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No. 96516-1

SUPREME COURT
OF THE STATE OF WASHINGTON

GROUP HEALTH COOPERATIVE,
a Washington nonprofit corporation,

Petitioner,

v.

NATHANIEL COON and LORI COON,
husband and wife,

Respondents.

PETITIONER'S ANSWER TO BRIEF OF WSAJ AMICUS CURIAE

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I. INTRODUCTION

Both the “made whole” doctrine and the requirement that an insurer show prejudice before it can deny coverage based on an insured’s breach of the cooperation or notice requirements of an insurance contract reflect a policy decision to ensure that insureds receive the benefits of an insurance policy intended to provide protection from the risk of loss the insurer agreed to cover.

Here, amicus WSAJ encourages this Court to adopt an unwarranted expansion of both these doctrines that, implemented together, would only penalize a health care services provider that never denied coverage and that scrupulously adhered to its obligations under its coverage agreement.

Worse, adopting WSAJ’s position would instead (as in this case) encourage the deliberate violation of the contractual obligations of the insured member, and the ethical duties of the member’s attorney holding settlement funds that could satisfy subrogation and reimbursement obligations to the member’s health care services provider, inevitably leading (as in this case) to collateral litigation over both the “made whole” and “prejudice” requirements that were instead intended to facilitate final, fair settlement of tort claims.

II. ARGUMENT

A. The “made whole” doctrine does not apply to a health care service provider’s contractual claim for reimbursement from a settlement that does not exhaust the policy limits of a third party that its member insured claims is not liable in tort.

The “made whole” doctrine allows an insured to be fully compensated from a tortfeasor before being compelled to reimburse an insurer for sums paid to cover its insured’s loss. Amicus’ overview of Washington’s made whole doctrine omits critical case law that limits its scope and application to further the doctrine’s purpose. The made whole doctrine has been applied only when the insured recovers 1) from a liable tortfeasor 2) whose assets are exhausted before the insured is fully compensated for his injuries. Neither of those conditions are met here. The “made whole” doctrine does not apply to this case, where after settlement the Coons consistently argued no tortfeasor exists, and in any event the Coons’ \$2.37 million settlement did not exhaust the settling Everett Clinic’s assets.

This Court promulgated the “made whole” doctrine in *Thiringer v. American Motors Ins. Co.*, 91 Wn.2d 215, 216-17, 588 P.2d 191 (1978), a PIP coverage case in which the insured recovered policy limits in a settlement from the tortfeasor responsible for his

damages. His PIP insurer refused to provide coverage even though plaintiff claimed his general damages exceeded his policy limits recovery. The *Thiringer* Court recited and adopted the made whole doctrine against this factual backdrop:

The general rule is that, while 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, it can recover only the excess which the insured has received from the wrongdoer, remaining after the insured is fully compensated for his loss.

91 Wn.2d at 219-20 (citing cases and authorities).

“Washington courts have applied the *Thiringer* rule only when a third party is liable to the insured.” *Cook v. USAA Cas. Ins. Co.*, 121 Wn. App. 844, 848, 90 P.3d 1154 (2004). Since *Thiringer*, the “made whole” doctrine has been consistently applied based on the third party’s legal liability:

In this case, there is a liable third party, the uninsured motorist who hit Sherry. And the arbitrator found that motorist 30 percent at fault. Therefore, Sherry suffered a compensable injury and is entitled to be made whole under the full compensation rule.

Sherry v. Financial Indem. Co., 132 Wn. App. 355, 369, 131 P.3d 922 (2006), *aff’d and remanded*, 160 Wn.2d 611, 160 P.3d 31 (2007). “The *Thiringer* full compensation rule has never been applied in situations where there was no liable third party,” *Cook*,

121 Wn. App. at 848, and amicus points to no subrogation case where the made whole doctrine applied in the absence of a liable third party. Such a holding would conflict with and signal a sharp departure from the Washington courts' subrogation case law to date.

The Court of Appeals erroneously disregarded this principle recognized in *Cook*, which was a homeowner's insurance case and where the "made whole" doctrine was inapplicable because there was no liable tortfeasor. Petitioner Group Health is not arguing that the made whole doctrine applies only to PIP and UIM policies, as amicus claims (Amicus 8), but that the doctrine cannot be applied where its policy principle – that of assuring that victims of wrongdoing receive full compensation from tortfeasors – is not furthered or even implicated. When, as here, the member insured asserts that he agreed to a settlement because he could not prove liability, there is no analytical or policy reason for the made whole doctrine to be applied to prohibit his health care service provider from asserting its reimbursement right under the health services contract.

Further, in *Thiringer* the critical fact that led this Court to conclude the insured had no duty to reimburse its insurer was that

the insured settled for policy limits that did not satisfy the total claims of the insured and insurer. 91 Wn.2d at 218. In other words, an inadequate pool of funds existed in *Thiringer*. But when an adequate pool of funds is available but not exhausted by the insured, the “made whole” doctrine does not apply. For instance, because the insurer was entitled to reimbursement when sufficient funds existed to satisfy both the insured’s and insurer’s claims but the insured had settled for less than policy limits, the Court of Appeals reversed a trial court decision denying the insurer’s subrogation claims in *Peterson v. Safeco Ins. Co. of Illinois*, 95 Wn. App. 254, 257, 976 P.2d 632 (1999).¹

As in *Peterson*, it is undisputed here that an adequate pool of funds existed to satisfy the total of both Group Health’s and Coon’s claims. Group Health paid \$372,000 of Mr. Coon’s medical expenses

¹ In *Liberty Mut. Ins. Co. v. Tripp*, 144 Wn.2d 1, 22, 25 P.3d 997 (2001), this Court disagreed with the presumption mentioned in *Peterson* that settlement “for less than the tortfeasor’s limits of liability raises a presumption that the insureds have been made whole,” but not with its conclusion that a settlement for less than policy limits can make an insured whole, and trigger a right to subrogation or reimbursement. See *Truong v. Allstate Property and Cas. Ins. Co.*, 151 Wn. App. 195, 205, ¶ 22, 211 P.3d 430 (2009) (“*Peterson* shows that a settlement with a tortfeasor for less than limits is evidence that the PIP recipient received full compensation.”). See also *Leader Nat. Ins. Co. v. Torres*, 113 Wn.2d 366, 373, 779 P.2d 722 (1989) (“The settlement between the insured and the tortfeasor was a compromise and represents what the case was worth to the insured without having to endure a trial.”).

and gave the Coons the opportunity to settle their claim against and recover Group Health's subrogation claim. The Coons were not forced to settle for less than full compensation; instead, they freely accepted the settlement in an arms-length transaction, but now claim that they knew they could not pursue litigation.

The question of full compensation does not arise because the Coons did not exhaust the Everett Clinic's assets, knowingly deprived Group Health of its reimbursement right, and have consistently asserted that there was no third party tortfeasor from whom it was entitled to be "made whole."² *Peterson*, 95 Wn. App. at 260 ("[T]he question whether an insured has been fully compensated does not arise until assets, or at least those assets readily accessible through a liability policy, have been exhausted."). Because the "full

² See, e.g., Court of Appeals Cause No. 76365-2-I, Appellant's Opening Brief 8 ("it was not possible to develop a theory of liability on the part of the [Everett] Clinic"); Appellants' Corrected Reply Brief 5 (relying on Coons' "inability to establish liability"); January 9, 2018 oral argument at minute 3:14 ("We felt ourselves that we did not have sufficient evidence to file a lawsuit because we didn't have an expert witness") and minute 6:16 ("Well, as a realistic matter, if you don't have an expert witness in a medical malpractice case that's credible, you can't bring that lawsuit. It's improper to bring it. . . . They didn't know that we were not going to bring a lawsuit. I mean, we were obviously playing some games with them to some extent in terms of the mediation that we held. But we did not have a valid theory . . ."). http://www.courts.wa.gov/appellate_trial_courts/appellateDockets/index.cfm?fa=appellateDockets.showOralArgAudioList&courtId=a01&docketDate=20180109

compensation” rule does not apply here, whether the Coons have been made whole is not a material issue of fact. *Dowler v. Clover Park Sch. Dist. No. 400*, 172 Wn.2d 471, 484, 258 P.3d 676 (2011) (genuine issue of material fact for purposes of CR 56 is one upon which the outcome of litigation depends).

As Amicus concedes (Amicus 7), the purpose of subrogation is to impose liability on the party responsible in law for the insured’s loss. *Mahler v. Szucs*, 135 Wn.2d 398, 414-15, 957 P.2d 632 (1998), *overruled on other grounds by Matsyuk v. State Farm Fire & Cas. Co.*, 173 Wn.2d 643, 272 P.3d 802 (2012). The Everett Clinic paid the Coons \$2.37 million, but the Coons now claim the Everett Clinic would not be liable for their loss. “Since the [insureds] did not suffer compensable injury, they bear the risk of loss.” *Cook*, 121 Wn. App. at 849 (alteration added). This should be dispositive of the claim that the Coons are not obliged to fulfill their obligation under the health services contract, under which Group Health provided Coon no-fault medical coverage and had no-fault reimbursement rights.

In denying Group Health its contractual right to reimbursement, the Coons do not claim that they were unable to obtain full compensation from a tortfeasor for a cognizable claim,

but that there was *no* liable tortfeasor. The Coons received the full benefit of their medical coverage agreement when Group Health paid Coon's medical expenses, *and* received funds from another source for those same expenses. "[I]nsureds are not entitled to double recovery." *Sherry v. Fin. Indem. Co.*, 160 Wn.2d 611, 618, ¶ 12, 160 P.3d 31 (2007). Consistent with *Sherry*, the health services contract provides that Group Health's responsibility is secondary to *any source* that pays for Mr. Coon's injuries, and that Group Health has a right to be reimbursed from amounts received from any source:

B. Subrogation and Reimbursement Rights

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

(CP 454) When the Coons received funds from the Everett Clinic, Group Health's payments became secondary and Group Health's

right to reimbursement was triggered under the terms of the medical coverage agreement.

Moreover, the Coons cannot be heard to say their recovery from the Everett Clinic did not include medical expenses where they knowingly deprived Group Health of its rights by fully releasing the Everett Clinic. *See Metropolitan Life Ins. Co. v. Ritz*, 70 Wn.2d 317, 422 P.2d 780 (1967). The “made whole” doctrine does not apply to a health care service provider’s contractual claim for reimbursement from a settlement, reached without notice to the provider, that does not exhaust the policy limits of a third party that its member insured after the settlement claims would not be liable in tort.

B. A health care service provider that has fully complied with its contractual obligations need not prove prejudice to enforce its reimbursement rights against a member insured who breached the policy.

Regardless whether the *Thiringer* “made whole” doctrine applies, the Coons’ breach of the medical coverage agreement and their attorney’s improper release of funds held as an escrow renders the doctrine contractually and equitably unenforceable. The rule proposed by Amicus, under which an insurer or health care contractor must prove that an insured has fully recovered all compensable damages from a third party liable in tort as a

predicate to exercising its right to reimbursement (Amicus 15) would only encourage an insured's violation of the duty of good faith, and counsel's breach of the Rules of Professional Conduct. Under the Coons' medical coverage agreement, as a result of the Coons' failure to cooperate Group Health instead is entitled to 100% reimbursement of the medical expenses it paid and has no obligation to prove prejudice.

The Legislature has imposed upon "all persons" involved in the business of insurance, "the insured," as well "their providers, and their representatives," the mandate to "be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters." RCW 48.01.030. Washington courts regularly enforce cooperation clauses in insurance cases without proof of prejudice. *See, e.g., Tran v. State Farm Fire & Cas. Co.*, 136 Wn.2d 214, 224, 961 P.2d 358 (1998) (reversing Court of Appeals' decision that there was a material factual issue whether insurer was prejudiced by insured's refusal to provide relevant financial records and entering judgment for insurer); *Koontz v. General Cas. Co. of America*, 162 Wash. 77, 81, 297 P. 1081 (1931) (directing judgment for insurer where insured breached policy provision requiring that he "not voluntarily assume liability, settle any claim or incur any

liability, without the written consent of his insurer”); *Pilgrim v. State Farm Fire & Cas. Ins. Co.*, 89 Wn. App. 712, 719, 950 P.2d 479 (1997) (insurer prejudiced as a matter of law where insured homeowners refused to disclose relevant financial documents).

The public policy against fraud, dishonesty, and collusion reflected in RCW 48.01.030 is furthered by such contractual obligations of disclosure and cooperation:

Conditions of this sort in an insurance policy are not without reason in their support. They are intended to prevent collusion between the person assured and the party claimed to have suffered damages at the hands of the assured, and to prevent the possibility of such an occurrence the insurer may guard against it in its contract with the assured, and hold the assured to a reasonably strict compliance with the terms of the contract.

Koontz, 162 Wash. at 81.

This is a provision for the benefit of the insurer, to prevent it from being imposed upon by scheming and dishonest men,— a provision which they have a right to incorporate in their policy, and a very necessary one for their protection.

Georgian House of Interiors v. Glens Falls Ins. Co., 21 Wn.2d 470, 494, 151 P.2d 598 (1944) (emphasis omitted).

The Pilgrims’ homeowner’s insurance policy requires that they cooperate with State Farm by providing it with requested records and documents as often as it reasonably requires. Such clauses are generally enforceable. They deter fraud, and facilitate proper adjusting decisions by insurers. Not only have such

clauses long been included in insurance policies, the Washington State legislature also recently required insurers to do more to root out fraud.

Pilgrim, 89 Wn. App. at 719. There is no authority, or principle of public policy, supporting a limitation of the insured's statutory duties to first party casualty insurance, nor prohibiting a health care service provider from relying on the provisions of its medical coverage agreement requiring the cooperation of its member insured in protecting its reimbursement rights.

The Coons failed to cooperate with Group Health in its efforts to recover the medical expenses it had paid, and settled with the Everett Clinic without protecting Group Health's interest. They fully released the Everett Clinic from all claims related to his injuries in a Settlement Agreement and Release that affirmatively required them to satisfy subrogated and reimbursement rights. They then failed to hold the full amount of Group Health's medical expenses in trust despite 1) knowing that Group Health had a claim for \$372,000 and a right to be reimbursed from funds received by the Coons from any source, 2) knowing the funds were disputed, and 3) knowing the funds could not be disbursed until the dispute with Group Health was resolved.

In addition to the Coons' obligations under the Medical Coverage Agreement and their Settlement Agreement and Release with the Everett Clinic, the Rules of Professional Conduct obligated their counsel to safeguard these funds:

(g) If a lawyer possesses property in which two or more persons (one of which may be the lawyer) claim interests, the lawyer must maintain the property in trust until the dispute is resolved. The lawyer must promptly distribute all undisputed portions of the property. The lawyer must take reasonable action to resolve the dispute, including, when appropriate, interpleading the disputed funds.

RPC 1.15A(g). *See* Comment [2] of the Washington Comments to RPC 1.15A “Client funds include, but are not limited to, . . . funds received on behalf of a client, funds to be paid by a client to a third party through the lawyer, [and] other funds subject to attorney and other liens”).

Amicus offers no case law requiring an insurer to prove prejudice for breach of a cooperation clause. Instead, proof of prejudice is not required. The penalty in the health services contract for failing to cooperate is not unfair; to refuse to enforce it, as Amicus proposes (Amicus 15) would provide yet another perverse incentive for policyholders and their counsel to fail to comply with their contractual and ethical duties.

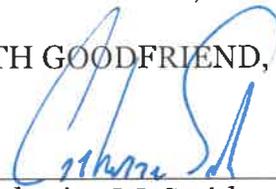
III. CONCLUSION

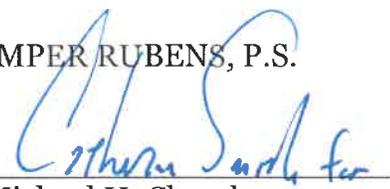
The “made whole” doctrine does not shield respondents from their contractual duties or the contractual consequences of their failure to cooperate in protecting their health care service provider’s reimbursement rights in receiving funds from a third party respondents asserted after settlement would not be liable in tort. On appeal, respondents did not challenge the trial court’s correct conclusion that they breached their duties to cooperate fully with Group Health in recovery of its medical expenses. This Court should reject Amicus’ invitation to use this case as a vehicle to dramatically expand application of both the “made whole” and “prejudice” requirements to a health care service provider that has fully complied with its contractual obligations. Petitioner Group Health is entitled to reimbursement of 100% of the medical expenses it paid.

Dated this 17th day of May, 2019.

SMITH GOODFRIEND, P.S.

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DECLARATION OF SERVICE

The undersigned declares under penalty of perjury, under the laws of the State of Washington, that the following is true and correct:

That on May 17, 2019, I arranged for service of the foregoing Petitioner's Answer to Brief of WSAJ Amicus Curiae, to the court and to the parties to this action as follows:

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DATED at Seattle, Washington this 17th day of May, 2019.



Sarah N. Eaton

SMITH GOODFRIEND, PS

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