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CERTIFICATION FROM THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
IN

(CONSOLIDATED CASES)

Case No. C18-1173RSL

KRISTA PEOPLES,
Appellee/Plaintiff,

v.

UNITED SERVICES AUTOMOBILE ASSOCIATION, ET AL.
Appellants/Defendants

Case No. C18-1254RSL

JOEL STEDMAN, ET AL.
Appellees/Plaintiffs,

v.

PROGRESSIVE DIRECT INSURANCE COMPANY,
Appellant/Defendant.

OPENING BRIEF OF APPELLANTS/DEFENDANTS
UNITED SERVICES AUTOMOBILE ASSOCIATION AND
USAA CASUALTY INSURANCE COMPANY

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QUESTIONS CERTIFIED TO THE SUPREME COURT

1. With regards to the injury to “business or property” element of a CPA claim, can insureds in Ms. Peoples’ and/or Mr. Stedman’s circumstances, who were physically injured in a motor vehicle collision and whose Personal Injury Protection (“PIP”) benefits were terminated or limited in violation of WAC 284-30-330, bring a CPA claim against the insurer to recover out-of-pocket medical expenses and/or to compel payments to medical providers?

2. With regards to the “injury to business or property” element of a CPA claim, can insureds in Ms. Peoples’ and/or Mr. Stedman’s circumstances, who were physically injured in a motor vehicle collision and whose Personal Injury Protection (“PIP”) benefits were terminated or limited in violation of WAC 284-30-330, bring a CPA claim against the insurer to recover excess premiums paid for the PIP coverage, the costs of investigating the unfair acts, and/or the time lost complying with the insurer’s unauthorized demands?

INTRODUCTION AND SUMMARY OF THE ARGUMENT

This case is before the Court on two certified questions from the United States District Court for the Western District of Washington. The district court consolidated this case with Case No. C18-1254RSL, *Stedman v. Progressive Direct Insurance Company*.

The consolidated cases both involve claims under the Washington Consumer Protection Act (“CPA”) by auto insureds against the defendant insurers arising under the Personal Injury Protection (“PIP”) provisions of their auto policies. The plaintiffs in both cases were injured in automobile accidents and sought reimbursement of their medical expenses incurred as a result of the personal injuries they sustained in those accidents. The plaintiffs complain that the defendants did not pay the full invoiced amounts of their medical bills as a result of reviews conducted by the defendants.

The alleged practices differ in the two cases, but the plaintiffs' CPA claims challenge the defendants' determinations that some of the submitted medical bills were not reasonable, medically necessary, and/or related to the auto accidents.

The CPA provides a private right of action only to persons who have been injured in their "business or property" by a CPA violation. RCW 19.86.090. The "business or property" requirement is restrictive; the legislature could have chosen to permit a private right of action for any type of injury, but did not. This Court consistently has held that "personal injuries" are not cognizable injuries to "business or property" within the meaning of the CPA. Likewise, the "financial consequences" of personal injuries are not cognizable under the CPA, either. *See, e.g., Ambach v. French*, 167 Wn.2d 167, 175, 216 P.3d 405 (2009); *Frias v. Asset Foreclosure Services, Inc.*, 181 Wn.2d 412, 431, 334 P.3d 529 (2014); *Washington St. Physicians Ins. Exch. & Assocs. v. Fisons Corp.*, 122 Wn.2d 299, 317, 858 P.2d 1054 (1993).

The alleged injuries identified in Question 1—the unreimbursed medical expenses—indisputably arise from, and are a direct financial consequence of, the plaintiffs' personal injuries sustained in their auto accidents. Indeed, the very insurance coverage at issue in these consolidated cases is ***Personal Injury*** Protection. Federal district courts uniformly have rejected CPA claims brought under the precise circumstances here: insureds seeking PIP reimbursement from their

insurers of medical expenses incurred as a result of personal injuries. Furthermore, this principle applies regardless of whether the defendant is the tortfeasor that caused the personal injuries resulting in medical bills, or the insurer that was requested to reimburse those medical bills. The key is the nature of the injury, not the identity of the defendant. This Court should confirm this unbroken line of authorities. Accordingly, the Court should answer Question 1 in the negative.

Regarding Question 2, the district court identified three additional types of purported damages: the payment of “excess premiums,” the “costs of investigating” the alleged CPA violations, and “the time lost” complying with the insurers’ demands. None of these alleged damages, however, was properly pleaded or addressed in the district court. Indeed, “excess premiums” and “time lost” were not even mentioned in Defendants’¹ case, and were referred to only in passing in briefing on Progressive’s motions. Because the record before this Court is insufficient to permit the Court to address these issues in anything other than an advisory opinion, the Court should decline to answer Question 2. If the Court decides to answer Question 2, it should answer in the negative. The types of alleged damages set forth in Question 2 also indisputably arise from the plaintiffs’ personal injuries, and are therefore not cognizable under the CPA.

¹ “Defendants” in this brief refers to United Services Automobile Association and USAA Casualty Insurance Company and does not include Progressive Direct Insurance Company, which is the defendant in the consolidated case.

STATEMENT OF THE CASE

I. Plaintiff's Complaint²

A. Plaintiff's Automobile Accident

On September 26, 2015, Plaintiff was injured in an automobile accident. (Dkt. 1-1 ¶ 1.)³ Plaintiff alleged that she was insured under automobile insurance company issued by "USAA"⁴ and that her medical providers submitted claims for reimbursement of her medical expenses under the PIP provisions of the auto policy. (*Id.* ¶ 22.)

B. The Automobile Insurance Policy

Both Washington law and Defendants' auto insurance policies limit the medical expenses reimbursable under PIP coverage to "reasonable" and "necessary" expenses. *See* RCW 48.22.005(7). Thus, when explaining to consumers what PIP insurance does and does not cover, Washington's Insurance Commissioner states:

What PIP doesn't cover

PIP doesn't cover services that your insurance company decides are not:

- Reasonable

² The district court's ruling certifying the two questions came on Defendants' motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6). (Dkt. 50.) Accordingly, the district court assumed the truth of the well-pleaded factual allegations. Defendants will do so here as well, and do not admit the truth of any factual allegations or legal conclusions.

³ Defendants' citations to the record transmitted by the district court refer to the docket numbers of the district court filings in the format (Dkt. __.) The district court record was transmitted to this Court on March 4, 2019. (Dkt. 51.)

⁴ Plaintiff's Complaint defines "USAA" as including both USAA and USAA CIC. (Dkt. 1-1 ¶ 2.) In fact, the policy was issued by USAA to Philip M. Peoples, Plaintiff's father. (Dkt. 12-2.) These factual inaccuracies are not relevant to the certified questions.

- Necessary

<https://www.insurance.wa.gov/personal-injury-protection-pip>.

The Insuring Agreement of the PIP section of the applicable auto policy provides that Defendants “will pay the following PIP benefits to or on behalf of each **covered person** because of **BI** [bodily injury] caused by an accident . . . : 1. **Medical and hospital benefits.**” (Dkt. 12-2 at 18 (emphasis in original).) The policy defines “medical and hospital benefits” as “the **medical payment fee for medically necessary and appropriate medical services.**” (*Id.* at 17 (emphasis in original).)

“Medical payment fee” is defined as “an amount, as determined by **us** or someone on **our** behalf, that **we** will pay for charges made by a licensed . . . provider for **medically necessary and appropriate medical services.**” (*Id.* (emphasis in original).) The policy specifically limits these payments to “[t]he lesser of the following:

- a. The actual amount billed; or
- b. *A reasonable fee for the service provided. A fee is reasonable if it falls within the range of fees generally charged for that service in the geographic area.*

(*Id.* (emphasis added).)

The policy defines “medically necessary and appropriate medical services” to be those determined by Defendants, or a third party, that are “required to identify or treat [bodily injury] caused by an auto accident” and that are, among other things, “appropriately documented” and “[n]ot excessive”:

1. Consistent with the symptoms, diagnosis, and treatment of the **covered person's** injury and *appropriately documented in the **covered person's** medical records*;
2. Provided in accordance with recognized standards of care for the **covered person's** injury at the time the charge is incurred;
3. Consistent with published practice guidelines and technology, and assessment standards of national organizations or multi-disciplinary medical groups;
4. Not primarily for the convenience of the **covered person**, his or her physician, hospital, or other health care provider;
5. The most appropriate supply or level of service that can be safely provided to the **covered person**; and
6. *Not excessive in terms of scope, duration, or intensity of care needed to provide safe, adequate, and appropriate diagnosis and treatment.*

(*Id.* at 17-18 (bolded text in original; italics added).)

Finally, the policy specifically informs insureds that Defendants or a third party will conduct an “audit” to review medical bills for reasonableness and necessity, and that medical bills in excess of that determination “are not covered”:

We or someone on **our** behalf will review, by audit or otherwise, claims for benefits under this coverage to determine if the charges are **medical payment fees for medically necessary and appropriate medical services** A provider of medical . . . services may charge more than the amount we determine to be **medical payment fees** and reasonable expenses, but such additional charges *are not covered*.

(*Id.* at 18 (bolded text in original; italics added).)

C. Plaintiff's PIP Claim

Plaintiff alleged that Defendants did not pay the full amount of

certain of her medical bills because Defendants determined that (1) portions of some of her providers' healthcare fees "exceeded a reasonable amount for the service provided" (her "reasonable fee" claim) and (2) in accordance with a review by a medical professional, the documentation Plaintiff's providers submitted to justify some of her treatments did not establish that the treatments were medically necessary (Plaintiff's "medical necessity" claim). (Dkt. 1-1 ¶¶ 26-28, 34-36, Exs. 1, 2.) Plaintiff brought her "reasonable fee" claim on behalf of herself and a class of Washington auto insureds, but her "medical necessity" claim was brought on behalf of herself individually. (*Id.* ¶¶ 85-90, 99-103.)

With respect to Plaintiff's "reasonable fee" claim under her PIP coverage, Plaintiff asserted that Defendants used a computerized bill review service provided by a third party, Auto Injury Solutions, to determine whether the billed amount "exceeded a reasonable amount for the service provided." (*Id.* ¶ 30.) The Explanation of Reimbursement ("EOR") forms that Plaintiff attached to the Complaint show that some, but by no means all, of the billed line items were not reimbursed in full, as indicated by an "RF_2" Reason Code, defined on the EORs as follows:

The charge exceeds a reasonable amount for the service provided. If you do not accept the recommended amount stated on this EOR as payment in full for this line item, please submit further documentation or explanation to support the reasonableness of the charge submitted by you for payment.

(*Id.*, Ex. 1.)

The EORs were accompanied by a document entitled "How to

Obtain Answers to Questions about USAA’s Explanation of Reimbursement (EOR) and How to Submit a Formal Appeal.” (*Id.*) Despite the fact that many of the charges shown on the EORs were paid in full, without any “RF” reduction, Plaintiff alleged, in wholly conclusory fashion, that Defendants’ fee review process was “arbitrary.” (*Id.* ¶ 30.)

With respect to Plaintiff’s “medical necessity claim” under her PIP coverage, Plaintiff alleged that Defendants relied on a computer program and its “flags” that “arbitrarily and automatically” denied reimbursement of medical bills when there was a 90-day gap in treatment or when the insured exceeded 13 treatments for certain procedures. (*Id.* ¶¶ 46-47.) But the partial EOR that Plaintiff attached to the Complaint (Exhibit 2) states that the basis for Defendants’ determination was not a computerized flag, but a review by a physician of the submitted documents:

Review of the submitted documentation does not substantiate the medical necessity and/or relatedness of the treatment to the loss following an apparent lapse in treatment. Please see the attached physician letter.

(*Id.*, Ex. 2 (emphasis added).)

D. Plaintiff’s Claims and Allegations of Injury

Plaintiff’s Complaint contains a single claim for alleged violations of the CPA based solely on the PIP coverage of the auto policy. (*Id.* ¶¶ 84-94, 98-114.) Plaintiff’s allegations of injury were cursory: she alleged that she had sustained “damages and injury caused by the underpayment of her bills, nonpayment of her bills, and/or delay in payment of her bills.” (*Id.* ¶ 33; *see also id.* ¶ 49 (“USAA’s practices proximately caused Ms. Peoples

to sustain injury and economic damages.”); *id.* ¶ 95 (“Plaintiff sustained injury to her property and damages in an amount to be established at trial.”).) Plaintiff also asserted that her injuries included “investigative expenses and out-of-pocket costs.” (*Id.* ¶ 96; *see id.* ¶ 74 (asserting damages sustained by class “in the form of reduced benefits, investigative costs, and out-of-pocket expenses.”); *id.* ¶ 116 (same).)

Plaintiff did not allege in the Complaint that she actually paid or was being held financially responsible for any of the medical expenses that Defendants did not reimburse. Nor did Plaintiff seek two elements of purported damages set forth in Question 2: “excess premiums paid for the PIP coverage” or “the time lost complying with the insurer’s unauthorized demands.” (*See id.* ¶¶ 95-97, 115-17.) In opposing Defendants’ motion to dismiss, however, Plaintiff submitted a declaration claiming that she had paid one of her providers for medical bills that were not reimbursed in full due to Defendants’ medical necessity review. (Dkt. 33.) At no point did Plaintiff assert in that declaration that she had incurred any other expenses or injuries identified in Question 2, including “investigative costs,” payment of “excess premiums,” or “lost time.” (*See id.*)

II. The Proceedings on Defendants’ Motion to Dismiss

On August 30, 2018, Defendants filed a motion to dismiss Plaintiff’s CPA claim. (Dkt. 12.) First among the reasons for dismissal was that Plaintiff had failed to allege an injury to “business or property” within the meaning of the CPA. Defendants argued that the CPA does not encompass

claims for medical expenses associated with personal injuries, like Plaintiff sought here under her PIP coverage. (Dkt. 12 at 11-13.)

In response, Plaintiff repeatedly argued that her damages were for “economic loss,” and therefore satisfied the CPA’s injury requirement. (Dkt. 31 at 19-21.) Other than quoting from *Folweiler Chiropractic, PS v. American Family Insurance Co.*, 5 Wn. App. 2d 829, 839-40, 429 P.3d 813 (2018), Plaintiff did not even mention—let alone explain how—she allegedly had incurred any “out-of-pocket expenses” or “investigative costs.”

In its ruling certifying the two questions, the district court stated that under this Court’s decisions in *Ambach* and *Frias*, “[d]amages arising from personal injury, including medical expenses, pain and suffering, and reimbursement for lost wages, are not injuries to business or property and are therefore not recoverable under the CPA.” (Dkt. 50 at 3-5 (emphasis added).) The district court concluded that the “actual holding” in *Ambach* does not bar the CPA claims asserted by Plaintiff because Plaintiff was not suing the person who caused her bodily injury. (*Id.* at 4-5.)

The district court acknowledged, however, that *Ambach* “contains language suggesting that a demand for insurance coverage to reimburse the insured for medical expenses or to pay medical providers is so connected to the insured’s personal injuries, that a CPA claim challenging the way the insurer handled the claim is barred.” (*Id.* at 5 (citing *Ambach*, 167 Wn.2d at 175-76).) The district court also cited the unbroken line of Washington

federal cases “precluding CPA claims against insurers for bad faith claim handling if the damages at issue involve unpaid medical bills.” (*Id.*; *see infra* pp. 18-20 (discussing those cases).) The district court stated that there was “some indication” Washington state courts “interpret *Ambach* more narrowly and have not yet embraced a categorical bar against CPA claims brought by an injured insured.” (Dkt. 50 at 5-6; *see infra* pp. 24-28 (addressing cited cases).) The district court found that “certification to the Washington Supreme Court to determine how *Ambach* applies in the insurance context is warranted.” (Dkt. 50 at 7.)

THE STANDARD OF REVIEW

Certified questions are issues of law that this Court reviews *de novo*. *Wright v. Lyft, Inc.*, 189 Wn.2d 718, 722, 406 P.3d 1149 (2017). The Court considers the legal issues presented “based on the certified record provided by the federal court.” *Id.* (citing *Bradburn v. North Cent. Reg’l Library Dist.*, 168 Wn.2d 789, 799, 231 P.3d 166 (2010)); RCW 2.60.030(2). A certified question that does not meet the criteria of RCW 2.60.030(2) “can be summarily rejected.” *In re Elliott*, 74 Wn.2d 600, 617, 446 P.2d 347 (1968).

Under RCW 2.60.020, this Court may answer certified questions “[w]hen in the opinion of any federal court . . . , it is necessary to ascertain the local law of this state in order to dispose of such proceedings and the local law has not been clearly determined.” Accordingly, in addressing certified questions, the Court considers the legal issues “not in the abstract but based on the certified record provided by the federal district court.” *St.*

Paul Fire & Marine Ins. Co. v. Onvia, Inc., 165 Wn.2d 122, 126, 196 P.3d 664 (2008). Advisory opinions are not appropriate for decisions on certified questions. *See, e.g., Obert v. Environmental Res. & Dev. Corp.*, 112 Wn.2d 323, 335, 771 P.2d 340 (1989). Decisions on certified questions should be based on the certified record and established facts of the case. *See, e.g., Hutchinson v. Port of Benton*, 62 Wn.2d 451, 455-56, 383 P.2d 500 (1963).

ARGUMENT

I. This Could Should Answer Question 1 in the Negative: Plaintiff’s Claim for Reimbursement of Medical Expenses Under Her PIP Coverage Is Not Injury to “Business or Property” Under the CPA.

The CPA provides a private right of action to “[a]ny person who is injured in his or her *business or property* by a violation of” the CPA. RCW 19.86.090 (emphasis added). The legislature could have chosen to recognize claims based on any type of “injury.” It did not. Instead, the legislature deliberately restricted CPA claims to those in which the plaintiff sustained injury to “business or property.” *See, e.g., Stevens v. Hyde Athletic Indus. Inc.*, 54 Wn. App. 366, 370, 733 P.2d 871 (1989) (noting that “[h]ad the Legislature intended to include” other forms of injury, “it would have used a less restrictive phrase than ‘business or property’ ”).

Under this Court’s decisions, personal injuries are not cognizable injuries to “business or property” within the meaning of the CPA, and the “financial consequences” of those personal injuries are not compensable under the CPA, either. All the injuries Plaintiff claims here—unpaid medical expenses, “investigative” costs, and the unspecified “out-of-

pocket” costs—are the financial consequences of personal injury and are therefore not cognizable under the CPA. Indeed, the district court correctly stated that, under this Court’s decisions, “[d]amages *arising from personal injury, including medical expenses, pain and suffering, and reimbursement for lost wages, are not injuries to business or property and are therefore not recoverable under the CPA.*” (Dkt. 50 at 3 (emphasis added).) There can be no dispute that all of Plaintiff’s claimed damages “arise from” her personal injury. Accordingly, this Court should answer “no” to Question 1 and rule that claims against insurers for reimbursement of unpaid medical bills resulting from personal injuries are not injuries to “business or property” within the meaning of the CPA.

A. The Financial Consequences of Personal Injuries Are Not Cognizable Under the CPA.

1. The Decisions Leading to *Ambach* Establish the Restrictive Nature of Injury to “Business or Property.”

The cases preceding this Court’s decision in *Ambach* clearly established that personal injuries—including the damages typically recovered in personal injury claims—are not injuries to “business or property” within the meaning of the CPA.

The Court of Appeals first addressed this issue in *Stevens v. Hyde Athletic Industries*, 54 Wn. App. 366, 733 P.2d 871 (1989). In *Stevens*, the plaintiff purchased softball cleats that later were shown to be dangerous. After fracturing her ankle while wearing the cleats, the plaintiff sued the

store and the shoe manufacturer for violations of the CPA. 54 Wn. App. at 367-68.

The Court of Appeals rejected the CPA claim. The court ruled that personal injuries do not fall within the meaning of injury to business or property under the CPA. *Id.* at 370. The court explained that the legislature’s use of the phrase “business or property” was “used in the ordinary sense [to] denote[] *a commercial venture or enterprise.*” *Id.* (internal quotation omitted) (emphasis added). The court rejected the plaintiff’s CPA claim, characterizing it as an “attempt[] to come within this [business or property] analysis by classifying her personal injury damages into a pseudo-property structure, i.e., [alleging that] special damages such as hospital, physician, and rehabilitative expenses, constitute property and economic interests.” *Id.*

This Court first addressed the question whether personal injuries are recoverable under the CPA in *Fisons*. In *Fisons*, a doctor accused of malpractice for misprescribing medication brought CPA claims against the drug company that manufactured the medication. 122 Wn.2d at 307. After the doctor was awarded damages in the trial court, the drug company sought direct review by this Court. *Id.* at 310. Among other issues, this Court addressed whether the personal injury damages awarded to the doctor were recoverable under the CPA. *Id.* at 317-18.

This Court held that such injuries were not within the scope of the CPA. The Court expressly approved the *Stevens* decision: “The *Stevens*

court . . . concluded that had our Legislature intended to include actions for personal injury within the coverage of the CPA, it would have used a less restrictive phrase than injured in his or her ‘business or property.’ We agree. Personal injuries are not compensable under the CPA.” *Id.* at 318.

The Court of Appeals again addressed the issue in *Hiner v. Bridgestone/Firestone, Inc.*, in which it held that medical expenses, lost wages, and damages to a vehicle could not support a CPA claim. 91 Wn. App. 722, 730, 959 P.2d 1158 (1998), *rev’d in part on other grounds*, 138 Wn.2d 248, 978 P.2d 1158 (1999). The Court of Appeals held that such damages are “commonly awarded in personal injury actions” and are therefore “not injuries to ‘business or property’ as contemplated by the CPA.” *Id.*

Finally, the Ninth Circuit weighed in on this issue in *Association of Washington Public Hospital Districts v. Philip Morris Inc.*, 241 F.3d 696 (9th Cir. 2001). There, the Ninth Circuit confirmed that payments for medical treatments are not a cognizable CPA injury, because “[e]xpenses for personal injuries are not injuries to business or property under the CPA.” *Id.* at 705. Accordingly, the court rejected the hospital districts’ CPA claims for patients’ smoking-related medical expenses, explaining that “the mere fact that a third party pays for their medical treatment should not transform such medical expenses into business or property harm recoverable under the CPA.” *Id.*

2. This Court’s Decision in *Ambach* Confirmed that Medical Expenses Arising from Personal Injuries Are Not Compensable Under the CPA.

Following the line of cases discussed above, this Court held in *Ambach* that medical expenses arising from personal injury are not injury to “business or property” within the meaning of the CPA.

The plaintiff in *Ambach* had suffered injuries as a result of a shoulder surgery. She brought a CPA claim seeking economic damages for the additional cost of that surgery above the cost of a more conservative, alternative-medicine treatment. 167 Wn.2d at 170-71. The trial court dismissed the CPA claim, ruling that the plaintiff’s injuries were the same as those recoverable in personal injury actions, and therefore were not injuries to “business or property.” *Id.* at 171. The Court of Appeals reversed, holding that the additional costs of the surgery were sufficient to establish CPA injury. *Id.*

This Court reversed. The Court held that “payment for medical treatment, like *Ambach*’s payment for surgery, does not transform medical expenses into business or property harm.” *Id.* at 175. According to the Court, what the plaintiff “really seeks is redress for her personal injuries, not injury to her business or property.” *Id.* at 178-79.

This Court began by analyzing the meaning of “business or property” under the CPA. *Id.* at 172. Because the statute does not define “business or property,” the Court first looked to dictionary definitions to assess the scope of those terms. *Id.* The Court noted that *Black’s Law Dictionary* defines “business” as “ [a] commercial enterprise carried on for

profit; a particular occupation or employment habitually engaged in for livelihood or gain.’ ” *Id.* (quoting *Black’s Law Dictionary* 226 (9th ed. 2009)). The Court also noted that the definition of “property” “does not include rights to one’s person or body.” *Id.*

The Court next quoted from *Stevens* to explain that “[t]he legislature’s use of the phrase ‘business or property’ in the CPA is restrictive of other categories of injury and is ‘used in the ordinary sense [to] denote[] a commercial venture or enterprise.’ ” *Id.* (emphasis added).

This Court rejected the plaintiff’s attempt to characterize her claim as one for economic loss to business or property. *See id.* at 174. The Court held that the plaintiff’s claimed injuries of “medical expenses, wage loss, loss of earning capacity, and out-of-pocket expenses” were all “personal injury damages.” *Id.* The Court rejected the plaintiff’s “attempts to use her payment for the surgery as the key to the door of compensation for a panoply of common personal injury damages.” *Id.* at 179 n.6. The Court explained that “the CPA was not designed to give personal injury claimants such backdoor access to compensation they were denied in their personal injury suits.” *Id.*

Following *Ambach*, this Court’s most recent ruling on this issue further confirmed the restricted scope of CPA injury: “The CPA’s requirement that injury be to business or property excludes personal injury, mental distress, embarrassment, and inconvenience. *The financial*

consequences of such personal injuries are also excluded.” Frias, 181 Wn.2d at 431 (emphasis added).

B. Federal Courts Consistently Have Held that, Under *Ambach* and Its Progeny, Insurance Claims Seeking Reimbursement for Medical Expenses Relating to Personal Injuries Do Not State Valid CPA Claims.

As the district court acknowledged, federal decisions uniformly have interpreted *Ambach* to preclude recovery under the CPA against insurers for reimbursement of unpaid medical expenses—precisely what Plaintiff is claiming here. These federal courts have concluded that the medical expenses are “derivative of [the insured’s] personal injuries” and therefore not compensable under the CPA. *Dees v. Allstate Ins. Co.*, 933 F. Supp. 2d 1299, 1310 (W.D. Wash. 2013).

For example, citing *Ambach*, a federal court recently dismissed a plaintiff’s CPA claims for injuries, including unpaid medical bills, on the grounds that a plaintiff cannot base a CPA claim “on his or her insurer’s failure to pay medical bills because those injuries are derivative of her personal injuries.” *Coppinger v. Allstate Ins. Co.*, No. 17-cv-1756-JCC, 2018 WL 278646, at *2 (W.D. Wash. Jan. 3, 2018) (internal quotation omitted). Similarly, in *Dees* the court dismissed an insured’s CPA claims seeking reimbursement of medical bills under PIP and UIM coverages because such expenses were personal injuries, which “are not compensable damages under the CPA and do not constitute an injury to business or property.” 933 F. Supp. 2d at 13010. Other federal district courts are in agreement. *See, e.g., Coppinger v. Allstate Ins. Co.*, No. C17-1756-JCC,

2018 WL 1121327, at *1 (W.D. Wash. Mar. 1, 2018) (dismissing insured’s CPA claims against insurer for unpaid medical expenses because “non-business and non-property damages that derive indirectly from personal injury do not qualify for relief under the CPA”); *Heide v. State Farm Mut. Auto. Ins. Co.*, 261 F. Supp. 3d 1104, 1109-10 (W.D. Wash. 2017) (rejecting CPA claims for injuries including unpaid medical bills; “[i]njuries that are derivative of a plaintiff’s personal injuries do not constitute an injury to business or property sufficient to sustain an action under the CPA”); *Bauman v. American Commerce Ins. Co.*, No. 15-cv-1909-BJR, 2017 WL 44439, at *4 (W.D. Wash. Jan. 4, 2017) (“[M]edical bills (which are derivative of personal injuries) are not considered compensable damages under the CPA.”); *Kovarik v. State Farm Mut. Auto. Ins. Co.*, No. 15-cv-1058, 2016 WL 4555465, at *3 (W.D. Wash. Aug. 31, 2016) (“[F]ailure to pay the claimed [insurance] benefits for personal injuries is not an injury to business or property.”); *Coleman v. American Commerce Ins. Co.*, No. 09-cv-5721, 2010 WL 3720203, at *4 (W.D. Wash. Sept. 17, 2010) (plaintiff’s claims against insurer for personal injury damages and “expenditures to secure the benefit of the insurance policy” did not constitute injury to business or property under CPA); *Haley v. Allstate Ins. Co.*, No. C09-1494 RSM, 2010 WL 4052935, at *8 (W.D. Wash. Oct. 13, 2010), *on reconsideration in part*, 2010 WL 5224132 (W.D. Wash. Dec. 14, 2010) (“Plaintiff’s asserted damages related to attorney’s fees, costs, and the payment of medical bills do not constitute damage to Plaintiff’s business or

property under the CPA.”); *Braden v. Tornier, Inc.*, No. 09-cv-5529-RJB, 2009 WL 3188075, at *4 (W.D. Wash. Sept. 30, 2009) (medical expenses are considered personal injury damages and, as such, are not within the scope of CPA); *Sadler v. State Farm Mut. Auto. Ins. Co.*, No. 07-cv-995-Z, 2008 WL 4371661, at *9 (W.D. Wash. Sept. 22, 2008) (claim that insurer improperly processed claim for PIP benefits “is not cognizable under the CPA”), *aff’d*, 351 F. App’x 234 (9th Cir. 2009).

Accordingly, just as this Court’s decisions in *Ambach* and *Fisons* established that the financial consequences of a personal injury do not constitute a CPA injury, these federal courts dismissed CPA claims against insurers for medical expenses arising from personal injury.

C. For Purposes of Determining Whether an Injury Is to “Business or Property,” the Key Is the Nature of the Injury, Not the Identity of the Defendant.

The district court suggested that *Ambach* may not apply here because Plaintiff is not bringing a CPA claim against the driver who caused her injury, but against her insurer for reimbursement of medical expenses for injuries caused by that driver. (Dkt. 50 at 4-5.) This is a distinction without a difference, and one that has not been drawn by the cases addressing the CPA injury issue. Courts have focused on the nature of the claimed injuries—not on the identity of the defendant or its role in the alleged injuries—in determining whether the CPA’s requirement of injury to “business or property” has been satisfied.

For example, in *Ambach* and *Fisons*, this Court considered the possibility of a second source of the plaintiff’s alleged injuries, yet when

analyzing whether the plaintiff had sustained an injury to “business or property,” the Court focused on the nature of the plaintiff’s injury, not on the CPA defendant. *Ambach*, 167 Wn.2d at 178-79; *Fisons*, 122 Wn.2d at 317-19. In *Ambach*, this Court emphasized that the CPA does not provide personal injury claimants with “backdoor access to compensation they were denied in their personal injury suits.” *Ambach*, 167 Wn.2d at 179 n.6; see *Williams v. Lifestyle Life Holdings, Inc.*, 175 Wn. App. 62, 72, 302 P.3d 523 (2013) (*Ambach*’s “backdoor access” point was Court’s “overriding concern”); *supra* p. 17. *Fisons* similarly rejected an effort to obtain “backdoor access” to personal injury damages through a CPA claim. There, a doctor sought damages for pain and suffering allegedly caused both by the CPA-defendant drug company and by the patient who had sued the doctor for malpractice. 122 Wn.2d at 319 n.19. This Court rejected the doctor’s attempt to obtain those damages through a CPA claim against the drug company. *Id.* at 317-19.

Likewise, the Court of Appeals in *Stevens* and *Hiner* was concerned that plaintiffs not be permitted to reclassify personal injuries “into a pseudo-property structure.” The Court of Appeals rejected attempts to turn damages flowing from personal injuries—“such as hospital, physician, and rehabilitative expenses”—into “property and economic interests.” *Stevens*, 54 Wn. App. at 370. Damages that are “commonly awarded in personal injury actions,” such as medical expenses and lost wages, are simply not

injuries to business or property within the meaning of the CPA. *Hiner*, 91 Wn. App. at 730.

Similarly, the federal district court cases that uniformly rejected the very same PIP/CPA claims Plaintiff brings here, *see supra* pp. 18-20, also focused on the nature of the injury and dismissed claims for reimbursement of medical expenses caused by personal injuries. In doing so, these courts did not consider it significant that the defendant was an insurer rather than the tortfeasor.

Here, the damages Plaintiff claims are precisely the type of damages she would attempt to seek against the driver of the vehicle who injured her. Accordingly, the core CPA principle is the same, regardless of the identity of the defendant or its role in causing the alleged injuries: claims for medical expenses arising from personal injury, like Plaintiff's here, do not constitute injury to "business or property."

D. Decisions Interpreting Federal Statutes Requiring Injury to "Business or Property" Likewise Look to the Nature of the Injury, Not the Identity of the Defendant.

Pursuant to RCW 19.86.920, Washington courts also look to federal decisions interpreting analogous federal statutes for guidance when interpreting the CPA. These decisions interpret federal statutes with the same "business or property" injury requirement as the CPA to preclude recovery of damages resulting from personal injuries.

For example, in both *Fisons* and *Ambach*, this Court looked to interpretations of the "business or property" injury requirement in federal antitrust law. *See Fisons*, 122 Wn.2d at 317-18 (quoting *Reiter v. Sonotone*

Corp., 442 U.S. 330, 339 (1979) for proposition that “[t]he phrase ‘business or property’ also retains restrictive significance. It would, for example, exclude personal injuries suffered.”); *Ambach*, 167 Wn.2d at 172-73 (discussing interpretation of “identical phrase in § 4 of the Clayton Act,” 15 U.S.C. § 15, as excluding personal injuries). This Court concluded that those federal decisions supported an interpretation of the “business or property” requirement that excludes personal injury damages.

The federal RICO statute also requires an injury to “business or property.” 18 U.S.C. § 1964(c). Courts interpreting this requirement have held that how the plaintiff characterizes the wrong and the defendant’s identity are both irrelevant to whether a claim impermissibly seeks personal injury expenses.

For example, in *Jackson v. Sedgwick Claims Management Services, Inc.*, the Sixth Circuit considered whether personal injuries become “property” injuries under RICO when “filtered through” insurance. 731 F.3d 556, 566 (6th Cir. 2013). The court held that “racketeering activity leading to a loss or diminution of benefits the plaintiff expects to receive under a workers’ compensation scheme does not constitute an injury to ‘business or property’ under RICO.” *Id.* The court emphasized “the underlying reality that an award of benefits under a workers’ compensation system and any dispute over those benefits are inextricably intertwined with a personal injury giving rise to the benefits.” *Id.*

In *Brown v. Ajax Paving Industries, Inc.*, the Sixth Circuit held that *Jackson's* holding also applied to claims against insurers, claims administrators, and doctors. 752 F.3d 656, 657-58 (6th Cir. 2014). The court again held that personal injury damages were not injuries to business or property, because RICO's "applicability turns on the nature of the *injury*—that the plaintiff was 'injured in his business or property'" and "does not turn on the nature of the *defendant*." *Id.* at 658 (emphasis in original). The court also observed that it could not "see how the same harm, loss of expected workers' compensation benefits, could count as an injury to business or property against some defendants but not against other defendants." *Id.*

The reasoning of these federal courts interpreting the "business or property" requirement in federal statutes is consistent with Washington courts' focus on the nature of the injury rather than the identity of the defendant when analyzing injury to "business or property" under the CPA. *See supra* pp. 20-22. This Court likewise should hold that medical expenses arising from a personal injury are not a CPA injury to "business or property" and do not support a CPA claim against an insurer.

E. The State Cases Cited by the District Court and Plaintiff Are Inapposite.

While acknowledging the consistent line of federal authorities rejecting CPA claims by insureds against their insurers for reimbursement of medical expenses incurred due to personal injuries (Dkt. 50 at 5), the district court stated that there was "some indication that the state courts

interpret *Ambach* more narrowly and have not yet embraced a categorical bar against CPA claims brought by an injured insured.” (*Id.* at 5-6.) But the issue here is not whether the CPA imposes a “categorical bar” against all possible CPA claims brought by an injured insured. The issue is whether an insured’s claims against an insurer for reimbursement of medical expenses incurred for personal injuries are cognizable under the CPA. As demonstrated above, they are not.

The cases cited by the district court are inapposite. None of these Washington state court cases held that medical expenses resulting from personal injuries are cognizable CPA injuries. For example, the district court cited *Williams v. Lifestyle Life Holdings, Inc.*, in which the plaintiff alleged that she was injured by a cosmetic procedure and brought a CPA claim against the surgical practice and the licensor of the procedure’s trademark. 175 Wn. App. 62, 65, 68-69, 302 P.3d 523 (2013). Among the plaintiff’s alleged injuries were \$4,600 she paid for what she asserted was a deceptively marketed surgery, along with alleged pain and suffering and economic damages. 175 Wn. App. at 69, 72. The Court of Appeals limited her CPA claim to the \$4,600—the cost of the deceptively marketed surgery. *Id.* at 74. The Court of Appeals distinguished *Ambach* on the ground that the plaintiff’s CPA claim for the deceptive marketing “does not depend on proof that she sustained a personal injury as a result of the surgery” and would have survived even if the surgery had not injured her. *Id.* at 73-74. The portion of the plaintiff’s CPA claim that survived, therefore, was not

for medical expenses resulting from personal injury. It was for amounts paid because of the deceptive advertising. *Id.* at 74.

By contrast, all of Plaintiff's claimed damages here "depend on proof that she sustained a personal injury." Indeed, without a personal injury to Plaintiff caused by a covered automobile accident, Defendants would have no obligation to pay Plaintiff anything under her PIP coverage—i.e., **Personal Injury** Protection. *See supra* pp. 4-6; Dkt. 12-2 at 16-20. Unlike the claim in *Williams* for deceptive marketing of the surgery, then, Plaintiff's CPA claim here is for personal injuries. In fact, if Plaintiff had been injured in her "business or property" as required under the CPA, her PIP coverage would not even apply.

The district court's citation to *Hayes v. USAA Casualty Ins. Co.*, No. 70735-3-I, 185 Wn. App. 1066, 2015 WL 677143 (Feb. 17, 2015) (unpublished), is similarly inapposite. *Hayes*—an unpublished opinion with no precedential value, *see* GR 14.1(a)—did not address the "personal injury" issue at all, but, as the district court noted, merely recounted the trial court's early ruling in the case denying the defendants' motion to dismiss the CPA claim. (Dkt. 50 at 6 (characterizing *Hayes* as "noting" trial judge's early ruling); *Hayes*, 2015 WL 677143, at *5-6.) The trial court ultimately granted Defendants' summary judgment motion, which the Court of Appeals affirmed. *Hayes*, 2015 WL 677143, at *7. The Court of Appeals decision was about judicial estoppel, not CPA injury. The Court held that the plaintiffs were judicially estopped from reformulating their claims after

they successfully resisted removal to federal court by asserting that their claims were more narrow than what the complaint had alleged. *Id.* at *9. Again, the Court of Appeals had no occasion to address *Ambach* or the scope of a CPA injury.

The district court also cited cases in which insureds were allowed to proceed with CPA claims “despite the connection to ‘personal injuries.’ ” (Dkt. 50 at 3.) But none of those cases addressed the question presented to this Court. Indeed, none of these cases even mentioned *Ambach* (three of them pre-date *Ambach*) or discussed the other cases addressing what constitutes a “personal injury” that is not compensable under the CPA. *See Keodalah v. Allstate Ins. Co.*, 3 Wn. App. 2d 312, 413 P.3d 1059, review granted, 191 Wn.2d 1004, 424 P.3d 1214 (2018) (finding individual employee insurance adjuster could be liable for bad faith and violation of the CPA, without addressing injury to business or property element); *Nelson v. GEICO Gen. Ins. Co.*, 192 Wn. App. 1007, 2016 WL 112475, at *7 (2016) (unpublished—see GR. 14.1) (finding delay in receiving payment could constitute injury under CPA without addressing whether personal injury damages are recoverable or discussing *Ambach*); *Anderson v. State Farm Mut. Ins. Co.*, 101 Wn. App. 323, 336, 2 P.3d 1029 (2000) (remanding CPA claim regarding improper claims handling and violations of insurance regulations without addressing whether claims were not injuries to business or property because they arose from personal injury); *Van Noy v. State Farm Mut. Auto. Ins. Co.*, 98 Wn. App. 487, 496-97, 983 P.2d 1129 (1999)

(finding that CPA claim could proceed without analyzing whether it constituted injury to “business or property”); *Escalante v. Sentry Ins. Co.*, 49 Wn. App. 375, 387, 743 P.2d 832 (1987) (concluding that third party beneficiary had standing to bring CPA claim against insurer without analyzing “injury to business or property” element).

Finally, Plaintiff asserted below that *Folweiler* held that “this type of allegation sets for [sic] CPA injury not personal injury damages.” (Dkt. 31 at 19.) Not so. *Folweiler*, which involved a claim by a provider (not an insured), did not address the question whether medical expenses arising from personal injury constitute injury to business or property. *Folweiler* therefore did not attempt to reconcile its holding with *Ambach* or any of the other cases establishing that claims for reimbursement of medical expenses are not a cognizable CPA claim. 5 Wn. App. 2d at 839-40.

F. The Dismissal of Plaintiff’s CPA Claim Would Not Leave Her Without a Remedy.

The dismissal of Plaintiff’s CPA claim would not leave her or plaintiffs like her without a viable remedy. The most obvious claim for Defendants’ alleged breach of their insurance policy obligations is one for breach of contract. Indeed, Plaintiff’s Complaint repeatedly mentions Defendants’ alleged policy obligations. (*See, e.g.*, Dkt. 1-1 ¶¶ 11-12, 25, 51, 68.) Yet Plaintiff steadfastly refused to bring such a contract claim—

until, that is, the district court certified the CPA “injury” question to this Court.⁵

The restrictive nature of the CPA’s “business or property” requirement demonstrates that the legislature intended claims arising from personal injury to be addressed by other causes of action. Requiring Plaintiff to pursue those alternative claims, rather than a CPA lawsuit, would not deprive Plaintiff of a viable remedy for any alleged wrongdoing, and would be consistent with this Court’s decisions in *Ambach* and *Fisons* as well as weight of other authorities rejecting CPA claims just like the one Plaintiff asserts here.

II. This Court Should Decline to Address Certified Question No. 2 Because Plaintiff Did Not Plead All the Potential Elements of Damages Cited by the District Court, and the Record Lacks Sufficient Facts to Enable This Court to Issue Anything Other Than an Advisory Opinion.

In Question 2, the district court requested this Court’s ruling on whether “excess premiums paid for the PIP coverage, the costs of investigating the unfair acts, and/or the time lost complying with the insurer’s unauthorized demands” constituted damages cognizable under the CPA. (Dkt. 50 at 8.) Yet of the three types of damages noted in Question 2, Plaintiff did not even allege damages for “excess premiums” or “time lost”—not in her Complaint, not in her brief, not in her declaration, not

⁵ Faced with the prospect of the dismissal of her CPA claim after the district court certified the questions to this Court (and after the record had been certified), Plaintiff moved for leave to amend the Complaint to assert a claim for breach of contract after the district court certified the questions to this Court. (Dkt. 53.) Defendants did not oppose Plaintiff’s request to assert an individual claim for breach of contract. (Dkt. 57 at 1.)

anywhere. The plaintiffs in the Progressive case apparently raised these issues—albeit not in their complaint, and only tangentially and vaguely in response to Progressive’s motions. Progressive has addressed the inadequacy of the record on these damages claims in its brief. Defendants adopt and incorporate Progressive’s arguments.

As for the supposed “investigative costs,” although Plaintiff’s Complaint mentions such damages, it does so in passing and in wholly conclusory fashion. *See supra* p. 9. Plaintiff never alleged what those costs were or how they related to her insurance claim, her alleged injuries, or this lawsuit. Furthermore, although Plaintiff took the opportunity to attempt to shore up her deficient injury allegations by submitting a declaration opposing Defendants’ motion to dismiss, she never once contended that she had incurred any “investigate expenses.” *See supra* p. 9.

Accordingly, the record is wholly insufficient to enable this Court to rule on the items of damages noted in Question 2. The issues are too hypothetical, abstract, and speculative for a ruling by this Court to be anything but advisory. *See, e.g., United States v. Hoffman*, 154 Wn.2d 730, 748, 116 P.3d 999 (2005), *as amended* Aug. 25, 2005 (declining to answer question that was “hypothetical and speculative” because the “record before us was insufficient and any attempt to answer would be improvident”); *Southwell v. Widing Transp., Inc.*, 101 Wn.2d 200, 207, 676 P.2d 477 (1984) (“[W]e are hesitant to decide a conflicts case on a record in which the facts before us may develop in a number of ways at trial, reducing our

opinion to nothing more than an advisory opinion.”); *Obert*, 112 Wn.2d at 335 (“To decide this case upon neither the facts presented nor the applicable law would constitute an advisory opinion.”).

III. If This Court Decides to Rule on Question 2, It Should Conclude That None of the Damages Theories Identified Is Viable Under the CPA.

If this Court decides to rule on Question 2, it should hold that the damages theories identified by the district court are not cognizable injuries to “business or property” within the meaning of the CPA, because they all are the “financial consequences” of Plaintiff’s personal injuries. *See supra* pp. 13-18.

As noted above, of the three damages theories set forth in Question 2, only one—“investigative expenses”—is even mentioned in Plaintiff’s Complaint. *See supra* p. 9. In any event, this Court previously has ruled that investigative expenses *may* be cognizable CPA injuries only under certain circumstances. *See Panag v. Farmers Ins. Co.*, 166 Wn.2d 27, 36, 41,62-64, 204 P.3d 885 (2009) (explaining that case “does not involve a contest over liability or damages resulting from an automobile accident” and finding costs to investigate collection agency notices could constitute CPA injury, but noting exceptions); *Frias*, 181 Wn.2d at 432 (explaining “expenses incurred in investigating their legality *may be* compensable” under the CPA in case that did not involve personal injury) (emphasis added). Those decisions, however, did not alter the longstanding rule that damages arising from personal injuries are not compensable under the CPA. *See supra* pp. 12-20. Indeed, the *Ambach* Court explicitly rejected an

analogous claim for “out-of-pocket expenses” arising from personal injury, finding they did not constitute injury to “business or property.” 167 Wn.2d at 174 (explaining that damages such as “wage loss, loss of earning capacity, and out-of-pocket expenses” arising from personal injury do not qualify as CPA injury to business or property); *see also Frias*, 181 Wn.2d at 431 (“The financial consequences of such personal injuries are also excluded” from CPA injury); *Philip Morris Inc.*, 241 F.3d at 705 (alleged damages “predicated on personal injuries” not recoverable under CPA); *Dees*, 933 F. Supp. 2d at 1311 (claimed injury that “is derivative of” personal injury “does not constitute a CPA injury”).

Here, Plaintiff’s CPA claim exists solely because she is seeking reimbursement of medical expenses incurred due to a personal injury. The so-called “investigative expenses” are the “financial consequences” of Plaintiff’s personal injury and resulting medical expenses and would not exist but for that personal injury. *See, e.g., Frias*, 181 Wn.2d at 431. Consistent with this Court’s prior decisions and the answer to Question 1, this Court should hold that investigative expenses and out-of-pocket costs incurred in pursuit of reimbursement for medical expenses arising from a personal injury are not a cognizable CPA injury. To hold otherwise would permit precisely the type of “backdoor access” to personal injury damages that this Court in *Ambach* sought to foreclose. 167 Wn.2d at 179 n.6.

The other damages elements identified in Question 2—“excess premiums” and “time lost”—are also the financial consequences of personal

injury and, for these same reasons, are not cognizable under the CPA. Because those damages were not even mentioned in Plaintiff's case, but only briefly in Progressive's, Defendants adopt and incorporate Progressive's arguments on these issues.

CONCLUSION

For the foregoing reasons, as well as those set forth in Defendants' briefing in the district court and in the briefing by Progressive Direct Insurance Company in the consolidated case, Defendants respectfully submit that the Court should answer Question 1 in the negative, and either decline to address Question 2 or answer it in the negative.

DATED: May 3, 2019

Respectfully submitted,

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