co.*, 103 Wn.2d at 417 (citation omitted).

Washington law adheres to the view that notwithstanding contractual language, an insurer cannot recover amounts paid under a contract of insurance which its insured recovers from another source unless and until its insured is fully compensated. *See Thiringer*, 91 Wn.2d at 219; *see also Liberty Mut. Ins. Co. v. Tripp*, 144 Wn.2d 1, 21, 25 P.3d 997 (2001). This rule provides that 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.” *Thiringer*, 91 Wn.2d at 219.

Enforcement of the insurer’s subrogation or reimbursement interest “is governed by the general policy of full compensation of the insured.” *Mahler*, 135 Wn.2d at 417-18. An insured is fully compensated when she has “made a complete recovery of the actual losses suffered.” *Sherry v. Fin. Indem. Co.*, 160 Wn.2d 611, 614, 160 P.3d 31 (2007). The burden of proving the insured has been fully compensated falls on the insurer. *See Weyerhaeuser Co. v. Commercial Union Ins. Co.*, 142 Wn.2d 654, 672-75, 15 P.3d 115 (2000); *Brown v. Snohomish County Physicians Corp.*, 120 Wn.2d 747, 759, 845 P.2d 334 (1993).

B. Subrogation Or Reimbursement Rights Asserted By A Health Insurer Should Be Governed By The Made Whole Doctrine.

GHO suggests that the *Thiringer* doctrine should be limited to PIP and UIM policies and should not apply to the health insurance policy at issue here. *See* GHO Supp. Br. at 10-11. It identifies no legally relevant feature of

health insurance, however, that would distinguish it from these other types of insurance. GHO's restrictive interpretation is unwarranted by equitable principles and this Court's case law, and should be rejected.

Certainly, there are public policy reasons for application of the "made whole" doctrine when an insurer attempts to enforce subrogation rights under PIP or UIM coverage. Both coverages are "creatures of public policy" because the Legislature requires every insurer writing automobile policies to offer those coverages. *Durant v. State Farm Mut. Auto. Ins. Co.*, 191 Wn.2d 1, 14, 419 P.3d 400 (2018); *Sherry*, 160 Wn.2d at 620. In addition, this Court has described full compensation of automobile accident victims as a "strong public policy" in Washington. *Brown*, 120 Wn.2d at 758.

However, Washington courts have frequently applied the made whole doctrine outside the context of PIP and UIM coverages. *See, e.g., Puget Sound Energy, Inc. v. Alba General Ins. Co.*, 149 Wn.2d 135, 137, 68 P.3d 1061 (2003) (environmental insurance coverage); *Weyerhaeuser*, 142 Wn.2d at 672 (comprehensive general liability policies); *Bordeaux, Inc. v. American Safety Ins. Co.*, 145 Wn. App. 687, 186 P.3d 1188 (2008), *review denied*, 165 Wn.2d 1035 (2009) (liability policies insuring against construction defect claims); *Polygon Nw Co. v. Am. Nat'l Fire Ins. Co.*, 143 Wn. App. 753, 189 P.3d 777, *review denied*, 164 Wn.2d 1033 (2008) (excess liability policy); *Paulsen v. Dep't of Soc. & Health Svcs.*, 78 Wn. App. 665, 668, 898 P.2d 353 (1995), *review denied*, 128 Wn.2d 1010 (1996) (insurers'

subrogation rights as against its insured injured at a construction site subject to the made whole rule, but for a statutory provision securing lien rights).

Washington courts have also applied the made whole doctrine in the context of health insurance policies. *See Brown*, 120 Wn.2d 747; *British Columbia Ministry of Health v. Homewood*, 93 Wn. App 702, 970 P.2d 381 (1999), *review denied*, 140 Wn.2d 1015 (2000). In *Brown*, this Court applied the rule to examine the relative responsibilities as between a health insurer, an insured, and a UIM carrier. *See* 120 Wn.2d at 754-58.¹ In *Homewood*, the court of appeals applied the rule in the context of a health insurer's action against its insured for reimbursement of medical payments from settlements by its insured with several tortfeasors. *See* 93 Wn. App. 712-715.

The Legislature has declared that the right of the people to obtain access to health insurance is a "paramount concern" warranting protection under the state's police power. *See* RCW 48.44.309.² GHO has identified no aspect of health insurance coverage that would exclude it from the protection of the made whole doctrine, and such an exclusion would be inconsistent with this Court's jurisprudence. The principles underlying this equitable rule

¹ The Court in *Brown* observed "there is some question about the extent to which insurance law applies" to health insurance contracts. 120 Wn.2d at 753. However, it applied general rules governing insurance to the public policy issues implicated by the medical and UIM policies there. *See Brown*, 120 Wn.2d at 754-58. Subsequently, in *Leingang v. Pierce County Medical Bureau, Inc.*, 131 Wn.2d 133, 930 P.2d 288 (1997), the Court examined its use of insurance jurisprudence in the context of health insurance in *Brown*. It noted that it had not applied insurance regulations "which specifically provide that they do not apply to health care service contracts," but otherwise "used the common law rules of interpretation generally applicable to insurance contracts." 131 Wn.2d at 152.

² The full text of the current version of RCW 48.44.309 is reproduced in the Appendix.

apply with equal force to health insurance policies, and the Court should decline to impose the limiting interpretation urged by GHO.

C. The Made Whole Doctrine Should Apply To Any Proceeds To Which An Insurer Claims Reimbursement Rights, And Should Operate As A “Counterbalance” To Provide The Insurer Only The Excess Beyond What Is Necessary To Make The Insured Whole.

GHO maintains the made whole rule does not apply here because, in its view, there is no third-party tortfeasor. *See* GHO Pet. for Rev. at 1. It urges that to be entitled to the protections of this doctrine, a policyholder must establish “on a more than probable than not basis” that a “third party is liable in tort for the policyholder’s injury.” GHO Supp. Br. at 9. GHO’s argument misapprehends the nature of the doctrine and proposes a rule that would erode well-established protections afforded insureds in this context.³

As a preliminary matter, it is difficult to ascertain from GHO’s briefing what it would submit distinguishes the settlement at issue here from any other settlement. As the Court of Appeals noted, “[t]he 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 contested liability.” *Coon*, 4 Wn. App. 2d at 752-53 (brackets added). There is no relevant distinction here that would warrant examining the facts of this case under a different lens.

³ While it argues that *Coon* must prove the fault of a third-party in order to invoke the “made whole” doctrine, GHO’s own policy language appears to require the fault of a third-party in order for GHO to have any subrogation or reimbursement rights. *See Coon*, 4 Wn. App. 2d at 742-43; 749-50 (noting that “[i]n view of Group Health’s position that the Clinic had no liability to *Coon*, one could reasonably infer that the Coons’ settlement did not impair any claim that Group Health might otherwise have pursued against the Clinic” (brackets added)).

More fundamentally, GHO overlooks the underlying purposes of an insurer's subrogation and reimbursement rights on the one hand and the made whole rule on the other. Subrogation typically implicates the interests of three parties: a "loss-causer," a "loss-victim," and the "loss-insurer." See Brendan S. Maher & Radha A. Pathak, *Understanding & Problematizing Contractual Tort Subrogation*, 40 Loy. U. Chi. L.J. 49, 54 (2008). It refers to "those remedies that permit the loss-insurer to recoup the indemnity it paid to the loss-victim." Maher & Pathak, 40 Loy. U. Chi. L.J. at 54.

The made whole doctrine was adopted to operate as a "counterbalance" to such rights, to ameliorate potentially harmful and inequitable effects on insureds. See Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 737 (2005). "The common law made whole doctrine is an equitable principle which generally limits the ability of an insurer to exercise its right of subrogation until the insured has been fully compensated or made whole." Parker, 70 Mo. L. Rev. at 737. To serve its equitable purpose, application of the made whole rule should generally track the scope of application of subrogation or reimbursement rights.

In this case, the policy afforded GHO reimbursement rights "for all benefits provided, from any amounts the [insured] received or is entitled to receive from any source." GHO Pet. for Rev. at 2 (brackets added). Consistent with *Thiringer*, the extent of GHO's rights under this provision should be governed by the made whole doctrine. This view captures the

Court's language in *Thiringer*, where it clarified that examination of an insurer's subrogation rights is "guided by the principle that a party suffering compensable injury is entitled to be made whole but should not be allowed to duplicate his recovery." 91 Wn.2d at 220.

GHO seizes on the use of the phrase "compensable injury" in *Thiringer* to urge that proof by the insured of a liable third-party is a predicate for application of the made whole rule. *See* GHO Supp. Br. at 10 (citing *Thiringer*, 91 Wn.2d at 219-20). However, this argument misapprehends the language in *Thiringer*. A similar argument was examined in *Sherry*. There, a pedestrian was hit by an automobile. He had PIP and UIM coverage with the same carrier. The insurer paid the PIP. The UIM claim was arbitrated, and it was determined the plaintiff was 70% at fault for his injuries. The arbitrator reduced the plaintiff's UIM recovery to reflect his percentage of fault. The UIM insurer then sought a full offset for the PIP benefits paid, claiming "full compensation" should be calculated based on what the plaintiff was legally entitled to recover. The court of appeals explained that a "compensable injury" under *Thiringer* means simply an injury for which an insured is entitled to receive compensation, which may be analyzed under tort or contract law, depending on the source of the compensation at issue:

FIC would have us assume that we should look to tort law concepts to determine what amount Sherry was entitled to recover in order to make him whole. . . . But we do not agree that this fault-based concept defines a compensable injury in the context of PIP. This case turns on contract law, not tort law. FIC contracted with Sherry to provide PIP coverage. We therefore look at the contract to

determine what was a compensable injury. In return for a separate PIP premium, FIC agreed to pay Sherry for his medical costs and lost wages regardless of fault. Even if Sherry were completely at fault for his injuries, FIC would have to pay the full PIP limits. In other words, because FIC had to compensate Sherry for injuries caused even by his own negligence, all of Sherry's damages, including those attributable to his 70 percent fault, are “compensable injuries.”

Sherry v. Financial Indem. Co., 132 Wn. App. 355, 370, 131 P.3d 922 (2006), *aff'd*, *Sherry v. Financial Indem. Co.*, 160 Wn.2d 611 (2007).⁴ The same may be said here. Coon’s policy provided no-fault medical coverage, entitling him to compensation for his injuries. Whether a third-party was separately liable for his injuries does not determine the existence or extent of his rights to be made whole under *Thiringer*, but defines instead only the extent of the rights he may have against that third-party. Coon’s injuries here were compensable under his policy with GHO, and he is entitled to be made whole before it may assert its reimbursement rights under that agreement.⁵

In this case, the Clinic paid the Coons the settlement amount “in order to resolve a questionable claim,” and in exchange for a release of “claims for bodily and personal injuries.” *See* Group Health Supp. Br. at 6; Coon Supp. Br. at 2. Whether additional discovery would have further developed a

⁴ In affirming the court of appeals, this Court’s holding in *Sherry* is consistent with the lower court’s analysis. This Court observed that the notion that an insured must be “legally entitled to recover” originated in the UIM statute, which is “unique among insurance.” It determined that phrase does not offer the proper measure for determining whether an insured has been fully compensated as contemplated by *Thiringer*. *See Sherry*, 160 Wn.2d at 622-23.

⁵ *Cook v. USAA Casualty Ins. Co.*, 121 Wn. App. 844, 90 P.3d 1154 (2004), relied upon by GHO, does not warrant a contrary conclusion. The facts of that case are somewhat anomalous, and as Coon points out, there are important distinctions between the facts in *Cook* and those before the Court here. *See* Coon Supp. Br. at 8-10. However, any suggestion that an insurer may retain subrogation proceeds before its insured is made whole would appear to be wholly inconsistent with *Thiringer*, and to the extent *Cook* can be read for that proposition, it should be disapproved.

liability claim against the Clinic is unknown. Defendants enter into settlement agreements to “purchase[] certainty by avoiding the risks of an adverse trial outcome – not to mention foregoing the expenses associated with a lengthy trial and appeal.” *Weyerhaeuser*, 142 Wn.2d at 673. Washington has a strong public policy of encouraging settlements. *Id.* at 674. Requiring a plaintiff to prove liability in a settled cause of action in order to foreclose an insurer’s reimbursement claim in a case where the plaintiff has not been “made whole” is an unnecessary exercise that would discourage settlement and deprive insureds of full compensation.

D. A Policy Provision Purporting To Entitle An Insurer To Full Reimbursement Rights For Breach Of A Notice Of Settlement Clause Should Be Enforceable Only If, And To The Extent That, The Insurer Can Prove It Has Been Prejudiced.

GHO argues the Court of Appeals erred in declining to strictly enforce its cooperation clause, which provided that if the insured failed “to cooperate fully with GHO in recovery of GHO’s Medical Expenses, the [insured] shall be responsible for directly reimbursing GHO for 100% of GHO’s Medical Expenses.” *Coon*, 4 Wn. App. 2d at 743 (brackets added). The court held GHO is entitled to a remedy for its insured’s breach only if, and to the extent that, it can show prejudice. *See Coon*, 4 Wn. App. 2d at 748 (citing *Tripp*, 144 Wn.2d at 16). The Court of Appeals correctly interpreted Washington law.

Generally, “if an insurer has not been prejudiced by a settlement and release, it cannot deny recovery on the policy.” *Thiringer*, 91 Wn.2d at 218 (citation omitted). This is consistent with the broader rule that “an insured that ‘substantially and materially’ breaches a cooperation clause is contractually barred from bringing suit under the policy if the insurer can show it has been actually prejudiced.” *Staples v. Allstate Ins. Co.*, 176 Wn.2d 404, 410, 295 P.3d 201 (2013) (emphasis added; citation omitted).

In *Staples*, the trial court granted summary judgment to an insurer that denied a claim under a homeowner’s policy based on the insured’s failure to cooperate with an insurer’s claim investigation. This Court reversed because the trial court did not require a showing of actual prejudice before dismissing the case. *See Staples*, 176 Wn.2d at 406, 421-22. The Court reviewed the law governing an insured’s duty to cooperate. *See id.*, 176 Wn.2d at 410-11, 418. It noted that some policies have general cooperation clauses, while others contain specific, enumerated duties. *Id.* The clauses concerning specific duties include requiring the insured to give notice of loss, to submit to an examination under oath, to submit to an independent medical examination, to provide notice of pending lawsuits, and to obtain the insurer’s consent before settling. *Id.* The insurer argued that its insured’s failure to comply with a requirement to give an examination under oath was “simply different” than a general duty to cooperate, so no showing of prejudice was required. *Id.* at 418. This Court disagreed:

But we see no meaningful difference. We have required a showing of prejudice in nearly all other contexts to prevent insurers from

receiving windfalls at the expense of the public and to avoid hinging relief on a discredited legalistic distinction. The same concerns apply equally to the [examination under oath] requirement.

Id. (Brackets added.)

The Court cited *Pub. Util. Dist. No. 1 v. Int'l Ins. Co.*, 124 Wn.2d 789, 803-04, 881 P.2d 1020 (1994), as an example of when it required the insurer to show prejudice for an insured's failure to comply with a clause requiring the insured to obtain the insurer's consent before settling. *See Staples*, 176 Wn.2d at 418, 421. In *PUD No. 1*, this Court commented on the insured's failure to obtain the insurer's consent before settlement:

Much like cooperation and notice clauses, a no-settlement clause contains a condition the insured must fulfill to create the insurer's obligation to pay under the policy. Such conditions... are clearly placed in policies to prevent the insurer from being prejudiced by the insured's actions. To release an insurer from its obligations without a showing of actual prejudice would be to authorize a possible windfall for the insurers.... Thus, we find an insurer cannot deprive an insured of the benefit of purchased coverage absent a showing that the insurer was actually prejudiced by the insured's noncompliance with conditions precedent such as those at issue in this case.

PUD No. 1, 124 Wn.2d at 803-04 (citation omitted).

In both *Staples* and *PUD No. 1*, the Court cited *Oregon Auto. Ins. Co. v. Salzberg*, 85 Wn.2d 372, 535 P.2d 816 (1975) as authority for the propositions that an insured's failure to comply with a cooperation clause releases the insurer from its responsibilities only if the insurer was actually prejudiced by the insured's actions, and that the insurer has the burden to prove prejudice. *See Staples*, 176 Wn.2d at 417; *PUD No. 1*, 124 Wn.2d at 803-04. In *Salzberg*, the Court reasoned:

The decisions of a majority of courts now simply require that the insurer demonstrate that it was prejudiced by the insured's actions before the cooperation clause will be considered breached so as to relieve the insurer from its obligations under the policy...

[I]nsurance policies, in fact, are simply unlike traditional contracts, *i.e.*, they are not purely private affairs but abound with public policy considerations.... It is manifest that this public policy consideration would be diminished, discounted, or denied if the insurer were relieved of its responsibilities although it is not prejudiced by the insured's actions or conduct in regard to its investigation or presentation and defense of the tort case. Such relief, absent a showing of prejudice, would be tantamount to a questionable windfall for the insurer at the expense of the public.

[W]e are convinced that sound public policy requires that an alleged breach of a cooperation clause may be considered substantial and material, and may affect a release of an insurer from its responsibilities *only* if the insurer was actually *prejudiced* by the insured's actions or conduct. The requirement of a showing of prejudice would pertain irrespective of whether the cooperation clause could be said to be a covenant or an express condition precedent and, in this regard, the burden of proof is upon the insurer.

Salzberg, 85 Wn.2d at 376-77 (brackets added).

GHO cites *Tran v. State Farm Fire & Cas. Co.*, 136 Wn.2d 214, 961 P.2d 358 (1998) for the proposition that GHO is not required to prove it was prejudiced. *See* Pet. for Rev. at 16-17. In *Staples*, this Court noted that in *Tran* it reaffirmed "that noncooperation does not absolve an insurer of liability unless the insurer was actually prejudiced." 176 Wn.2d at 417-18 (citing *Tran*, 136 Wn.2d at 228). Like GHO in the present case, in *Staples* Allstate cited *Tran* in support of its argument that it was prejudiced as a matter of law. *See Staples*, 176 Wn.2d at 419-20. While acknowledging that *Tran* was an "extreme case" in which it found prejudice as a matter of law, the Court placed its holding in *Tran* in its proper context:

We should not allow the result in *Tran* to overshadow the rule established by that case, which is that an insurer must show actual prejudice, which is “seldom... established as a matter of law” and requires the insurer to produce “affirmative proof of an advantage lost or disadvantage suffered....”

Instead of reading *Tran* to create a per se rule relieving the insurer of its burden, we require affirmative proof of prejudice as we did in *Public Utility District No. 1*. There, we refused to establish prejudice as a matter of law while applying *Salzberg* by analogy to a consent-to-settle clause.... We reiterated that the burden to affirmatively show prejudice is on the insurer, and that prejudice is a fact issue. We also stated the policy reason behind this rule: insurers should not get a windfall at the insured’s expense.

Staples, 176 Wn.2d at 420-21 (citations omitted).

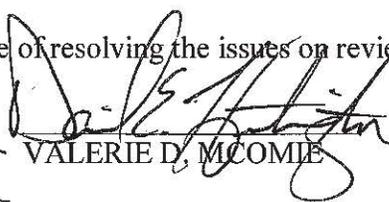
In *Mutual of Enumclaw v. USF*, *supra*, this Court examined the prejudice requirement, and held that to show prejudice, an insurer must establish that breach of a notice provision by an insured “had an identifiable and material detrimental effect on [the insurer’s] ability to defend its interests.” *Mutual of Enumclaw*, 164 Wn.2d at 430 (brackets added). This is a “flexible” rule that may turn on a “variety of factors,” and will manifest differently depending on the particular circumstances and the prejudice claimed. *See id.*, 164 Wn.2d at 429, 430. The Court recognized that this approach “effectuates the longstanding *Salzberg* rule that the insurer has the burden of proving actual and substantial prejudice.” *Id.* at 430-31.

Here, GHO made no attempt to prove it was prejudiced by Coon’s alleged breach of the notice provision. Instead, GHO claims that Coon’s failure to strictly comply entitles it to a recovery otherwise unavailable to GHO: 100% reimbursement of medical expenses paid. It claims this benefit without proving that Coon was made whole by his settlement, without

proving that GHO was prejudiced by the breach, and without providing any equitable contribution toward attorney fees and expenses Coon incurred to obtain the settlement. GHO's desired remedy violates the policy behind the rule that an insurer must affirmatively show prejudice – "insurers should not get a windfall at the insured's expense." *Staples*, 176 Wn.2d at 421.⁶

VI. CONCLUSION

The Court should adopt the analysis advanced in this brief in the course of resolving the issues on review.

for 
VALERIE D. MCOMIE


DANIEL E. HUNTINGTON

On behalf of
Washington State Association for Justice Foundation

⁶ Relying on *Loc Thien Truong v. Allstate Prop. & Cas. Ins. Co.*, 151 Wn. App. 195, 211 P.3d 430 (2009), GHO argued at the Court of Appeals that the settlement constitutes evidence of full compensation. *See* GHO Resp. Br. at 15. In *Tripp*, this Court clarified that settlement for less than policy limits does not raise a presumption of full compensation "or otherwise prejudice[] the insured's PIP benefits." 144 Wn.2d at 22 (brackets added). GHO does not appear to revisit this argument on review to this Court, instead maintaining that *Thiringer* does not apply and Coon is not entitled to be made whole.

APPENDIX

Legislative finding.

The legislature finds and declares that there is a paramount concern that the right of the people to obtain access to health care in all its facets is being impaired. The legislature further finds that there is a heavy reliance by the public upon prepaid health care service agreements and insurance, whether profit or nonprofit, as the only effective manner in which the large majority of the people can obtain access to quality health care. Further, the legislature finds that health care service agreements may be anticompetitive because of the exclusion of other licensed forms of health care and that because of the high costs of health care, there is a need for competition to reduce these costs. It is, therefore, declared to be in the public interest that these contracts as a form of insurance be regulated under the police power of the state to assure that all the people have the greatest access to health care services.

[**1983 c 286 § 1.**]

NOTES:

Severability—1983 c 286: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [**1983 c 286 § 5.**]

CERTIFICATE OF SERVICE

I hereby declare under penalty of perjury, under the laws of the State of Washington, that on the 15th day of April, 2019, I served the foregoing document by email to the following persons:

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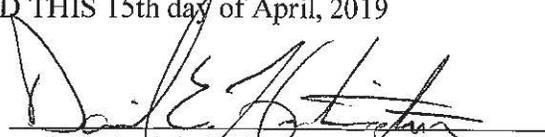
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