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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.

SUPPLEMENTAL BRIEF OF RESPONDENTS

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I. INTRODUCTION

The trial court improperly granted summary judgment on a disputed fact question: whether a health insurance company had proven that its policyholders were fully compensated by a personal injury settlement so as to justify reimbursement of some or all of its payments out of the settlement. The insurer asks this Court to overturn 40 years of case law and—simply because the policyholders had a weak case—give the insurer an automatic recovery of its payments, with interest, without its ever proving that the policyholders were fully compensated. The Court of Appeals correctly held that this would violate the made-whole rule, decades of this Court's decisions, and the specific terms of the insurance contract in this case. Because the insurer never met its burden to establish full compensation—the prerequisite to reimbursement—this Court should affirm the Court of Appeals' reversal of the trial court and remand.

II. STATEMENT OF THE CASE

Nathaniel Coon had anterior cruciate ligament surgery on his right knee on March 1, 2012, at the Everett Clinic (Clinic). CP 151. This should have been a straightforward surgery, but Coon developed a serious fungal infection requiring amputation of his right leg above the knee. *Id.* The Coons' health insurer, Group Health Options, Inc. (GHO) paid $372,634.07 in medical expenses arising out of the infection. CP 486.

The amputation exposed the Coons to an estimated $3.3 million in future medical costs. CP 174. It devastated Mr. Coon's successful landscaping business. At the time of mediation, the Coons had lost $211,726 in past profits and $70,864 in additional payroll. They estimated future lost profits up to $3.4 million, and future additional payroll up to $3.3 million. CP 211. The Coons have general damages from impairment of family and recreational activities. CP 241–48.

On its own initiative, the Clinic paid the family "$322,645.72 in uncompensated medical expenses, travel and accommodations." CP 160.

The Coons retained counsel to investigate possible legal claims. CP 353. In pre-suit mediation, the Coons had "several hypothetical theories about how the fungal infection was acquired." CP 145. Without having pinpointed a cause, however, "[b]asically, at this point [the Coons had] a *res ipsa loquitur* case." CP 145. The Clinic denied the claims, arguing Coon most likely "was the carrier of the fungal SP spores" given his "occupation as a landscaper." CP 159.

On April 25, 2014, the Coons and the Clinic settled for an additional $2 million. CP 256. The settlement covered all damages, including "claims for bodily and personal injuries." CP 254. The Coons made no concessions about reimbursement due to GHO, but agreed to "pay, resolve or otherwise fully satisfy all such claims or liens." *Id.*

Nothing in the settlement suggests that the Clinic's payments duplicated benefits GHO had paid.

GHO's contract included a section on subrogation and reimbursement. CP 343–44. The contract incorporated the made-whole rule expressly. CP 343. It required the Coons to give notice to GHO of a "tentative settlement," and to refrain from settling "without protecting GHO's interest." *Id.* In case of dispute, it authorized the Coons to hold disputed funds "in a separate identifiable account." CP 344.

The settlement occurred on a Friday. The following Monday, April 28, 2014, the Coons' counsel informed GHO, asking it to waive reimbursement based on the made-whole rule. CP 253. GHO replied that Coon was "fully compensated," based on his having "freely entered into a voluntary settlement." CP 486. GHO argued it was Coon's burden to show "that his damages were greater than the amount he settled for." *Id.*

On June 9, 2014, counsel replied that the Coons' damages were in the $8–$12 million range. CP 488. Counsel explained a lawsuit would require a viable theory. He stated, "unless discovery in the lawsuit produced different facts and evidence, a motion for summary judgment likely would have resulted in dismissal. CP 489. As a result, the Coons "were not even close to being 'made whole.'" *Id.*

Eighteen months later, GHO filed this action. CP 499. Despite its June 3, 2014 position that the Coons had been made whole, GHO admitted it never learned the extent of the Coons' damages. Besides the medical bills, GHO had "no knowledge" of "any other special damages." CP 133. The Coons provided analyses by attorneys Todd Gardner and Kathy Cochran. CP 349–61; CP 363–69. Both concluded the settlement fell well short of the Coons' damages. CP 356, 367.

Making no inquiry into the Coons' damages, the trial court ruled that the Coons' accepting the settlement automatically deemed them fully compensated. CP 512. The trial court ruled the Coons breached the contract, CP 514–16, and entered a judgment for GHO awarding $372,634.07 in reimbursement, an additional $109,401.31 in prejudgment interest, and post-judgment interest accruing at 12%, CP 4.[1]

III. ARGUMENT

A. The made-whole rule required GHO to show the Coons were fully compensated.

GHO's position in the trial court—and the basis for summary judgment—was that the Coons *were* fully compensated as matter of law.

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[1] Pre-judgment interest was improper, because it is allowed only when a claim can be determined with precision. *Prier v. Refrigeration Eng'g Co.*, 74 Wn.2d 25, 32, 442 P.2d 621 (1968). The determination of what part, if any, of the Coons' settlement duplicated medical expenses that GHO had paid cannot be made with precision. Because establishing an excess recovery, including the extent of the excess, is a prerequisite to GHO's claim, pre-judgment interest was inappropriate. Medical bills are not liquidated sums. *Hansen v. Rothaus*, 107 Wn.2d 468, 477, 730 P.2d 662 (1986).

CP 486, 512. In this Court, GHO argues that the made-whole rule *does not apply*. GHO is wrong on both counts. The made-whole rule applies and whether GHO can establish full compensation is a question of fact.

1. Under Washington's made-whole rule, reimbursement is allowed only to the extent necessary to prevent a double recovery.

In *Thiringer v. Am. Motors Ins. Co.*, 91 Wn.2d 215, 219, 588 P.2d 191 (1978), this Court announced the rule that controls here:

> 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.

The rule is grounded in equity. It balances the interests of the insurer and the insured by providing that "a party suffering compensable injury is entitled to be made whole but should not be allowed to duplicate his recovery." *Id.* at 220. As a result, policyholders in Washington retain recoveries up until the point of duplication.[2]

The *Thiringer* court found "nothing in the language of the policy to indicate that the parties agreed that a different principle would apply." *Id.*

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[2] GHO asserts a *reimbursement* right to be paid out of the recovery the Coons obtained. This is distinct from a *subrogation* right, which would allow GHO to "step into the shoes" of the Coons to pursue a claim but require GHO to prove the claim, which it never did. *See Mahler v. Szucs*, 135 Wn.2d 398, 419–20, 957 P.2d 632 (1998). The made-whole rule applies to both reimbursement and subrogation. Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 Loy. U. Chi. L.J. 49, 64–65 (2008) (footnotes omitted).

at 220. But such a provision "would be obviously unfair," the Court said, because the made-whole rule was one of public policy, "in that it fosters the adequate indemnification of innocent automobile accident victims." *Id.* Both as a matter of equity and under the Coons' policy, CP 343, the *Thiringer* rule "determine[s] the priorities, as between an insurer and its insured, in the proceeds of a settlement." 91 Wn.2d at 216.

Since *Thiringer* was decided 40 years ago, the Court has endorsed a broad application of the made-whole rule as a fundamental policy. In *Brown v. Snohomish Cty. Physicians Corp.*, 120 Wn.2d 747, 845 P.2d 334 (1993), the Court relied on *Thiringer* to void a health-insurance exclusion, rejecting a narrow reading of the made-whole rule:

> The Court of Appeals reads *Thiringer* too narrowly. As we expressly observed in *Keenan v. Industrial Indem. Ins. Co. of Northwest*, 108 Wn.2d 314, 319, 738 P.2d 270 (1987) "[t]he key factor" in *Thiringer* was "the presence or absence of double recovery," not subrogation principles or premiums.

120 Wn.2d at 755–56. The rule is "settled Washington law." *Leingang v. Pierce Cty. Med. Bureau, Inc.*, 131 Wn.2d 133, 138 n.2, 930 P.2d 288 (1997). It is the state's "general public policy," permitting reimbursement only "[*p*]*rovided* the insurer recognizes the public policy in Washington of full compensation of insureds." *Mahler*, 135 Wn.2d at 436 (emphasis added). This accords with "the great majority of jurisdictions." *Id.* at 417.

The insurer bears the burden to establish full compensation. *Liberty Mut. Ins. Co. v. Tripp*, 144 Wn.2d 1, 21, 25 P.3d 997 (2001).

Thiringer explicitly grounded the made-whole rule in the prohibition against double recovery. 91 Wn.2d at 219–20. This is echoed by the leading treatises on insurance. *See* 16 Couch on Insurance 3d, § 222:8 (explaining that the doctrine of subrogation "has the objective of preventing the insured from recovering twice for one harm"); 6A John A. Appleman, Insurance Law & Practice § 4054 (Rev. ed. 1975)), at 143 (noting that the doctrine rests on maxim that no one should be enriched by another's loss).[3]

Because the rationale for allowing recoupment by the insurer is based on preventing a double recovery, it follows that there is no justification for recoupment in the absence of a double recovery.

As *Thiringer* recognized, it would be inequitable to require an insured who has not been made whole to reimburse the insurer. This is true whenever some losses resulting from a casualty are covered by

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[3] Because of the precondition of duplicate recovery, most courts refused any reimbursement to health insurers from personal injury settlements well into the 20th century. "Legal 'compensation' for personal injuries does not actually compensate." *Hudson v. Lazarus*, 217 F.2d 344, 346 (D.C. Cir. 1954). This Court has observed, "[t]he truth is, very few cases result in plaintiff obtaining exactly one full recovery, no more and no less." *Washburn v. Beatt Equip. Co.*, 120 Wn.2d 246, 297, 840 P.2d 860 (1992). Critics have argued that health insurance recovery from injury settlements amounts to a windfall for the insurer. *See, e.g.*, Roger M. Baron, *Subrogation: A Pandora's Box Awaiting Closure*, 41 S.D. L. Rev. 237, 242 (1996).

insurance, but others are not. The insured has paid "a premium for the [] coverage and has a right to expect that the payments promised under this coverage will be available to him if the amount he is able to recover from other sources, after diligent effort, is less than his general damages." *Thiringer*, 91 Wn.2d at 220. If the insured never obtains a recovery duplicating the insurer's payment, then there is no equitable basis to reimburse the insurer.

2. The made-whole rule applies to any recovery obtained by the insured, regardless of the fault of the payor.

GHO asserts, however, that *Thiringer* does not apply, citing *Cook v. USAA Cas. Ins. Co.*, 121 Wn. App. 844, 90 P.3d 1154 (2004). In *Cook*, the Cooks claimed property and other damage resulting from a gas water heater, which they contended third parties had negligently installed. 121 Wn. App. at 846. The Cooks' homeowners' insurer, USAA, paid policy limits to the Cooks. *Id.* Meanwhile, the Cooks asserted claims against the third parties they contended were responsible for the loss. *Id.* While the Cooks litigated their claim, USAA "sold" its subrogation interest to one of the third parties in exchange for $126,000. *Id.* The Cooks lost at trial—and recovered nothing. *Id.* at 847.

The Cooks filed a new lawsuit, this time against USAA, citing *Thiringer* to support a claim seeking the proceeds from USAA's sale of its

subrogation rights. *Id.* The Court of Appeals dismissed this claim, allowing USAA to retain its settlement with the third party. The court concluded—and it is this language on which GHO relies—that "the *Thiringer* subrogation rule favoring full compensation of insureds over subrogation rights of insurers does not apply [] because there is no third party liable to the insured." 121 Wn. App. at 846. GHO asks to apply this language to the Coons' settlement, arguing that because the Coons' liability theory was tenuous, the Clinic was not truly a liable third party.

Cook is distinguishable for many reasons, but the most significant is that unlike in this case, there was a final adjudication of nonliability. The insured never made a recovery to which the *Thiringer* priority rule could apply. In contrast, the Coons recovered a settlement with both liability and damages disputed. The Coons' situation is analogous to *every* settlement to which the *Thiringer* priority rule has been applied in the last 40 years. There is no reason to treat the Coons' settlement any differently.

The context of *Cook* also makes clear that the import of the Court of Appeals' comment is that *Thiringer* did not apply because there was no third party liable *to pay a recovery to the insured.* The *Cook* court used the term "liability" to mean simply any settlement. *Cook* distinguished *Mahler*, *Winters v. State Farm Mut. Auto. Ins. Co.*, 144 Wn.2d 869, 31 P.3d 1164 (2001), and *Safeco Ins. Co. v. Woodley*, 150 Wn.2d 765, 82

P.3d 660 (2004), saying that "[t]he common denominator of all these cases is third party liability." 121 Wn. App. at 849. But *Mahler* and *Winters* arose out of settlements, in which liability was never determined. *See Mahler*, 135 Wn.2d at 407; *Winters*, 144 Wn.2d at 873. When the rationale of reimbursement to prevent double recovery is also considered, *Cook*'s inapplicability to the present facts becomes all the more clear: no party in *Cook* enjoyed a double recovery, and so equity was not called upon to act. But only a double recovery would justify reimbursement to GHO here. The trial court erred by not requiring GHO to establish one.

Cook is distinguishable in additional ways, which is not surprising given that it involved "unusual facts." *Grp. Health Coop. v. Coon*, 4 Wn. App. 2d 737, 751, 423 P.3d 906 (2018), *review granted*, 433 P.3d 812 (Wash. 2019). In *Cook*, the insurer devoted its own resources to making its own recovery, making it clear that the recovery offset *only* losses the insurer had paid as opposed to the insured's other losses. The Cooks sought to transform *Thiringer* from a shield into a sword, seeking to make a new cause of action to serve as a "backup," where their own decision to go to trial had resulted in no recovery. In contrast, GHO relied on the Coons to obtain the recovery and now asks to recoup 100% of what it paid even as the Coons are recovering only a small fraction of millions of dollars in uninsured business, medical, and personal losses.

Last, GHO's argument that the priority rule applies only if there is a liable tortfeasor is inconsistent with this Court's decisions and standard treatises. *Thiringer* makes the made-whole inquiry depend on whether the insured obtained a recovery duplicating the insurer's payment "from other sources." 91 Wn.2d at 220. In *Leingang*, the court explained that the rule applies when the insured makes a recovery from "more than one source." 131 Wn.2d at 138 n.2. A tortfeasor is merely one example of a potential source of recovery. *Id.* Traditional equitable principles hold that the priority rule applies to a recovery from *any* third party, including but not limited to *tortfeasors*: a double recovery occurs only "when an injured beneficiary recovers money from both his insurer and *a third party, such as a tortfeasor, for the same loss*, for example, medical expenses." 4 G. Palmer, *Law of Restitution* § 23.16(b), at 444 (1978) (emphasis added).

For purposes of applying the *Thiringer* rule, there is no justification for treating one recovery differently from another.

3. The policyholder is not automatically deemed fully compensated merely by entering into a settlement.

Because *Thiringer* does apply, the next question is whether GHO proved the Coons were fully compensated—and obtained a recovery duplicating GHO's payments. Ignoring the Coons' damages evidence, GHO argued in the trial court that their accepting a settlement deemed

them fully compensated as a matter of law. But in *Tripp*, this Court *rejected* "the position that settlement for less than the tortfeasor's policy limits somehow raises a presumption of full compensation." 144 Wn.2d at 22. In *Tripp*—as in *Thiringer*—this Court remanded to determine the injured party's total damages. *Id.* at 23. The same must occur here.

GHO relies on *Loc Thien Truong v. Allstate Prop. & Cas. Ins. Co.*, 151 Wn. App. 195, 211 P.3d 430, 433 (2009). *Truong* supports the Coons. GHO argued, and the trial court ruled, that the Coons were fully compensated because, as the insured did in *Truong*, they "freely accepted an arms-length settlement from [a third party] in an amount less than the limits of [the third party's] liability insurance." 151 Wn. App. at 201. But *Truong* never held that accepting a settlement for any amount of the third party's available insurance automatically deems the insured made whole. Rather, *Truong* held, consistent with *Tripp*, that accepting the settlement is "some evidence," but not "irrefutable evidence," of full compensation. *Id.*

The insured in *Truong* never came forward with non-speculative evidence to overcome summary judgment. The third-party adjuster testified that the settlement reflected her total valuation of the insured's injuries, assuming 100% liability. 151 Wn. App. at 203. Unlike here, the insured in *Truong* pointed to no specific reasons to settle for less than his actual damages, and relied on a conclusory two-paragraph opinion stating

that the recovery was less than "the settlement value" for the case. *Id.* at 204. The Court of Appeals held this conclusory evidence did not create a fact question for trial under CR 56.

In contrast, the Coons' evidence overcomes summary judgment. The Coons had a compelling reason why they would settle for less than their damages: the difficulty of prevailing on liability. The Coons provided *20 pages* of expert analysis by leading plaintiff and defense medical negligence attorneys. CP 349–61; CP 363–69. The Coons showed damages stemming from Mr. Coon's amputation, economic damages in the millions, and staggering general damages. This evidence created a fact question on whether the Coons' damages exceeded their settlement. Just as in *Thiringer* and in *Tripp*, their case should be remanded so that this factual determination can be made. GHO itself indicated in its very first letter that this was the test: whether "[Coon's] damages were greater than the amount he settled for." CP 486. Only remand can answer this question.

B. GHO's contract makes its subrogation and reimbursement rights conditional on GHO first establishing an at-fault party.

Separate from the *Thiringer* rule, the trial court erroneously did not require GHO to meet its contractual conditions for reimbursement.

The relevant contract terms begin with an opening paragraph stating that GHO "will be subrogated to any rights" that the Coons may

have; that the Coons "shall reimburse" GHO for benefits provided from "any amounts" they receive from "any source"; and defers to the remainder of the section which "more fully describes" GHO's rights. CP 343. The contract then imposes limitations on GHO's rights which GHO ignores and which the trial court ignored, but which the Court of Appeals recognized and enforced.

First, the contract makes GHO's rights conditional on an *if*-clause requiring GHO to show that the insured's injuries were "caused by a third party": "***If*** the Injured Person's injuries were caused by a third party giving rise to [*a*] a claim of legal liability against the third party and/or [*b*] payment by the third party to the Injured Person and/or [*c*] a settlement between the third party and the Injured Person, GHO shall have the right to recover GHO's Medical Expenses from any source available to the Injured Person ..." *Id.* (emphasis added). The grammar is compound and the *if*-clause can be triggered by the injury being caused by a third party leading to either a claim, a payment, or a settlement, but in all cases the *if*-clause requires that the injury be "caused by a third party" in order for GHO to "have the right to recover." If the injury is not "caused by a third party," then the condition for GHO's "right to recover" is not triggered.

Second, the contract expressly incorporates the made-whole rule, specifying that GHO's rights "shall be limited to the excess of the amount required to fully compensate the Injured Person." *Id.*

Third, the contract states that "[s]ubject to the above provisions"—*i.e.* "subject to" the immediately preceding *if*-clause and made-whole rule—if the insured makes a recovery "from any source" GHO's payments are "secondary, not primary." *Id.*

Together, the *if*-clause and the *subject-to* language make GHO's reimbursement rights conditional on a showing that the insured's injuries were "caused by a third party." The Court of Appeals explained why the contract allows only this conclusion: "The policy itself, in the paragraph that fully describes the insurer's subrogation rights, states that Group Health has a right to recover its medical expenses from any source available to the injured person 'as a result of the events *causing the injury*.'" *Coon*, 4 Wn. App. 2d at 750. If Mr. Coon's injury was not "caused by a third party," then the *if*-clause and the *subject-to* language are not satisfied, and no reimbursement right arises under the contract.

The Court of Appeals' interpretation of the contract is reasonable. Because this is an insurance contract, a reasonable interpretation favoring the insured prevails over a competing interpretation favoring the insurer absent clarifying extrinsic evidence. *Quadrant Corp. v. Am. States Ins.*

Co., 154 Wn.2d 165, 173, 110 P.3d 733 (2005). The trial court erred by not holding GHO to the contract language making its rights conditional.

C. GHO proved no breach of contract by the Coons, nor any resulting damages.

GHO argues three contract breaches by the Coons. It has not shown entitlement to relief on any of them.[4]

First, GHO argues the Coons breached by not reimbursing GHO. As shown above, there is a fact question concerning whether the Coons were fully compensated and so obligated to reimburse GHO.

Second, GHO asserts the Coons failed to comply with the requirement that they hold disputed funds in trust or in a separate identifiable account. It is undisputed that the Coons did not hold the money in trust; but GHO offered no evidence that the Coons also failed to hold the funds in a separate identifiable account. No breach was shown.

Last, GHO argues the Coons breached by failing to give GHO notice of a "tentative settlement" before completing the settlement. The Coons settled on a Friday and alerted GHO the following Monday. Even if

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[4] GHO argues that the Coons did not appeal the trial court's order denying their summary judgment motion, in which the court also ruled that they breached the contract. However, under RAP 2.4(b), "[t]he appellate court will review a trial court order or ruling not designated in the notice, including an appealable order, if (1) the order or ruling prejudicially affects the decision designated in the notice and (2) the order is entered, or the ruling is made, before the appellate court accepts review." Both summary judgment orders are properly reviewed as part of the Coons' appeal from the judgment. *Fox v. Sunmaster Products, Inc.*, 115 Wn.2d 498, 505, 798 P.2d 808 (1990).

this did not strictly comply with the contract, GHO showed neither prejudice nor damages resulting from the timing of the Coons' notice. GHO provided no evidence, for example, that phoning during the mediation would have changed its position that accepting *any* settlement would deem the Coons fully compensated, nor the Coons' position that settlement for $2.3 million would leave them less than fully compensated.

This Court analyzed a similar notice deficiency in *Tripp*. In *Tripp*, a UIM case, the insured's neglect to give notice before perfecting a settlement denied the insurer the opportunity to substitute payment for the settlement to preserve its subrogation rights under *Hamilton v. Farmers Insurance Co.*, 107 Wn.2d 721, 733 P.2d 213 (1987). Despite this, the Court held it was the insurer's burden to show that the notice deficiency caused prejudice, and the insurer could obtain relief "only to the extent it was prejudiced." 144 Wn.2d at 17. The same rule was applied in *British Columbia Ministry of Health v. Homewood*, 93 Wn. App. 702, 706, 970 P.2d 381 (1999), in which the claimant settled with some defendants for their liability limits and with another defendant for much less than her damages. Applying *Thiringer*, the court held that reimbursement was not allowed unless the insurer could prove that the claimant was fully compensated and that it was prejudiced by the settlements. *Id.* at 713 (citing *Elovich v. Nationwide Ins. Co.*, 104 Wn.2d 543, 556, 707 P.2d

1319 (1985)). These holdings follow from basic contract law. Nonperformance of a contractual duty will give rise to a remedy only to the extent it proximately causes actual damages. *Ketchum v. Albertson Bulb Gardens, Inc.*, 142 Wash. 134, 139, 252 P. 523 (1927); WPI 300.02.

GHO had no legal right to substitute payment like the UIM carrier had in *Tripp*. To the contrary, as this Court has explained, settlement by the Coons was a necessary prerequisite to GHO having even a potential reimbursement right, because "[u]ntil the settlement agreement[] became effective, [] there was no way to know if [the insureds] had been made whole. Thus, [the insurer] could do nothing until the settlements were executed." *Mahler*, 135 Wn.2d at 424; *cf. Tripp*, 144 Wn.2d at 23 ("Because the Tripps' total damages have not yet been determined, we do not know if they have been fully compensated."); *Elovich*, 104 Wn.2d at 556 ("the insurance company's subrogation rights arise only after the plaintiffs have received full compensation for their injuries.").

There is no evidence that informing GHO of the intent to enter into the settlement on Friday would have altered the parties' disagreement about the made-whole rule, and certainly no evidence GHO could have done anything to obtain a greater settlement. *Id.* GHO never proved any damages resulting from the timing of the notice, let alone the *hundreds of thousands of dollars* in liability that the trial court imposed. The Court of

Appeals was correct to apply *Tripp* and require GHO to show prejudice—and damages—on remand.

Attempting to avoid *Tripp*, GHO argues that *Tran v. State Farm Fire & Cas. Co.*, 136 Wn.2d 214, 961 P.2d 358 (1998), and *Pilgrim v. State Farm Fire & Cas. Ins. Co.*, 89 Wn. App. 712, 950 P.2d 479 (1997), mandate a draconian rule under which *any* breach of the notice provision would deprive the insured of the made-whole rule and automatically require return of all coverage without the insurer ever having to prove that it was harmed in any way.

These decisions show the opposite. Both were cases of suspected insurance fraud in which the claimants refused to disclose financial information. Yet this Court and the Court of Appeals required the insurers to show prejudice. In *Tran*, this Court explained, "[a]n insured's breach of a cooperation clause releases the insurer from its responsibilities if the insurer was actually prejudiced by the insured's breach." 136 Wn.2d at 228. In *Pilgrim*, the court concluded, "[i]n Washington, [] the rule is well established. In every cooperation clause, notice clause, and 'no settlement clause' case, where the prejudice issue has been raised, the court *has* analyzed prejudice." 89 Wn. App. at 723 (emphasis in original). Because these provisions are "designed 'to prevent the insurer from being prejudiced by the insured's actions,'" releasing an insurer from its

obligations without a showing of prejudice "would be to authorize a possible windfall for the insurers." *Id.* at 724 (quotation omitted).

GHO's notice clause is in this category. It states the insured shall do nothing to "prejudice" GHO. CP 343. It requires notice for the sake of "protecting" GHO's interest. *Id. Tripp, Homewood, Tran,* and *Pilgrim* all hold that GHO must show prejudice, and can obtain relief "only to the extent it was prejudiced." *Tripp*, 144 Wn.2d at 17. The timing of notice was not the reason GHO did not recover its payments. The parties have a factual dispute about whether the Coons were fully compensated.

Because GHO offered no evidence that would support any breach causing actual damages, the trial court's conclusion of breach must be vacated and remanded.

IV. CONCLUSION

This Court should hold that insurers seeking reimbursement from a settlement must first show that the claimant has been fully compensated.

RESPECTFULLY SUBMITTED this 5th day of April, 2019.

KELLER ROHRBACK L.L.P.

By _____
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By _____
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Attorneys for Nathaniel Coon and Lori Coon

CERTIFICATE OF SERVICE

I, Chris Jarman, declare under penalty of perjury under the laws of the State of Washington that at all times hereinafter mentioned, I am a resident of the State of Washington, over the age of eighteen (18) years, not a party to the above-entitled action, and competent to be a witness herein.

On the date below, I caused a copy of the foregoing document to be served on the individuals identified below via email

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Dated this 5th day of April, 2019.

Chris Jarman

4837-9226-4595, v. 1

KELLER ROHRBACK L.L.P.

April 05, 2019 - 2:45 PM

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