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Supreme Court No. 96931-1
(United States District Court, Western District of Washington, Case No.
C18-1173RSL (Consolidated with Case No. C18-1254RSL))

SUPREME COURT
OF THE STATE OF WASHINGTON

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

KRISTA PEOPLES,
Appellee/Plaintiff,

v.

UNITED SERVICES AUTOMOBILE ASSOCIATION, ET AL.
Appellant/Defendants

AND

JOEL STEDMAN, ET AL.

Appellees/Plaintiffs,

v.

PROGRESSIVE DIRECT INSURANCE COMPANY,
Appellant/Defendant.

APPELLEES JOEL STEDMAN, ET AL.'S RESPONSE BRIEF

Randall C. Johnson, WSBA #24556 Law Office of Randall C. Johnson P.O. Box 15881 Seattle, WA 98115 Telephone: 206-890-0616 rcjj.law@gmail.com	Duncan C. Turner, WSBA #20597 Daniel A. Rogers, WSBA #46372 Badgley Mullins Turner 19929 Ballinger Way NE, #200 Seattle, WA 98155 Telephone: 206-621-6566 dturner@badgleyturner.com drogers@badgleyturner.com
Daniel R. Whitmore, WSBA #24012 Law Office of Daniel R. Whitmore 2626 15th Avenue West, #200 Seattle, WA 98119 Telephone: 206-329-8400	

Attorneys for Appellees/Plaintiffs

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I. CERTIFIED QUESTIONS.

The United States District Court for the Western District of Washington certified two questions to this Court concerning the injury to “business or property” element of a Washington Consumer Protection Act (“CPA”) claim.

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?

As discussed below, the Court should answer “YES” to each of these certified questions and reaffirm that when an insured files claims of bad faith against her insurance carrier for violations of claims handling regulations, those claims of bad faith can be enforced through the Consumer Protection Act, RCW 19.86. Damages recoverable include all damages proximately caused by the breach of the claims handling regulation, including medical expenses paid by the insured as a result of

the insurer's breach, the premiums paid for "defective" insurance, time lost to complying with the insurer's improper requests, and the cost of investigation of the insurer's wrongful conduct.¹

II. INTRODUCTION AND SUMMARY OF THE ARGUMENT.

This Court should answer "YES" to both certified questions. Following this Court's decision in *Durant v. State Farm Mutual Auto. Ins. Co.*, 191 Wn.2d 1, 419 P.3d 400 (Wash. 2018), Plaintiffs Joel Stedman and Karen Joyce² (Appellees/Plaintiffs) filed claims against Appellant Progressive Direct Insurance Company ("Progressive"). Like *Durant*, Plaintiffs were entitled to insurance coverage for "Personal Injury Protection" (PIP). Like *Durant*, Progressive used "maximum medical improvement" ("MMI") to limit or deny its contractual obligation to pay reasonable and necessary PIP medical expenses incurred under RCW 48.22.085. Like *Durant*, Plaintiffs' claims were filed as a putative class action and address Progressive's pattern and practice of using MMI to limit or terminate PIP benefits. Plaintiffs requested an award of "all damages" attributable to Progressive's conduct, including any and all medical expenses incurred by claimants where Defendant denied of PIP benefits using MMI as a criterion for the termination. Dkt. #11, ¶8.6; Prayer for Relief ¶¶ 10,

¹ Progressive concedes that Washington law currently allows for recovery of the costs expended by the insured in investigating an insurer's wrongful conduct. Progressive Opening Brief, p. 36.

² Karen Joyce is also a named plaintiff in this lawsuit. The District Court has dismissed her *non-CPA* claims for bad faith as untimely. Dkt.# 27, p.6.

12, 13. At the outset of this case, before conducting any discovery, Progressive moved to dismiss Plaintiffs' Consumer Protection Act ("CPA") claims, asserting that Plaintiffs' damages are damages flowing from personal injuries that do not qualify as injuries to "business or property" under the CPA. Dkt. #19, 2.

Washington law requires all parties to act in good faith in all insurance matters. To that end, the Office of Insurance Commissioner has promulgated regulations specifying standards of conduct insurance carriers must follow when adjusting claims. This Court has long held that claims of bad faith against an insurance carrier for violations of the claims handling regulations are enforced through the CPA. No business is immune to the scope of the CPA. Progressive is asking this Court to find an exception to that rule. Progressive entered into an indemnity contract, agreeing to pay reasonable and necessary medical expenses when an insured was in an accident, regardless of fault. Progressive then violated Washington claims handling regulations when adjusting PIP claims. Progressive's argument that its failure to pay contractual benefits for medical care under PIP coverage do not constitute an injury to business or property would exempt PIP and UIM automobile insurers from the reach of the CPA.

Progressive's argument is an elevation of form over substance. Case law reflects that bad faith claims asserted against an insurer—claims asserted under the CPA—often include damages for medical expenses. In the context of insurance and bad faith under the CPA, no Washington case has excluded "medical expenses" from recovery of bad faith damages. The Court has

implicitly recognized that recovery for covered medical expenses in the context of a bad faith action does not depend on proof of a personal injury that is independently recoverable from another. Indeed, in this case, the insurance that applies is PIP, which pays for medical expenses without consideration of fault. In an insurance case, the medical expenses an insured seeks in recovery are one step removed from a claim asserted against the underlying tortfeasors. Thus, the damages flow from the insurance carrier's violation of a claims handling statute to deprive the insured of what the insurance carrier had promised to contractually provide.

Progressive does not rely upon an insurance case to make its argument that medical expenses are not recoverable. Instead, Progressive relies upon *Ambach v. French*, 167 Wn.2d 167 (2009), where a claim against a tortfeasor was dressed up to look like a CPA claim. *Ambach* is distinguishable. Plaintiffs in this case are pursuing claims for violations of Washington's claims handling regulations, and insurance bad faith that have traditionally been enforced through the CPA. Progressive disguises this case as a claim for personal injuries and ignoring the nature of the claims as an action for bad faith.

Finally, Progressive has understated both the damages Plaintiffs requested in their complaint and the procedural posture of this dispute. Plaintiffs seek "all damages" to which they are entitled. Before submitting to discovery to explore those items of damages, Progressive moved to dismiss Plaintiffs' claims under the CPA, treating Plaintiffs' identification of the medical expenses

Progressive denied based on MMI as the only damages Plaintiff seeks to recover. Under a motion to dismiss standard, neither the Western District Court nor this Court needs to determine how many hours of time an individual spent attending an IME that was scheduled for purposes of determining MMI, or what the amount of lost wages the insured incurred as a result of attending an IME that was set for an improper purpose. That level of detail is not required to be pled. Rather, the Court need only determine if the category of damages consisting of time spent attending an IME that was set by the insurance carrier and tainted by MMI, or the cost of the premium an insured paid toward insurance tainted by MMI, is recoverable as a matter of law. This Court is not issuing an advisory opinion on a hypothetical issue when it decides, as a matter of law, what categories of damages are recoverable under the CPA. This Court should answer both certified questions “YES”.

III. STATEMENT OF THE CASE.

A. The Allegations of the Complaint.

The operative facts—deemed true in light of the procedural steps taken to bring this matter before this Court—are clear:³

- The gravamen of this case concerns claims of insurance bad faith. Plaintiff asserted five causes of action against Progressive: 1) declaratory relief; 2) violations of the Insurance Fair Conduct Act;

³ Like Defendant Progressive, Plaintiff recites the allegations from the Complaint as if they are true, without prefacing “Plaintiff alleged” with each statement.

3) violations of the CPA; common law bad faith; and 5) breach of the implied covenant of good faith and fair dealing. Dkt. #11.

- Progressive has engaged in a systematic practice of prematurely and unlawfully depriving its injured claimants of medical benefits under Personal Injury Protection (PIP) coverage. Dkt. #11, ¶1.1.
- PIP coverage promises to pay the “reasonable and necessary” medical expenses incurred from injuries sustained in an automobile accident. Id.
- PIP benefits may be terminated by an insurance carrier for only one of four reasons: if treatment is not (1) reasonable, (2) necessary, (3) related to the accident, or (4) incurred within three years of the accident. WAC 284-30-395(1). No other reasons for terminating benefit payments are permitted. Dkt. #11, ¶1.2.
- Progressive terminated PIP benefits by asserting that its first party insured reached “Maximum Medical Improvement” (MMI). Dkt. #11, ¶1.2.
- Ms. Joyce was a first party insured of Progressive’s and opened a PIP claim with Progressive. Dkt. #11, ¶2.4.
- While Ms. Joyce was receiving PIP benefits, Progressive requested that she undergo a medical examination for determining, among

other things, whether she had reached, in the eyes of Progressive, “maximum medical improvement” or MMI. Dkt. #11, ¶5.20.

- Mr. Stedman was a third-party beneficiary of a Progressive policy, and he too opened a PIP claim with Progressive. Dkt. #11, ¶2.3.
- While Mr. Stedman was receiving PIP benefits, Progressive requested that he undergo a medical examination for determining whether he reached, in the eyes of Progressive, “maximum medical improvement” or MMI. Dkt. #11, ¶5.11.
- Progressive’s insurance policy promised to pay the reasonable and necessary medical expenses incurred by an insured as a result of an automobile accident. Dkt. #11, ¶5.1.
- Despite Washington laws prohibiting Progressive from terminating, limiting or denying PIP benefits on grounds other than those identified in WAC 284-30-395 (1), Progressive terminated PIP benefits by arguing that claimants had reached maximum medical improvement, and therefore, further treatment was no longer reasonable or necessary. Dkt. #11, ¶5.4.
- Progressive “is engaging in a scheme to manufacture a defense to first-party and third-party beneficiary claims.” Dkt. #11, ¶5.5.
- With respect to the CPA claim, Plaintiff made a specific claim that stated “Plaintiffs and the Class have been damaged as a result of

these violations, and Plaintiffs are entitled to recover their damages, including attorney fees, prejudgment interest, and exemplary damages.” Dkt. 11, ¶8.6.

- Plaintiffs also included a list of items requested in a Prayer for Relief—not all of which were tied to specific causes of action. Plaintiffs’ general Prayer for Relief requests an award of “all damages” suffered as a result of Defendant’s conduct, and includes, but is not limited to “any and all medical expenses incurred by claimants following Defendant’s denial of PIP benefits using MMI as a criterion for the termination.” Dkt. #11, ¶¶10, 12.

B. Facts to be Inferred from the Purchase of Personal Injury Protection Insurance.

Because Washington law identifies PIP insurance as an optional layer of coverage (RCW 48.22.085), and the statute provides the layer of coverage that must be provided when offering PIP insurance (RCW 48.22.090), some relevant facts are reasonably inferred by the nature of these claims.⁴ The unstated inferences to be drawn are as follows:

- Because PIP insurance is not mandatory, Ms. Joyce (and others similarly situated) purchased automobile insurance coverage that

⁴ Not only are the allegations of fact in the complaint deemed true when assessing the complaint under this motion to dismiss standard, but the facts are also construed in the light most favorable to the nonmoving party. *Cousins v. Lockyer*, 568 F.3d 1063, 1067 (9th Cir.2009)

went beyond the statutory minimum required coverage. They engaged in a consumer transaction in buying insurance. Dkt. #20, p.4.

- Progressive is not the only insurance carrier to offer PIP coverage, and it is reasonable for a consumer in the marketplace to shop for insurance based on coverages available, balanced by the premiums required to pay for coverage. Dkt. #20, p.4.
- Ms. Joyce (and others similarly situated) discussed the coverages available with Progressive before purchasing insurance, including the optional coverage for PIP benefits. Dkt. #20, p.4.
- Progressive informed consumers like Ms. Joyce of the benefits of securing PIP coverage, *i.e.*, that it covers payment for medical expenses when a person is involved in an automobile accident. Dkt. #20, p.5.
- Progressive did not tell Ms. Joyce (or others similarly situated) that it would be using criteria the legislature has prohibited it from using when evaluating her claims for PIP benefits, namely MMI. Dkt. #20, p.5.
- Ms. Joyce (and others similarly situated) were charged a premium for their PIP coverage, so their automobile policy premium is

necessarily higher than the premium they would have paid if they had declined PIP coverage. Dkt. #20, p.5.

- When an individual is in an automobile accident, PIP insurance is treated as “primary” insurance, meaning that the PIP payments are applied to medical expenses incurred by the insured, whether the insured has additional health insurance or not. Dkt. #20, p.5.
- And when an insured does not have health insurance, but maintains PIP coverage, PIP coverage is the only source of insurance applicable for payment of medical expenses arising out of an automobile accident. Dkt. #20, p.5.
- Ms. Joyce made a valid claim for PIP benefits. Progressive opened a file and informed her that she was entitled to PIP benefits under the policy. Whether she was injured and entitled to make a claim for PIP benefits is not in dispute. Dkt. #20, p.5.
- Mr. Stedman made a valid claim for PIP benefits—Progressive opened a file and informed him that he was entitled to PIP benefits under the policy. Whether he was injured and entitled to make a claim for PIP benefits is not in dispute. Dkt. #20, p.5.
- Ms. Joyce and Mr. Stedman looked to Progressive to provide them with information about what was or was not covered by their policy. Dkt. #20, p.5.

- When Progressive asked Ms. Joyce and Mr. Stedman to submit to a medical examination from a doctor of Progressive’s choosing, and asked the doctor to render an opinion on whether or not the insureds had reached maximum medical improvement, Progressive was requiring these claimants to spend time away from business or family in order to address their PIP coverage in a way that violated WAC 284-30-395. Dkt. #20, p.6.
- When Progressive terminated Ms. Joyce and Mr. Stedman’s PIP coverage and denied them future treatment payments, it did not inform them that it was using criteria that the legislature has forbidden insurance carriers from using when terminating, limiting, or denying PIP benefits. Dkt. #20, p.6.
- Mr. Joyce and Ms. Stedman sought additional treatment after Progressive’s denial of PIP benefits, and incurred expenses that should have been paid by Progressive’s PIP coverage. Dkt. #20, p.6.

IV. ARGUMENT.

A. The Answer to the First Certified Question is “Yes”; Damages Flowing from Breaches of Indemnity Contracts Are the Value of the Indemnity.

When a party enters into an indemnity contract with another, whereby the indemnitor agrees to indemnify the contracting party in the event of an occurrence, upon breach, the gravamen of the claim is the value of indemnity lost by the breach. The fact that the insurer agreed to indemnify a specific type of damage, like payments for medical expenses, does not convert the gravamen of the dispute against the insurance carrier into a claim for personal injuries.

1. Claims of Bad Faith Are Traditionally Pursued By Filing CPA Claims.

In order to address the question certified by the Western District Court, the nature of this dispute must be properly understood. This is a suit for breach of insurance handling regulations and insurance bad faith where Progressive used MMI to improperly limit or terminate coverage that has been mandated by the Washington legislature.⁵ Under Washington law, the business of insurance “is one affected by the public interest, requiring that *all persons* be actuated by good faith, abstain from deception, and practice honesty and equity *in all insurance matters.*” RCW 48.01.030 (emphasis supplied). RCW 48.30.010 prohibits insurers from engaging in unfair or deceptive acts in their business practices. Pursuant to the statute, the Insurance Commissioner has promulgated regulations that define specific acts and practices that constitute both

⁵ Not only were these allegations made in the Complaint, and taken as true for purposes of this motion, but Progressive’s letter denying and terminating PIP benefits identifies MMI as a basis for the denial.

unfair or deceptive acts, and breaches of the insurer's duty to act in good faith. WAC 284-30. Violations of the insurance claims handling practices listed under WAC 284-30 are designated by the regulations as *per se* unfair insurance **business practices**. *Anderson v. State Farm Mut. Ins. Co.*, 101 Wn.App. 323, 331-332, 2 P.3d 1029 (2000).

It has long been held that an insured "may bring a private action against their insurers for breach of duty of good faith under the CPA. *Tank v. State Farm*, 105 Wn.2d 381, 386, 715 P.2d 1133 (1986), citing *Salois v. Mutual of Omaha Ins. Co.*, 90 Wn.2d 355, 581 P.2d 1349 (1978); *Levy v. North Am. Co. for Life & Health Ins.*, 90 Wn.2d 846, 586 P.2d 845 (1978); *Rice v. Life Ins. Co. of North Am.*, 25 Wn.App. 479, 609 P.2d 1387 (1980). Plaintiffs' claims follow in this long-standing tradition. Plaintiff has filed suit for Progressive's unfair and deceptive acts in adjusting PIP claims, and has asserted a breach of the duty of good faith under the CPA. In other words, Plaintiffs in this case are pursuing bad faith claims that have long been pursued by asserting CPA violations committed by the insurance carrier. Progressive is attempting to recast this claim for bad faith under the CPA into a claim for recovery of personal injuries.

2. The Fact that These Claims Are Asserted Against an Insurance Carrier Does Make a Difference.

Progressive's attempt to characterize Plaintiffs' claims for bad faith into "personal injury" damages is simply misdirection. While it is true Plaintiffs seek recovery for medical expenses that Progressive refused to

pay, it is not accurate to describe these damages as damages for “personal injuries.”⁶ Progressive repeatedly refers to “personal injury” to plant the false premise that seeking payment for medical expenses from one’s PIP carrier equates to seeking recovery from underlying tortfeasors who caused a physical injury. However, the “personal injury” aspect of the underlying claims is separate and distinct from the claims Plaintiffs have asserted against their insurance carrier. The personal injury origins of the damages are incidental to, and remote from, the claims of bad faith arising under the CPA.

The fact that the “personal injury” claim is one step removed from the nature of the claim asserted against the insurance carrier is a significant difference. As discussed more fully below, *Ambach*’s prohibition on recovery for “personal injuries” is limited to the facts of that case, and under the facts of that case, *Ambach* sought recovery from a medical provider for the medical expenses she incurred as a result of medical malpractice. She was “disguising her PI claim to look like a claim under the CPA.” *Williams v. Lifestyle Lift Holding, Inc.*, 175 Wn.App. 62, 71, 302 P.3d 523 (Div. 1, 3013). Here, Plaintiff has filed suit against an

⁶ Defendants use the term “personal injury” in both a specific and general sense, vacillating between the two and conflating the legal recovery for the medical expenses incurred as a result of the accident *from the actual tortfeasors*, with recovery Plaintiffs seek from Progressive as elements of Progressive’s bad faith under the CPA.

insurance company who sold a promise to indemnify, agreeing to pay the reasonable and necessary medical expenses of Plaintiffs under PIP coverage. It is the promise to pay that has been breached, and the nature of the claims asserted against Progressive seek to hold Progressive responsible for violating Washington law and claims handling regulations. Progressive caused no “personal injury” that led to the PIP claims.

Progressive attempts to re-define Plaintiffs’ claims as claims for “personal injury” fail to recognize that the present case arises in the context of an insurance dispute. The fact that Progressive promised to pay reasonable and necessary medical expenses and breached that promise by systematically limiting or terminating benefits by using criteria it was prohibited by law from using should not disqualify Plaintiffs from pursuing their claims against Progressive under the CPA. Plaintiffs are entitled to recover all damages proximately caused by Progressive’s violations of the claims handling regulations.

3. The CPA Applies to Every Business, Without Exception.

Progressive is arguing that the CPA does not apply to insurers who promise payment for PIP or underinsured motorist protection because the nature of their business is to insure against payment of medical expenses. According to Progressive, violations of claims handling regulations in the context of PIP or UIM insurance seek, not the damages proximately

caused by the violation of the claims handling regulation, but “personal injury” damages associated with the facts giving rise to the insurance claim. If Progressive’s argument were correct, insurers could engage in unfair and deceptive acts in the sale of policies or in claims handling and yet be immune from suit under the CPA. There is no such exemption under the CPA.⁷ The CPA prohibits unfair and deceptive acts in trade and commerce, regardless of industry. The statute is remedial in purpose and is "liberally construed that its beneficial purposes may be served." RCW 19.86.920; *Short v. Demopolis*, 103 Wash.2d 52, 61, 691 P.2d 163 (1984). A holding that mischaracterizes bad faith claims asserted under the CPA as seeking recovery of “personal injury” damages is not a liberal interpretation of the statute, and would create an impermissible exception under the CPA for insurance carriers who promise to pay medical expenses on behalf of their insured. This Court should not create an exception to CPA enforcement under the guise of construing the damages proximately caused by an insurers’ unfair and deceptive acts in failing to honor its contractual obligations as “personal injury” damages.

⁷ The concurrence in *Ambach*, filed by Justice Chambers, makes clear that “the CPA does reach ‘every person who conducts unfair or deceptive acts in any trade or commerce,’ including lawyers and doctors.” *Ambach*, at 179. Justice Chambers’ concurrence, standing alone, would be sufficient to allow CPA claims against Progressive to proceed, as Progressive informed its insureds it would pay “reasonable and necessary” medical expenses, although it failed to use the “reasonable and necessary” standard required by Washington law in connection with these claims.

Not only is the adjustment of a claim an issue impacting the public interest element of the CPA, the purchase of insurance is a transaction to which the act applies. In order to drive a vehicle in Washington, the legislature has mandated a certain level of liability insurance. It has *not* mandated coverage for personal injury protection. A consumer has an option to purchase or decline additional amounts of coverage from an insurance provider to cover these expenses. RCW 48.22.085. Plaintiffs need not plead this as part of their Complaint—it is a contextual fact that is subsumed within the very type of insurance coverage involved in this case. Progressive, in selling this *optional* coverage, informed its insureds that it would cover the “reasonable and necessary” medical expenses. Again, Plaintiffs need not plead this fact—that is what Washington law requires PIP insurance to cover, and insurers are prohibited from offering policy terms that provide for less coverage than that mandated by the legislature. RCW 48.22.090; *Durant*, *supra*; *Elovich v. Nationwide Ins. Co.*, 104 Wn.2d 543, 707 P.2d 1319 (1985); *Britton v. Safeco Insurance*, 104 Wn.2d 518, 707 P.2d 125 (1985); *Touchette v. Northwestern Mut. Ins. Co.*, 80 Wn.2d 327, 494 P.2d 479 (1972); *Federated Am. Ins. Co. v. Raynes*, 88 Wn.2d 439, 563 P.2d 815 (1977); *Grange Ins. Ass'n v. Great Am. Ins. Co.*, 89 Wn.2d 710, 575 P.2d 235 (1978). These inferences are reasonably inferred from the stated facts and, it is reasonable to presume that Progressive complied with Washington law in describing the nature of PIP coverages available.

Likewise, once a PIP claim arises, the insurance carrier is required

to inform its insured about the scope of coverage, and its failure to disclose benefits is actionable as a claim of bad faith. *Anderson v. State Farm, supra*. Further, WAC 284-30-330 (13) requires “a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.” Accordingly, Progressive would need to have informed its insured about the nature of the PIP coverage offered and the reason it was limiting or terminating benefits. Progressive’s representations when selling the policy – informing the insured that PIP coverage paid “reasonable and necessary” medical expense – are misleading because the insurer failed to disclose its use of MMI in the determination. Progressive’s statements in limiting or terminating benefits are also misleading, because they equate MMI with “reasonable and necessary” medical expenses under the statute. As *Durant* holds, such a determination violates Washington law. When an insurer like Progressive fails to inform prospective insureds that in making a determination of “reasonable and necessary” medical expenses it is using criteria the legislature has prohibited it from using, it is engaging in an unfair business practice in trade or commerce that is clearly covered by the CPA. A liberal construction of the damages element Progressive challenges would recognize that Plaintiffs’ claims are actionable under the CPA.

4. Allowing CPA Claims to Proceed is Consistent with Prior Authority.

Allowing Plaintiffs claims against Progressive to proceed under the CPA is consistent with prior Washington authority. For example, in *Escalante v. Sentry Insurance Co.*, 49 Wn.App. 375,743 P.2d 832 (Div. 1, 1987), Linda1, 1987), Escalante was killed in an automobile accident. *Escalante*, 49 Wn.App at 376. Her parents and estate filed a tort claim against the at fault party, and upon its resolution, filed suit against her UIM carrier for bad faith and CPA claims for the injuries she sustained in the accident. *Id.* at 380. The CPA claims were allowed to proceed against the insurance carrier, despite the fact that the plaintiffs were seeking recovery of damages equating to those of the underlying “personal injuries.” *Id.* at 388, 390. *Van Noy v. State Farm Mut. Auto. Ins. Co.*, 98 Wn.App. 487,983 P.2d 1129 (Div. 1, 1999) was also a class action concerning PIP coverage. There, the class members were injured in automobile accidents and insured by State Farm under a policy of insurance that promised to pay reasonable and necessary medical expenses caused by an accident. *Van Noy*, 98 Wn.App at 489, 491, and n. 2. “The claims were for the medical expenses of injured insureds that were retroactively disallowed more than 30 days after State Farm received the claim.” *Id.* at 489. Plaintiffs sought these elements as damages in their CPA claims. State Farm moved to dismiss the CPA claims on summary

judgment, contending the Plaintiffs did not prove harm or damages under the CPA. *Id.* at 496. The Court of Appeals disagreed, finding:

the delay in determining the amount covered caused economic harm by increasing personal liability to the members of the class. But for State Farm's delay, the class members may not have incurred additional medical or therapy expenses. State Farm claims that the only damages for which it could be liable are the benefits due but not paid. We disagree. It appears that a determination could well be made that State Farm's practices result in the delay of claim resolutions that harm the insureds by the insureds seeking a continuing course of medical or therapy treatment for which they may ultimately be deemed liable and which they would not have pursued had they known.

Van Noy at 497.

The *Van Noy* court certainly had the opportunity to say that the claims under the CPA could not go forward when State Farm moved for summary judgment on the CPA claim, but it did not. Plaintiff's claims were allowed to proceed.

Likewise, in *Anderson v. State Farm Mut. Ins. Co.*, 101 Wn.App. 323, 2 P.3d 1029 (2000), Anderson was injured in an automobile accident when the car she was driving crashed into a cement barrier on the side of the freeway. *Id.* at 326. State Farm assessed the damages for her personal injuries to be between \$150,000 and \$200,000. *Id.* at 328. State Farm failed to advise Anderson of her UIM coverage, which would have provided her coverage for \$100,000 toward payment of her medical expenses. The court found that this "failure to disclose UIM coverage ...

establishes as a matter of law an unfair claims practice actionable under the Consumer Protection Act.” *Id.* at 331. In this context, State Farm had even argued that the insured could not show injury to business or property under the CPA because she was ultimately made whole. *Id.* at 333. Being “made whole” means that State Farm paid her UIM benefits, *i.e.*, her medical expenses, for her personal injuries.

In *Keodalah v. Allstate Insurance Co.*, 3 Wn.App.2d 31, 13 P.3d 1059 (Div. 1, 2018), Keodalah was injured in an automobile accident with a motorcyclist. *Keodalah*, 3 Wn.App. 2d at 33. The motorcyclist was uninsured and Keodalah submitted a UIM claim to his insurance carrier. *Id.* Allstate refused UIM coverage. Keodalah sued Allstate for UIM coverage, and a jury awarded him \$108,868.20 “for his injuries, lost wages, and medical expenses.” *Id.* at 34. He then filed a second lawsuit against Allstate, contending that Allstate had acted in bad faith and had violated the CPA. *Id.* His claims, for bad faith and CPA violations, including his claims against the individual adjuster, were allowed to proceed. *Id.* at 43.⁸

⁸ Cases like *Hiner v. Bridgestone*, 91 Wn.App. 722, 959 P.2d 1158 (1998) and *Washington State Physicians Ins. Exch. & Ass'n v. Fisons Corp.*, 122 Wash.2d 299, 858 P.2d 1054 (1993) also demonstrate that cases traditionally brought as personal injury actions are treated differently. In *Hiner*, for example, the Plaintiff filed a CPA claim against Bridgestone alleging personal injury damages for failure to advise on tire handling issues associated with putting snow on the front, but not the back, of her

These cases demonstrate that in the context of insurance bad faith, the insurer's conduct is being regulated under RCW 48.01.030, RCW 48.30.010, WAC 284-30, and RCW 19.86. The fact that the insurer agrees to pay the reasonable and necessary medical expenses of the insured, then in bad faith breaches that promise, does not transform the damages flowing from the defendant's unfair business practice into a claim for "personal injuries."⁹

5. Progressive's reliance on *Ambach* is Misplaced; *Ambach* is Inapplicable.

In *Ambach*, plaintiff Teresa Ambach was being treated by an orthopedic surgeon for pain in her shoulder. *Ambach*, 167 Wn.2d. at 170.

vehicle. This was not sufficient to allege an unfair or deceptive act under the CPA, or damages to business or property. In *Fisons*, the Court was asked to decide "whether a physician has a cause of action against a drug company for personal and professional injuries which he suffered when his patient had an adverse reaction to a drug he had prescribed." The physician sought to recover damages for emotional distress caused by the drug company's action. Mental pain and suffering was not recoverable under the CPA. *Fisons* at 318. The defendants in *Hiner* and *Fisons* were not insurance carriers. The damages plaintiffs sought – and the Court's pronouncement on recoverable damages – show that these plaintiffs were seeking to recover traditional tort damages directly from the tortfeasors who had caused the personal injuries.

⁹ Progressive attempts to distinguish these cases by arguing that they relate to UIM coverage, which is different from PIP coverage. *Van Noy* concerned a class action for PIP benefits. While PIP insurance and UIM insurance may be different in some circumstances, Progressive is raising a distinction without a difference in this case. PIP coverage applies without regard to fault. UIM applies when it is determined that the liability limits of the at fault party are insufficient to cover a given plaintiff's medical expenses. In each of the UIM cases referred to above, the UIM claimant first sued the at-fault party and established a UIM claim based upon the shortfall between the liability policy, and the recoverable damages. They then sued to the insurers who were legally required to pay damages, just as a PIP insurer is legally required to pay damages, regardless of fault.

The physician operated on Ms. Ambach, but she continued to experience pain in her shoulder. *Id.* Eventually she was diagnosed with osteomyelitis from a staph infection, and sued her physician for professional negligence and a CPA violation. *Id.* Citing prior Supreme Court decisions, the *Ambach* court noted that the CPA injury need not be great, or even quantifiable to meet the damage element of the statute. *Ambach*, at 171-72, citing *Mason v. Mortgage Am. Inc.*, 114 Wn.2d 842, 854, 792 P.2d 142 (1990).¹⁰ The *Ambach* Court discussed a wide variety of injuries that qualified as injuries to business or property, but held that Ms. Ambach’s claims against her physician were not related to the entrepreneurial aspects of her physician’s practice, and that she would be able to recover her damages as part of her claims of negligence against the physician. In doing so, it held that her damages were predicated on personal injuries, and her attempt to describe her CPA as “the cost of a product...acquired due to fraud or deception” was unsuccessful. *Ambach*, at 174. The Court was also troubled by Ambach’s failure to allege “the truly public nature of Dr. French’s actions.” *Id.* at 178. The Court noted that by not demonstrating the public nature of her claim, “what she really seeks is

¹⁰ In *Mason*, for example, the Court held that the “injury element will be met if the consumer’s property interest or money is diminished because of the unlawful conduct even if the expenses caused by the statutory violation are minimal.” *Mason*, 114 Wn.2d at 854.

redress for her personal injuries, not injury to her business or property.”

Id. at 179.

Ambach is clearly inapplicable. *Ambach* concerned claims asserted against a doctor for ordinary malpractice in performing a surgery. The present dispute concerns claims asserted against an insurance carrier for the insurance carrier’s systematic violation for Washington’s insurance claims handling regulations. *Ambach* tried to mask her negligence claim by asserting she was injured as a result of this elective surgery—a claim which requires proof of the doctor’s medical negligence. The present dispute concerns claims that Progressive violated Washington’s claims handling regulations and acted in bad faith, and is not dependent on, or a derivative of, proving the insurer is liable for the underlying injuries giving rise to the insurance claim. Progressive opened a PIP claim, and PIP applies without regard to fault, meaning the issues in the present case are not dependent on proving anyone’s liability for causing personal injuries. And *Ambach* did not allege the “the truly public nature” of the defendant’s actions. The Plaintiffs in the present case have. Plaintiffs have filed a putative class action against Progressive for systematically violating claims handling regulations by using claim evaluation criteria Washington law prohibited it from using. And in contrast to *Ambach*, Plaintiffs are asserting claims of bad faith against the insurance carrier.

Claims of bad faith have historically and properly been brought under the CPA, not as “personal injury” actions.

Ambach is unremarkable and limited to its facts. The Court simply noted that the CPA claim was “part and parcel of a personal injury claim.” *Ambach*, at 174. The *Ambach* Court did **not** hold that in a CPA claim involving violations of the claims handling regulations and bad faith, “medical expenses” were personal injury damages unrecoverable as business or property damages. *Ambach* does not alter the rule that any individual—even doctors providing medical treatment—are subject to CPA claims for the entrepreneurial aspects of their business. *Ambach* does not address claims handling regulation violations or the fact that claims handling violations are typically filed under the CPA. The applicability of *Ambach* is limited to cases where an injured plaintiff seeks to apply the CPA against the defendant who directly caused his personal injury. It offers no guidance in the context of claims for bad faith against an insurance company who promised to pay reasonable and necessary medical expenses.

6. Washington Does not Categorically Exclude Medical Expenses from the CPA.

Progressive is overreaching in its assertion that Plaintiffs’ medical expenses as categorically excluded under Washington law. In *Williams v.*

Lifestyle Lift Holdings, Inc., 175 Wn.App. 64, 302 P.3d 523 (Div.1 2013), the Court rejected this argument. There, the Court noted that asserting personal injury claims for damages are not categorically excluded.

Williams, 175 Wn.App at 71. The *Williams* Court noted that *Ambach's* “overriding concern was that the Consumer Protection Act not be used to give plaintiffs ‘backdoor access to compensation they were denied in their personal injury suits.’” *Williams*, 175 Wn.App at 72, citing *Ambach*, 167 Wn.2d at 179 n.6. The *Williams* court noted that the defendant in that case was not a physician and was not practicing medicine, *i.e.*, the claims were not governed by simple negligence. “They were in the business of selling surgeries.” *Williams*, 175 Wn.App at 72. The Court went on to note that *Williams's* Consumer Protection Act claim did not depend on proof that she sustained a personal injury as a result of the surgery, but rather, on the deceptiveness of the Defendant’s conduct. *Id.* at 73. In short, medical expenses are not categorically excluded as “damages” under the CPA. The test is whether the claims concern deceptive practices covered by the CPA, or whether they are a backdoor attempt to obtain compensation not awarded in a suit for personal injuries.¹¹

¹¹ See also *Dees v. Allstate Ins. Co.*, 933 F.Supp.2d 1299,1311, (W.D. Wash. 2013): “The court, however, will not go so far as to categorically preclude Ms. Dees from claiming injury to her property related to her car accident. A CPA injury can include monetary losses: Ms. Dees may be able to prove a property injury resulting from Allstate’s non-payment of her medical bills.”

Likewise, *Panag v. Farmers Ins. Co. of Wash.*, 166 Wn.2d 27, 204 P.3d 885 (2009), concerned a class action against a collection agency using deceptive efforts to collect on an insurance company's underinsured motorist subrogation rights relating to medical expenses paid by the insurer. Panag paid Farmers \$4,500 in settlement "in connection with her personal injury claim." *Panag*, 166 Wn.2d at 35. Defendants argued that Plaintiffs lacked standing to bring a CPA claim "and that respondent Panag has not shown sufficient injury for purposes of a CPA claim." *Id.* at 37. Even the dissent recognized that the nature of the claim involved deceptive methods, rather than personal injury liability or damages. *Id.* at 44. The Court stated that the injury to business or property requirement is met upon proof the plaintiff's "property interest or money is diminished because of the unlawful conduct even if the expenses caused by the statutory violation are minimal." *Panag*, at 47, citing *Mason v. Mortgage Am., Inc.*, 114 Wn.2d 842, 854, 792 P.2d 142 (1990) (temporary loss of use of property while brokerage company improperly withheld title constituted sufficient injury to support attorney fee award under the CPA (citing *Hangman Ridge*, 105 Wn.2d at 792)). "Pecuniary losses occasioned by inconvenience may be recoverable as actual damages." *Id.* citing *Tallmadge v. Aurora Chrysler Plymouth, Inc.*, 25 Wn. App. 90, 605 P.2d 1275 (1979) (costs associated with traveling to dealership in reliance on

false advertisements). “Monetary damages need not be proved; unquantifiable damages may suffice [under the injury to business or property element of the CPA].” *Id.* at 48. In the present case, there is a direct causal connection between Progressive’s deceptive act, and Plaintiffs’ loss of insurance benefits, or Plaintiffs’ payment of expenses that Progressive unlawfully avoided paying. Medical expenses as an element of damages are not categorically excluded by the Act.

7. Citation to Federal Law is Inapposite.

As the Western District Court noted, the federal courts have seized on language in *Ambach*, and have denied recovery in claims asserted against insurance carriers. The federal courts in this district have precluded CPA claims against insurers for bad faith claim handling if the damages at issue involve unpaid medical bills. *Heide v. State Farm Mut. Auto. Ins. Co.*, 261 F. Supp. 3d 1104, 1109-10 (W.D. Wash. 2017) (“Injuries 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.”); *Dees v. Allstate Ins. Co.*, 933 F. Supp 1299, 1310-11 (W.D. Wash. 2013) (“Although [the plaintiff] is correct that money is property, and [the insurance company’s] alleged failure to pay her medical bills may have caused her to pay those bills, payment for medical treatment ‘does not transform medical expenses into business or property harm.’” (quoting

Ambach, 167 Wn.2d at 175)); *Haley v. Allstate Ins. Co.*, C07-1494RSM, 2010 WL 4052935, at *7-8 (W.D. Wash. Oct. 13, 2010) (dismissing CPA claim based on property damage consisting of the loss of funds necessary to pay uncovered medical bills).

The fact that the federal Court has had the opportunity to rule on this issue, however, is not dispositive. As the District Court noted, the federal court may have over-emphasized the reach of *Ambach*, applying *Ambach* to the CPA claims for insurance claims handling violations when it is not warranted. The issue before this Court is whether the federal courts have correctly applied the law. Progressive's reliance on federal cases is not proof of the correctness of *Ambach* but demonstrates the acknowledged need for resolution of this this certified question.

Likewise, Progressive cites Federal RICO statutes and a "business or property" requirement to argue this Court should follow federal law. The Supreme Court of Washington has the final say on Washington law. This Court should not be swayed by Progressive's arguments that the Court should adopt federal definitions of "business or property" damage found in RICO statutes when determining whether Plaintiffs are entitled to recover the damages proximately caused by an insurance carrier's violations of claims handling regulations, which are enforced under the CPA. Moreover, the CPA is to be liberally construed to affect its purpose, and is

one means by which insureds are able to hold their insurance carriers to the good faith standard. The purposes behind RICO, and the federal court's discussions on RICO, are different. This Court need not look at federal authority, or statutes that are different from Washington's CPA both in scope and purpose, in order to resolve this question.

B. The Court Should Answer the Second Certified Question "YES"; All Damages Are Recoverable Under the CPA.

The answer to the second certified question is "Yes." First, Plaintiffs' complaint seeks "all damages" and is not limited to "medical expenses." Second, whether specifically pled or not, the payment for PIP coverage that was tainted by Progressive's use of MMI, as well as the time lost by the Plaintiffs complying with the insurer's unauthorized demands, are facts to be inferred from the Complaint, and are recoverable. Third, in order to undertake its duty to determine the types of damages that are recoverable under CPA, the Court need not consider in the instant case the amount of damages recoverable in order to address the question from the Western District Court.

1. The Western District Court Has Certified This question over Progressive's Objection.

Progressive's argument for the Court to refuse to answer certified question two is built upon an untenable foundation. Before the Western

District Court, Progressive argued that the federal court should not consider any damage claims for premiums paid for PIP coverage, the costs of investigating Progressive's claims handling violations, and/or the time lost complying with Progressive's demand to submit to a medical examination for purposes of determining MMI. Dkt.# 21, p.8.

Progressive argued that these were not damages that had been identified or implicated by Plaintiffs' complaint. The federal court rejected Progressive's argument in certifying this question to this Court.

Progressive now seeks to relitigate that determination, inviting this Court to second-guess the federal court on whether Plaintiffs' complaint meets federal pleading standards. This is a task that the District Court did not ask the Supreme Court to undertake. Even so, there is no state or federal pleading requirement for the level of specificity Progressive asserts is "lacking" from Plaintiff's complaint. There is no state or federal pleading requirement that requires a party to identify the number of hours spent attending a medical examination, or the dollar amount they incurred as a result of each wrongful act performed by a defendant. These details are properly left for discovery. The issue here is whether, as a matter of law, a claim for premiums paid for the PIP coverage, the costs of investigating Progressive's claims handling violations, and/or the time lost complying with Progressive's demand to submit to an examination improperly used

to claim an insured has reached MMI may be recoverable elements of damages under the CPA. *Panag, supra*, holds that, *supra*, these elements of damages are recoverable under the CPA in claims against businesses committing unfair or deceptive acts in trade and commerce. A related question before this Court is whether Plaintiffs' are precluding from recovering these categories of damages because the deceptive act occurred in connection with insurance involving indemnification for payments of medical expenses.

2. Progressive Has Understated Plaintiff's Claims and the Misinterpreted the Western District Court's Order.

Even if this Court does examine the Complaint for sufficiency of allegations, Progressive has grossly minimized both the damages Plaintiffs seek and the damages Plaintiffs have alleged in their complaint. Plaintiffs' complaint seeks "all damages" that were proximately caused by Progressive's use of MMI in limiting or terminating their PIP benefits. With respect to the CPA claim, Plaintiff made a specific claim that stated "Plaintiffs and the Class have been damaged as a result of these violations, and Plaintiffs are entitled to recover their damages, including attorney fees, prejudgment interest, and exemplary damages." Dkt. 11, ¶8.6. Plaintiffs' complaint includes a "Prayer for Relief" and not all of the items listed in the prayer for relief are tied to specific causes of action.

Regardless, Plaintiffs' prayer for relief requests an award of "all damages" suffered as a result of Defendant's conduct, and includes, but is not limited to "any and all medical expenses incurred by claimants following Defendant's denial of PIP benefits using MMI as a criterion for the termination." Dkt. #11, ¶¶10, 12. Progressive has mischaracterized Plaintiffs' claims.¹²

Progressive has also mischaracterized Plaintiffs' arguments on the need to amend the complaint, and the Western District Court's ruling on leave to amend. Progressive even argues that the "federal court denied leave to amend, so the premium damages theory remains unpled." Progressive Opening Brief at p. 28, n. 10. That is not an accurate description. In the district court, Plaintiffs concluded their arguments by noting that once a court determines that the motion to dismiss is merited, the court must then determine if the claimed deficiencies can be cured through an amended pleading. Dkt. #20, p. 21. Plaintiffs asserted that they had sufficiently addressed the damages claimed, *but to the extent there was any defect*, they should be allowed to amend "if necessary." *Id.*

¹² Progressive also claims Plaintiffs "did not allege any injury theories other than unpaid medical bills." Progressive Opening Brief, p.4. This is simply not true, it and assumes a pleading requirement that every single item of damages must be pled with specificity in a complaint.

In denying leave to amend, Judge Lasnik stated: “Because litigation will continue, plaintiffs will have an opportunity to file a fully-supported motion for leave to amend. In such circumstances, the Court will not blindly grant leave to amend.” Dkt. #27 at n. 4. Again, by certifying this question over Progressive’s objection, the federal court has rejected Progressive’s argument that Plaintiffs have not pled claims for damages in the form of the premiums they paid for PIP insurance that was tainted by Progressive’s use of MMI.

3. The Record is Sufficiently Developed for This Court to Address the Question

Progressive concedes that loss of time can be a CPA injury when it causes the plaintiff to take time away from business and results in lost business profits, “at least for a self-employed business owner.” Progressive Opening Brief, p. 31-32, citing *Panag; Sign-O-Lite Signs, Inc. v. DeLaurenti Florists, Inc.*, 64 Wn. App. 553, 564, 825 P.2d 714 (1992), review denied, 120 Wn.2d 1002 (1992). But after objecting to the Western District Court citing an unpublished opinion, Progressive then cites an unpublished opinion to argue that “[t]aking time off work is compensable only when it results in lost business or lost profits.” Progressive Opening Brief, p. 32, citing *Malloy v. Quality Loan Serv. of Washington*, 1 Wn.App. 2d 1038, 2017 WL 6335994, at *6 n.30 (2017)

(unpublished). The facts of the present case, construed favorably to the non-moving party, would support a claim for CPA violations for time spent attending a medical examination that was improperly ordered by Progressive.

Progressive also argues that the Court should refuse to answer the second question because the record has not been sufficiently developed. This case arose upon a motion to dismiss based on the pleadings. Dkt. #19. Progressive did not conduct discovery before filing its motion, nor did it ask for a more definite statement on the damages Plaintiffs were claiming. The fact that Progressive elected to file this motion to dismiss on the pleadings instead of conducting discovery does not make the Plaintiff's allegations of damages inadequate. This question was certified because the Western District Court seeks guidance on determining whether Plaintiffs have stated a claim for relief, or if the damages they seek are excluded under the CPA. The record has been sufficiently developed in order to answer that question.¹³

4. Progressive's Arguments on Number of Hours and Rates are Irrelevant.

¹³ And to the extent Progressive seeks the factual information identified in its motion, such as the number of hours spent attending a meaningless medical examination, or the amount of the Plaintiffs PIP premiums (which it knows, since it sold the PIP coverage to Plaintiffs), Progressive is free to conduct discovery like any other party in litigation.

In an attempt to portray this certified question as giving rise to a hypothetical, Progressive stretches logic and reason to argue that this Court will need to know the number of hours or amount of time Plaintiffs' spent complying with a request to submit to a medical examination (for purposes of determining MMI) in order for this court to rule if such losses are recoverable as a matter of law. This Court is not being asked to decide the amount that Plaintiffs are entitled to recover. Rather, this Court is being asked to decide if the items listed in certified question two are recoverable damages. Progressive's argument on the number of hours and rates charged for attending the medical examination is irrelevant. This court can state as a matter of law what damages are recoverable under the CPA without the need to determine how many hours Mr. Stedman and Ms. Joyce spent at an improperly scheduled medical examination.

5. The Filed-Rate Doctrine does Not Apply.

Progressive treats the Plaintiffs' claims for recovery of the PIP premiums they paid, tainted by Progressive's use of MMI, as an "excess premium" barred by the filed-rate doctrine. In support of this argument, they cite *McCarthy Fin., Inc. v. Premera*, 182 Wn.2d 936, 347 P.3d 872 (2015) for the proposition that the filed-rate doctrine bars a CPA claim. However, *McCarthy* makes clear that Courts may consider, under the

CPA, claims that are related to rates approved by the Office of Insurance Commissioner but do not require the courts to reevaluate any such rate. *Id.* at 938. “In most cases, Washington courts must consider Consumer Protection Act, Wash. Rev. Code §§ 19.86.170,.920, claims alleging general damages merely related to agency-approved rates.” *Id.* at 943. The mere fact that a CPA claim is related to an agency approved rate is not a bar to a CPA claim. *Id.* at 942-943. The filed-rate doctrine does not apply.

V. CONCLUSION.

This Court should answer “YES” to both certified questions. This Court has long held that insurance carriers are required to act in good faith in all insurance matters. The Consumer Protection Act is one of the means available to an insured to enforce that duty. This Court has long held that claims of bad faith against an insurance carrier for violations of the claims handling regulations are enforced through the CPA. No business is immune to the scope of the CPA. In this case, Progressive insured the payment of reasonable and necessary medical expenses of its insureds who were involved in motor vehicle accidents. Progressive breached the claims handling regulations, and Plaintiffs seek all damages proximately caused by Progressive’s actions. This is not a claim for personal injuries, where a plaintiff attempts to shoehorn a claim for personal injuries into the

mold of the CPA, nor a claim that requires proof of the fault for the underlying injury. Rather this claim concerns Progressive's use of deceptive practices to deprive its insureds of what it agreed to indemnify them for. The CPA applies.

Going beyond the scope of this case, Progressive's argument, if adopted, would create an exception under the CPA for insurers who insure payment of medical expenses. The CPA's application to any business or commerce, and the statute's liberal interpretation, do not contemplate creating the exception to enforcement that Progressive proposes. Plaintiffs are entitled to all elements of injury proven to have been a result of Progressive's deceptive acts, even if those damages are indemnification for medical expenses Progressive promised to pay.

This Court has also noted that the damages recoverable under the CPA need not be significant and can include lost interest for money paid out of pocket, and the time spent complying with or addressing unfair or deceptive acts. Even if the cost of treatment itself were not recoverable under the Act, this Court should reaffirm that the amounts Plaintiffs paid in premiums for coverage tainted by MMI are recoverable as damages, as would be the time spent submitting to a medical examinations Progressive

requested in order to conclude that its insureds had reached MMI status.

This Court should answer both certified questions “YES”.

Respectfully submitted this 3rd day of June, 2019.

LAW OFFICE OF RANDALL C. JOHNSON

/s/ Randall C. Johnson
Randall C. Johnson, Jr., WSBA #24556
P.O. Box 15881
Seattle, WA 98115
Telephone: 206-890-0616
Email: rcjj.law@gmail.com

BADGLEY MULLINS TURNER

/s/ Duncan C. Turner
Duncan C. Turner, WSBA #20597
Daniel A. Rogers, WSBA #46372
19929 Ballinger Way NE, Suite 200
Seattle, WA 98155
Telephone: 206-621-6566
Email: dturner@badgleyturner.com
Email: drogers@badgleyturner.com

LAW OFFICE OF DANIEL R. WHITMORE

/s/ Daniel C. Whitmore
Daniel R. Whitmore, WSBA #24012
2626 15th Avenue West, Suite 200
Seattle, WA 98119
Telephone: 206-329-8400
Email: dan@whitmorelawfirm.com

Appellees/Plaintiffs Joel Stedman, et al.

CERTIFICATE OF SERVICE

I declare that on June 3, 2019, I caused a true copy of the foregoing

APPELLEES JOEL STEDMAN, ET AL.'S RESPONSE BRIEF to be

served on the following via the Appellate Court's Portal:

Paul G. Karlsgodt, WSBA No. 40311
James R. Morrison, WSBA No. 43043
Baker & Hostetler LLP
999 Third Avenue, Suite 3600
Seattle, WA 98104-4040
Tel: (206) 332-1101
pkarlsgodt@bakerlaw.com
jmorrison@bakerlaw.com

Philip A. Talmadge, WSBA No. 6973
Talmadge/Fitzpatrick
2775 Harbor Avenue SW
Third Floor, Suite C
Seattle, WA 98126
(206) 574-6661
Phil@tal-fitzlaw.com

David E. Breskin
Brendan W. Donckers
Breskin Johnson & Townsend PLLC
1000 Second Avenue, Suite 3760
Seattle, WA 98104

Michael A. Moore
John T. Bender
Corr Cronin, LLP
1001 Fourth Avenue, Suite 3900
Seattle, WA 98154

Young-Ji Ham
Washington Injury Lawyers, PLLC
1001 Fourth Avenue, Suite 3200
Seattle, WA 98154

David C. Scott
Jay Williams
Schiff Hardin
233 S. Wacker, Suite 6600
Chicago, IL 60606

s/Jennifer Bates
Jennifer Bates, Paralegal
BADGLEY MULLINS TURNER

BADGLEY MULLINS TURNER PLLC

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