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Court of Appeals
Division Two

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

GROUP HEALTH COOPERATIVE, Respondent, v. TERRI LYN HALL, a widow, Appellant.	No. 53381-2-II UNPUBLISHED OPINION

SUTTON, J. — This appeal arises from Terri Lyn Hall's settlement of a personal injury lawsuit and Group Health Cooperative's efforts to investigate her claim to determine whether it had a right of reimbursement after paying over $83,000 in medical expenses resulting from her injuries. Hall asserted that Group Health had no right to reimbursement under well settled law because her settlement did not make her whole. Group Health sued Hall for reimbursement, claiming that she could not challenge the right to reimbursement because she had breached the duty to cooperate under Group Health's Medical Coverage Agreement (MCA) by failing to provide Group Health with information regarding her personal injury claim. Hall appeals the superior court's grant of summary judgment in favor of Group Health and the summary judgment dismissal of her counterclaims for breach of contract, bad faith, and Consumer Protection Act (CPA), chapter 19.86 RCW, violations.

Hall argues that (1) being made whole is a condition precedent to a duty to cooperate under the MCA and because she was not made whole, a duty to cooperate never arose; (2) even if a duty

to cooperate did arise, there are genuine issues of material fact as to whether she failed to cooperate; and (3) genuine issues of material fact exist as to whether any breach of the cooperation provision prejudiced Group Health. She also argues that factual issues remain regarding her counterclaims for breach of contract, bad faith, and CPA violations.

We hold that the superior court erred by granting summary judgment in favor of Group Health. However, we affirm the court's partial summary judgment dismissal of Hall's counterclaims of bad faith and CPA violations, but we reverse partial summary judgment dismissal of Hall's counterclaim for breach of contract. Accordingly, we reverse in part, affirm in part the court's summary judgment order, and remand for further proceedings consistent with this opinion.

FACTS

I. BACKGROUND

A. THE MCA

Group Health provided Hall with medical insurance coverage beginning in January 2012. Group Health's coverage was subject to Group Health's MCA, which required Hall and her attorneys to not prejudice Group Health's rights to subrogation and reimbursement when Group Health paid medical benefits and to protect Group Health's interest when engaging in settlement with a third party.

The MCA contained a subrogation and reimbursement provision that gave Group Health the right to recover medical expenses paid on Hall's behalf from any third-party settlement:

> If [Group Health] provides benefits under this Agreement for the treatment of the injury or illness, [Group Health] will be subrogated to any rights that the Member may have to recover compensation or damages related to the injury or illness and the Member shall reimburse [Group Health] for all benefits provided, from any

> amounts the Member received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise.

Clerk's Papers (CP) at 1269. However, the MCA also limited Group Health's subrogation and reimbursement rights to "the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages." CP at 1269.

The MCA required Hall and her attorney to cooperate with Group Health in its efforts to collect its medical expenses by, among other things, giving Group Health certain information:

> *The Injured Person and his/her agents shall cooperate fully with [Group Health] in its efforts to collect [Group Health]'s Medical Expenses*. This cooperation includes, but is not limited to, *supplying [Group Health] with information* about the cause of injury or illness, any potentially liable third parties, defendants and/or insurers related to the Injured Person's claim and *informing [Group Health] of any settlement* or other payments relating to the Injured Person's injury.

CP at 1269 (emphasis added). In addition, the MCA stated:

> If the Injured Person fails to cooperate fully with [Group Health] in recovery of [Group Health]'s Medical Expenses, *the Injured Person shall be responsible for directly reimbursing [Group Health] for 100% of [Group Health]'s Medical Expenses*.

CP at 1270 (emphasis added).

The MCA also stated:

> To the extent that the Injured Person recovers funds from any source that may serve to compensate for medical injuries or medical expenses, *the Injured Person agrees to hold such monies in trust* or in a separate identifiable account until [Group Health]'s subrogation and reimbursement rights are fully determined and that [Group Health] has an equitable lien over such monies to the full extent of [Group Health]'s Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of [Group Health]'s Medical Expenses.

CP at 1270 (emphasis added).

Finally, the MCA provided that "under certain conditions" Group Health would "reduce the amount of reimbursement to [Group Health] by the amount of an equitable apportionment" of attorney's fees so long as Hall provided Group Health with "a list of the fees and associated costs before settlement" and "the Injured Person's attorney's actions were reasonable and necessary to secure recovery." CP at 1270.

B. THE ACCIDENT

On September 18, 2012, Hall fell and fractured her right leg and her left pinky finger. On October 4, she notified Group Health of her injury and stated that she had filed a personal injury claim with the insurance company of the building where she fell. Group Health ultimately paid over $83,000 in medical benefits because of Hall's injuries.

On May 8, 2013, an attorney sent Group Health a letter informing Group Health that Hall had retained his firm to represent her in all matters arising from her fall.

C. HALL'S PERSONAL INJURY SETTLEMENT AND GROUP HEALTH'S COMMUNICATIONS

In December 2014, Hall filed suit against the owner of the building where she fell, Labor 1992 Corporation. Following Hall's notice that she intended to settle, Group Health's attorney sent three letters and one email to Hall's attorney. None of those communications stated that Group Health needed information from Hall in order to determine whether it had a right to reimbursement.

1. April 5, 2016 Letter from Group Health

The first of Group Health's letters was dated April 5, 2016. In that letter, Group Health's attorney stated that he would review the file and would be in touch. The letter did not request any information from Hall.

Significantly, Group Health's attorney later claimed in a June 10, 2016 letter (discussed below) that "[i]n my letter of April 5, 2016, I requested that you provide our office with certain information in support of your claim for a reduction in Group Health's subrogation claim." CP at 1217. That statement was not accurate.

2. April 27, 2016 Letter from Group Health

The second of Group Health's letters was dated April 27, 2016. The letter noted that Hall had settled for less than available policy limits, and that such a settlement was evidence that she had been fully compensated.[1] The letter discussed two cases in which the courts ruled that an injured person had been fully compensated by a settlement for less than their policy limits. The letter then stated, "[Y]ou and Ms. Hall were aware of Group Health's subrogation claim, and also knew of the other attorney fees and costs that would have to be deducted from any settlement amount. *If the settlement offer did not reflect what you believed to be full compensation, then you did not have to accept it.* You could have, instead, had the question of full compensation decided through trial." CP at 1207 (emphasis added).

Finally, the letter asserted that Group Health was entitled to reimbursement: "Based on the information I have been provided and the above-cited case law, *it is Group Health's position* that Group Health is entitled to be reimbursed for the amounts it expended for Ms. Hall's medical care." CP at 1207 (emphasis added).

In conclusion, the letter stated,

[1] Hall's settlement was for $600,000. The tortfeasor's policy limits were $2 million.

> Our position is based upon the information made available to us to date. *Should you wish to provide additional evidence to support your claim for a reduction in Group Health's subrogation claim, we would, of course, be willing to review the same.* Information which would be helpful in that review would be a copy of your mediation statement, as well as all materials provided to the mediator, copies of medical records, expert reports and any other information you believe supports your position.

CP at 1207 (emphasis added).

3. May 5, 2016 Email from Group Health

On May 5, 2016, Group Health's attorney sent an email to Hall's attorney. The email stated, "I have not received any of the records I requested in my last letter to you. When will you be providing me the requested information?" CP at 1213. This email was somewhat misleading. Group Health's attorney did not specifically request records from Hall's attorney in the April 27 letter. He stated that *if* Hall's attorney *wished* to provide additional information, Group Health would review it.

4. June 10, 2016 Letter from Group Health

Group Health's final letter before filing suit was dated June 10, 2016. The letter stated that Group Health's attorney had not received information requested in the April 5 letter and the May 5 email. The letter quoted the cooperation provision in the MCA and related provisions, and stated,

> As a result of the foregoing, your client has failed to cooperate fully with Group Health in regard to this claim and is in violation of the terms of her policy. Said policy violations include, but are not limited to:
>
> 1. Failure to promptly notify Group Health of a tentative settlement;
> 2. Prejudicing Group Health's rights to reimbursement; and
> 3. Failure to cooperate with Group Health and provide requested information.

> Accordingly, your client's policy requires that you and your client directly reimburse Group Health for the full amount of any benefits paid on her behalf to date.

CP at 1218. The letter did not state that any additional information would change Group Health's position or that additional information would be required by Group Health.

II. PROCEDURAL HISTORY

On September 16, 2016, Group Health filed a complaint seeking a declaratory judgment of $83,580.66 to reimburse it for medical expenses it paid related to Hall's personal injury claim. The complaint alleged that Hall failed to cooperate, breached the MCA, and prejudiced Group Health. Hall counterclaimed for breach of contract, bad faith, and violations of the CPA.

During discovery, Hall and her attorney produced medical records and expert reports addressing the injuries purportedly caused by her fall and disclosing that she had a long history of problems with her right leg.

Group Health filed a motion for summary judgment, arguing that Hall breached her duty to cooperate by refusing to provide any of the information Group Health requested, and thus, she was required to reimburse Group Health for all of its medical expenses. It also requested dismissal of Hall's counterclaims. The superior court granted summary judgment ruling that "based on the undisputed facts and the case law . . . Ms. Hall has not fully cooperated" and dismissed her claim with prejudice and entered judgment for Group Health in the amount of $83,329.66.[2] CP at 1920-

[2] The total amount Group Health was awarded at summary judgment, $83,329.66, differs from the amount it initially sought, $83,580.66, because it was reimbursed in the amount of $251.00 by Labor 1992 Corporation's insurer, Mutual of Enumclaw.

22, 1923-28; Verbatim Report of Proceedings (VRP) (Nov. 2, 2018) at 76-77. The superior court also dismissed Hall's counterclaims. Hall appeals the superior court's summary judgment orders.

ANALYSIS

I. LEGAL PRINCIPLES

A. SUMMARY JUDGMENT STANDARD

We review summary judgment orders de novo. *Mackey v. Home Depot USA, Inc.*, 12 Wn. App. 2d 557, 569, 459 P.3d 371, *review denied*, 195 Wn.2d 1031 (2020). We review all evidence and reasonable inferences in the light most favorable to the nonmoving party. *Mackey*, 12 Wn. App. 2d at 569. But if there are genuine issues of material fact, then the order granting summary judgment must be overturned. CR 56(c); *Mackey*, 12 Wn. App. 2d at 569. There is a genuine issue of material fact when reasonable minds could disagree on the facts controlling the outcome of the litigation. *Mackey*, 12 Wn. App. 2d at 569.

The party moving for summary judgment bears the initial burden of demonstrating that there is no genuine issue of material fact. *Mackey*, 12 Wn. App. 2d at 569. A moving defendant can meet this burden by demonstrating that the plaintiff cannot support his or her claim with any evidence. *Mackey*, 12 Wn. App. 2d at 569. After the defendant has made such a showing, the burden shifts to the plaintiff to present specific facts that reveal a genuine issue of material fact. *Mackey*, 12 Wn. App. 2d at 569. Summary judgment is appropriate if a plaintiff fails to show sufficient evidence that creates a question of fact about an essential element on which he or she will have the burden of proof at trial. *Mackey*, 12 Wn. App. 2d at 569.

When an appeal arises out of an order granting summary judgment, we engage in the same inquiry as the trial court. *Group Health Coop. v. Coon*, 193 Wn.2d 841, 849, 447 P.3d 139 (2019).

Summary judgment is proper only when "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." CR 56(c). "'All facts and reasonable inferences are considered in the light most favorable to the nonmoving party, and all questions of law are reviewed de novo.'" *Coon*, 193 Wn.2d at 849-50 (quoting *Mountain Park Homeowners Ass'n v. Tydings,* 125 Wn.2d 337, 341, 883 P.2d 1383 (1994)).

B. FULL COMPENSATION RULE

Interpretation of an insurance contract is a question of law that we review de novo. *Woo v. Fireman's Fund Ins. Co.*, 161 Wn.2d 43, 52, 164 P.3d 454 (2007).

In *Coon*, our Supreme Court reiterated that

> "while an insurer is entitled to be reimbursed to the extent that its insured recovers payment for the same loss from a [tortfeasor] responsible for the damage, it can recover only the excess which the insured has received from the wrongdoer, remaining after the insured is *fully compensated* for the loss."

193 Wn.2d at 850 (alteration in original) (quoting *Thiringer v. Am. Motors Ins. Co.*, 91 Wn.2d 215, 219, 588 P.2d 191 (1978)). "This 'made whole' principle 'embodies a policy deemed socially desirable in this state.'" *Coon*, 193 Wn.2d at 850 (quoting *Thiringer*, 91 Wn.2d at 220). This rule applies to health insurance policies. *Coon*, 193 Wn.2d at 854.

"Settlement for less than the tortfeasor's policy limits does not create a presumption of full compensation." *Coon*, 193 Wn.2d at 855. "Instead, acceptance of a settlement is simply *some evidence* that the insured has been full compensated." *Coon*, 193 Wn.2d at 855. In addition, full compensation is determined without any reduction for comparative fault. *Sherry v. Fin. Indem. Co.*, 160 Wn.2d 611, 625-26, 160 P.3d 31 (2007). "An insurer is entitled to an offset, setoff, or reimbursement when both: (1) the contract itself authorizes it and (2) the insured is fully

compensated by the relevant 'applicable measure of damages.'" *Sherry*, 160 Wn.2d at 619 (quoting *Barney v. Safeco Ins. Co. of Am.*, 73 Wn. App. 426, 429, 869 P.2d 1093 (1994)).

If the insured breaches the contract, the insurer has a remedy, but only if there is prejudice to the insurer from the insured's breach. *Coon*, 193 Wn.2d at 858. The insurer has the burden of proof to demonstrate prejudice by the insured's actions. *Coon*, 193 Wn.2d at 857. "'To establish prejudice, the insurer must show concrete detriment . . . together with some specific harm to the insurer caused thereby.'" *Coon*, 193 Wn.2d at 857 (alteration in original) (internal quotation marks omitted) (quoting *Pilgrim v. State Farm Fire & Cas. Co.*, 89 Wn.2d 712, 724-25, 950 P.2d 479 (1997)). "Determining prejudice from a policy breach is a question of fact for the jury and 'will seldom be established as a matter of law.'" *Coon*, 193 Wn.2d at 857 (quoting *Tran v. State Farm Fire & Cas. Co.*, 136 Wn.2d 214, 228, 961 P.2d 358 (1998)).

II. BREACH OF DUTY TO COOPERATE

Hall argues that the superior court erred by granting summary judgment in favor of Group Health based on a finding that she breached the duty to cooperate. She argues that full compensation was a condition precedent to the duty to cooperate, she was not fully compensated, and there are genuine issues of material fact as to whether she breached the duty to cooperate and whether any breach of the duty to cooperate prejudiced Group Health. We agree that factual issues remain regarding Hall's alleged breach of the duty to cooperate and prejudice.

A. EXISTENCE OF DUTY TO COOPERATE

"[T]o determine the scope of [an insured's] duty to cooperate with the insurer, we must first look to the relevant policy language." *Tran*, 136 Wn.2d at 225. Here, the MCA expressly

required Hall and her attorneys to "*cooperate fully* with [Group Health] in its efforts to collect [Group Health]'s Medical Expenses." CP at 1269 (emphasis added).

This cooperation included providing information related to the cause of her injuries, any potential third party liability and applicable insurance, promptly informing Group Health of any settlement, and not settling the claim without protecting Group Health's interest. The MCA also required Hall and her attorneys to do nothing to prejudice Group Health's right of subrogation or reimbursement, and hold in trust any recovered monies as a constructive trustee. Thus, we hold that the superior court correctly found that Hall and her attorneys had a duty to cooperate under the MCA.

B. "MADE WHOLE" IS NOT A CONDITION PRECEDENT TO THE DUTY TO COOPERATE

Hall argues that being made whole is a condition precedent for a duty to cooperate to arise under the MCA. We disagree because the MCA does not require that Hall be made whole prior to a duty to cooperate with Group Health.

Whether an insured has been "made whole" is determined "by the relevant 'applicable measure of damages.'" *Sherry*, 160 Wn.2d at 619 (quoting *Barney*, 73 Wn. App. at 429). "A condition precedent is an event occurring after the making of a valid contract which must occur before a right to immediate performance arises." *Jones Assocs., Inc. v. Eastside Properties, Inc*., 41 Wn. App. 462, 466, 704 P.2d 681 (1985). "'Whether a provision in a contract is a condition, the nonfulfillment of which excuses performance, depends upon the intent of the parties, to be ascertained from a fair and reasonable construction of the language used in the light of all the surrounding circumstances.'" *Jones*, 41 Wn. App. at 466-67 (quoting *Ross v. Harding*, 64 Wn.2d 231, 236, 391 P.2d 526 (1964)). "'An intent to create a condition is often revealed by such phrases

and words as "provided that," "on condition," "when," "so that," "while," "as soon as," and "after."'" *Jones*, 41 Wn. App. at 467 (quoting *Vogt v. Hovander*, 27 Wn. App. 168, 178, 616 P.2d 660 (1979)). "Where it is doubtful whether words create a promise or an express condition, they are interpreted as creating a promise." *Jones*, 41 Wn. App. at 467.

The MCA requires that Hall and her attorneys "shall cooperate fully with [Group Health] in its efforts to collect [Group Health]'s Medical Expenses." CP at 1269. Hall acknowledges that assessing whether she was made whole is a prerequisite to Group Health determining whether it has a right to reimbursement, and thus a necessary part of Group Health's "efforts to collect or recover its Medical Expenses." Appellant's Opening Br. at 22.

Construing Hall's duty of cooperation as arising only after she has been fully compensated would nullify the duty to cooperate clause and Group Health's right to reimbursement. *See Seattle–First Nat'l Bank v. Westlake Park Assocs.*, 42 Wn. App. 269, 274, 711 P.2d 361 (1985) ("An interpretation which gives effect to all of the words in a contract provision is favored over one which renders some of the language meaningless or ineffective."). If insureds are not required to cooperate until an insurer proves the insured has been made whole, an insured's duty of cooperation would never arise because an insurer cannot prove that the insured has been made whole without the insured's cooperation.

No language in the MCA conditions a duty to cooperate on Hall being made whole. CP at 1269-70. Hall's argument would negate her duty to cooperate because, as the superior court recognized, Group Health could not prove Hall had been "made whole" without the information Hall refused to provide so that Group Health could assess her claim that she was not made whole. VRP (Nov. 2, 2018) at 76-77. Accordingly, Hall and her attorney were required to cooperate with

Group Health's efforts, including by providing "information about the cause of injury." CP at 1269.

The MCA contains no conditional qualifiers on a duty to cooperate, nor does it in any way reference the language limiting Group Health's reimbursement "to the excess of the amount required to fully compensate" Hall. CP at 1269. Moreover, the MCA states that an insured who "recovers funds from any source that may serve to compensate for medical injuries or medical expenses" must "hold such monies in trust or in a separate identifiable account until [Group Health]'s subrogation and reimbursement rights are fully determined." CP at 1270. This language underscores that a duty to cooperate arose when Hall received the settlement funds, and that it was not conditioned on Group Health proving that she had been made whole.

The superior court correctly rejected Hall's interpretation of the MCA because of the impossible scenario it required Group Health to resolve in order to assert its right to reimbursement: "how is it that Group Health meets its burden of showing that your client was not fully compensated, if there is no obligation on your client's part to cooperate with Group Health?" VRP (Nov. 2, 2018) at 62.

We hold that the superior court correctly ruled that a duty to cooperate is not a condition precedent of Hall being made whole by the settlement. We next address whether there was a breach of the MCA.

C. BREACH OF DUTY TO COOPERATE

"[T]o determine the scope of [an insured's] duty to cooperate with the insurer, we must first look to the relevant policy language." *Tran*, 136 Wn.2d at 225.

Group Health claims that Hall breached her duty to cooperate because Group Health expressly requested that she provide information about her claim and she refused. But there is at least a question of fact as to whether Group Health actually requested such information.

As noted above, the April 5, 2016 letter from Group Health did not request any information despite Group Health's later claim that it did. And in the April 27 letter, Group Health did not *request* that Hall provide any information. Instead, Group Health's attorney took a firm position that Group Health was *entitled* to reimbursement because Hall had settled for less than the tortfeasor's insurance policy limits. The letter then stated that *if* Hall's attorney *wished* to provide additional information, Group Health would review it. In other words, Group Health had made its decision. But if Hall wanted Group Health to change its position, Hall would have to provide additional information.

Group Health's May 5 email asked when Hall's attorney would be providing the requested information. But this email must be read in light of the April 27 letter. Again, that letter did not request any information; it merely invited Hall's attorney to provide it if Hall wanted Group Health to change its position.

The actual language of Group Health's letters creates a question of fact as to whether Group Health requested that Hall provide information, and therefore, whether Hall failed to cooperate by disregarding that request. There is evidence that Hall merely declined Group Health *invitation* to provide additional information, which a jury could find did not breach the duty to cooperate.

D. PREJUDICE FROM BREACH

Hall argues that the superior court erred by determining that Group Health was prejudiced as a matter of law by the breach of the MCA. We agree.

Prejudice can "be established as a matter of law" only when the insurer shows "specific harm" from the insured's refusal to cooperate. *Tran*, 136 Wn.2d at 228; *Pilgrim*, 89 Wn. App. at 725.

Even if Hall breached the cooperation provision, Group Health is entitled to a remedy only if the breach caused prejudice. *Coon*, 193 Wn.2d at 856-57. In insurance law, "'not every breach discharges performance by the other party.'" *Coon*, 193 Wn.2d at 856 (quoting *Pilgrim*, 89 Wn. App. at 724)). Significantly, the insurer has the burden of proving that it was prejudiced. *Coon*, 193 Wn.2d at 857.

Our Supreme Court in *Coon* emphasized that "[d]etermining prejudice from a policy breach is a question of fact for the jury and 'will seldom be established as a matter of law.'" *Coon*, 193 Wn.2d at 857 (quoting *Tran*, 136 Wn.2d at 228).

Group Health now claims that it was prejudiced because Hall's failure to provide information about her claim prevented it from evaluating the right to reimbursement from Hall's settlement. Group Health also claims that it could not evaluate the right to reimbursement because it did not have enough information to determine whether Hall had been fully compensated. But there is at least a question of fact as to whether Group Health was prevented from evaluating its right to reimbursement.

The undisputed evidence shows that Group Health *did* evaluate its right to reimbursement without the need for any information from Hall. As noted above, the April 27 letter unequivocally stated Group Health's legal position that there was a right to reimbursement *because Hall settled for less than available policy limits*. Thus, it appears the only information Group Health needed to make this decision was the amount of the settlement and the amount of the tortfeasor's policy

limits, which Group Health already had. Additional information about Hall's claim was not relevant to that decision.

Group Health continued to assert this position in the superior court. In its summary judgment brief, Group Health stated, "Because Defendant Hall did not exhaust the tortfeasor's assets, the full compensation rule upon which the Defendant relies does not apply." CP at 1347. Later in their brief, Group Health stated, "The question of whether an insured has not been fully compensated, and therefore need not reimburse her insurer for its subrogated interest from third-party settlement proceeds, arises only when the tortfeasor's assets, or at least those assets readily accessible through an insurance policy, have been exhausted." CP at 1357.

Finally, Group health concluded, "An adequate pool of funds existed to satisfy Defendant Hall's and [Group Health]'s claims. Under these circumstances, [Group Health] is entitled *as a matter of law* to reimbursement of its subrogation claim. In summary, Defendant Hall did not exhaust the tortfeasor's assets, so the question of full compensation does not arise." CP at 1361-62 (emphasis added).

In fact, the position Group Health took in the April 27 letter and the summary judgment briefing was wrong. The Supreme Court in *Coon* stated, "Settlement for less than the tortfeasor's policy limits does not create the presumption of full compensation. Instead, acceptance of a settlement is simply *some evidence* that the insured has been fully compensated." 193 Wn.2d at 855 (citation omitted).

The fact that Group Health took a firm position that it was entitled to reimbursement before requesting any information from Hall creates a question of fact regarding prejudice. There is evidence that Group Health would have maintained that position even if Hall had provided

additional information, because it was based on an erroneous legal conclusion that settlement for less than the tortfeasor's policy limits established that Hall had been fully compensated. Based on this evidence, a jury could find that any breach of the duty to cooperate did not prejudice Group Health.

III. DISMISSAL OF HALL'S COUNTERCLAIMS

Hall argues that the superior court erred by dismissing her counterclaims for breach of contract, bad faith, and CPA violations. We hold that the superior court did err by dismissing the breach of contract claim because there are genuine issues of material fact, but it did not err by dismissing the claims of bad faith and CPA violations.

A. BREACH OF CONTRACT

Hall argues that she was forced to sue Group Health "in order to gain the benefits of the contract," and that Group Health violated its duty of good faith under *Tank v. State Farm Fire and Casualty Co.*,[3] and its duty of good faith under RCW 48.01.030[4] and WAC 284-30-330(1).[5]

Group Health paid $83,580.66 for Hall's medical expenses promptly and without question. Group Health then requested that Hall and her attorneys provide it with necessary information that

[3] 105 Wn.2d 381, 387, 715 P.2d 1133 (1986). In *Tank*, the court held that an insurer owes its insured a duty of good faith. 105 Wn.2d at 387.

[4] RCW 48.01.030 states, "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. Upon the insurer, the insured, their providers, and their representatives rests the duty of preserving inviolate the integrity of insurance."

[5] WAC 284-30-330(1) states, "The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance, specifically applicable to the settlement of claims: . . . [m]isrepresenting pertinent facts or insurance policy provisions."

would have allowed it to determine whether she had been fully compensated for her injuries. But Hall and her attorneys then refused to provide that information, forcing Group Health, not Hall, to sue for a declaratory judgment to gain the benefit of its contract. We held earlier that the actual language of Group Health's letters creates a question of fact as to whether Group Health requested that Hall provide information and therefore whether Hall failed to cooperate by disregarding that request and caused prejudice to Group Health. There is evidence that Hall merely declined Group Health's *invitation* to provide additional information, which a jury could find that Hall did not breach the duty to cooperate. For similar reasons and viewing the evidence in the light most favorable to Hall, there is a genuine issue of material fact as to whether Group Health breached its contract. Thus, we hold that the superior court erred by dismissing her breach of contract claim on partial summary judgment.

B. BAD FAITH

Insurers owe policy holders a duty to act in good faith. *Smith v. Safeco Ins. Co.*, 150 Wn.2d 478, 484, 78 P.3d 1274 (2003). "To succeed on a bad faith claim, the policyholder must show the insurer's breach of the insurance contract was unreasonable, frivolous, or unfounded." *Smith,* 150 Wn.2d at 484. Evidence of intentional bad faith or fraud is not required. *Indus. Indem. Co. of the Nw., Inc. v. Kallevig*, 114 Wn.2d 907, 916, 792 P.2d 520 (1990). An insurer has acted in bad faith if it denies coverage without a reasonable justification. *Kallevig,* 114 Wn.2d at 917. "Harm . . . is an essential element" of a bad faith claim and an insurer is entitled to summary judgment "if a reasonable person could conclude that the insured suffered no harm." *Werlinger v. Clarendon Nat'l Ins. Co.*, 129 Wn. App. 804, 808, 120 P.3d 593 (2005). We hold that Hall fails to establish

a factual issue that Group Health acted in bad faith, and thus, the court did not err by dismissing this counterclaim.

Hall first claims that Group Health acted in bad faith and breached its duty to evaluate her $5,000 settlement offer to resolve the reimbursement issue, citing *Truck Ins. Exch. of the Farmers Ins. Group. v. Century Indem. Co*., 76 Wn. App. 527, 534, 887 P.2d 455 (1995). But here, the settlement offer was from Hall not a third party, and Group Health did not act in bad faith by rejecting her settlement offer which required it to forfeit its contractual right of reimbursement.

Hall next claims that Group Health misrepresented pertinent facts and insurance policy provisions by sending her multiple collection letters. The record does not support Hall's claim because the letters Group Health sent her were not collection letters. Nor did Group Health ever tell Hall it had commenced a collection proceeding against her; instead, it requested that her attorneys "please contact [it] . . . to discuss . . . reimbursement." CP at 1218, 1213 (Group Health's attorney wrote, "I have not received any of the records I requested in my last letter . . . . When will you be providing me the requested information?").

Group Health did not act improperly by asking Hall to cooperate with its investigation of its right to reimbursement or by filing this action when she and her attorneys refused to cooperate. Group Health did not act in bad faith because it was within its right to pursue its right to reimbursement under the policy and to request information from Hall and her attorneys in order to investigate and determine whether Hall had been fully compensated.

Hall next claims that Group Health misrepresented a pertinent fact in its letter to her attorneys by informing her that it was "entitled to reimbursement for its medical treatment." Appellant's Opening Br. at 40. She argues that the Group Health also failed to inform her that

Group Health's right to reimbursement arose after she was "fully compensated." Appellant's Opening Br. at 41. But in a letter sent before the one cited by Hall, Group Health told Hall that it would have the right to reimbursement "if the at-fault party is liable and the at-fault party has sufficient assets to compensate you." CP at 1220. Group Health's actions do not constitute bad faith.

Hall next argues that Group Health overemphasized its own interests and failed to practice honesty and equity by pursuing its right of reimbursement of the entire $83,580.66, without paying a share of her attorney fees and costs. But the language in Group Health's policy provided for reimbursement without paying attorney fees if Hall breached the cooperation clause. Although we find questions of fact regarding breach of the cooperation clause, Group Health's position is not unreasonable, and therefore does not constitute bad faith.

Hall then argues that Group Health's proceeding to litigate the medical expenses, which expenses had already been paid by a third party insurer, constitutes bad faith. Again, Group Health's position was not unreasonable. These actions do not rise to the level of bad faith.

Hall also claims that Group Health dealt unfairly with her by circumventing its legal obligations to pay its share of her fees and costs, construing the contract in an absurd way to sidestep the fee provision, constituting bad faith. Again, we do not find that Group Health's interpretation of the policy was unreasonable. These actions do not constitute bad faith. Because Hall fails to raise any factual issues of bad faith by Group Health, we hold that the court did not err by dismissing this counterclaim.

C. CPA VIOLATIONS

To prevail in a private CPA claim, Hall must prove the following: "'(1) unfair or deceptive act or practice; (2) occurring in trade or commerce; (3) public interest impact; (4) injury to plaintiff in his or her business or property; [and] (5) causation.'" *Mellon v. Reg'l Tr. Services Corp.*, 182 Wn. App. 476, 487-88, 334 P.3d 1120 (2014) (alteration in original) (quoting *Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co.*, 105 Wn.2d 778, 780, 719 P.2d 531 (1986)).

Hall claims that under RCW 48.30.010, a single violation of WAC 284-30-330 is an unfair trade practice under the CPA and Group Health's breach of its duty of good faith is a "per se" violation of the CPA. Appellant's Opening Br. at 45 (citing *Gosney v. Fireman's Fund Ins. Co.*, 3 Wn. App. 2d 828, 419 P.3d 447 (2018)). However, as discussed above, we hold that Group Health did not act in bad faith in its dealings with Hall. Therefore, Hall's CPA claim also must fail.

ATTORNEY FEES

Hall requests an award of appellate attorney fees and costs under RAP 18.1, RCW 19.86.090, *McRory v. N. Ins. Co. of New York*, 138 Wn.2d 550, 980 P.2d 736 (1999), and *Olympic S.S. Co., Inc. v. Centennial Ins. Co.*, 117 Wn.2d 37, 811 P.2d 673 (1991). But those authorities do not provide a basis for an award of attorney fees in this case. Accordingly, we deny Hall's request for attorney fees.

CONCLUSION

We hold that the superior court erred by granting summary judgment in favor of Group Health. However, we affirm the court's partial summary judgment dismissal of Hall's counterclaims of bad faith and CPA violations, but we reverse partial summary judgment dismissal of Hall's counterclaim for breach of contract. Accordingly, we reverse in part, affirm in part the court's summary judgment order, and remand for further proceedings consistent with this opinion.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

Sutton, J.

SUTTON, J.

We concur:

, C.J.

LEE, C.J.

Maxa, J.

MAXA, J.