FILED
SUPREME COURT
STATE OF WASHINGTON
3/21/2023 11:01 AM
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CLERK

No. 101576-3

SUPREME COURT
OF THE STATE OF WASHINGTON

STAN SCHIFF, M.D., PH.D.,

Respondent,

v.

LIBERTY MUTUAL FIRE INSURANCE CO., LIBERTY MUTUAL INSURANCE COMPANY,

Petitioners.

PETITIONERS' ANSWER TO AMICI CURIAE BRIEFS IN SUPPORT OF PETITION FOR REVIEW

John M. Silk,
WSBA #15035
Wilson Smith Cochran Dickerson
901 Fifth Avenue, Suite 1700
Seattle, WA 98164
(206) 623-4100

Philip A. Talmadge,
WSBA #6973
Talmadge/Fitzpatrick
2775 Harbor Avenue SW
Third Floor, Suite C
Seattle, WA 98126
(206) 574-6661

James A. Morsch
Saul Ewing Arnstein & Lehr
161 N. Clark St., Suite 4200
Chicago, IL 60601
(312) 876-7100

Marc A. Fuller
Jackson Walker LLP
2323 Ross Avenue, Suite 600
Dallas, TX 75201
(214) 953-6000

Attorneys for Petitioners Liberty Mutual Fire Insurance Company and Liberty Mutual Insurance Company

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A. INTRODUCTION

The briefs submitted by *amici curiae* Mitchell International, Inc. ("Mitchell") and the American Property Casualty Insurance Association ("APCIA") confirm that Division I's decision will have broad, severely negative impacts on the PIP and MedPay markets in Washington.[1] They explain that the decision creates an "unworkable" framework in which insurers must investigate the reasonableness of providers' billed charges—and do so in a short timeframe—but are denied the automated data tools necessary to perform those investigations. The *amici* also show how policyholders and providers will suffer as a result of this "unworkable" framework. On issues ranging from the reasonableness of Liberty's practices to Division I's disregard of the Office of Insurance Commissioner's ("OIC")

[1] This answer will use the same shorthand references as Liberty's petition for review ("Petition" or "Pet."). Citations to Division I's decision will be to the slip opinion ("Op.") in the appendix of Liberty's Petition.

regulatory determinations, the *amici* emphasize the need for this Court's review.

B. THE AMICI CONFIRM THAT DIVISION I'S DECISION IS UNTENABLE FOR INSURERS AND WILL ADVERSELY IMPACT POLICYHOLDERS AND MEDICAL PROVIDERS.

The *amici* confirm that Division I's erroneous interpretation of the Insurance Code and applicable WAC regulations will "negatively and significantly" affect insurers, policyholders, and medical providers. Mitchell Br. at 2. The decision makes Washington an outlier in PIP and MedPay, and undermines the State's ongoing efforts to use medical claims data to improve efficiency, foster transparency, and contain rising costs in health care.

(1) The Decision Imposes an "Unworkable" Framework for PIP and MedPay Claims Investigations.

Liberty's petition noted that the type of investigations that Division I's decision requires "would be impossible to implement." Pet. at 13-14. In response, Dr. Schiff scoffed at the suggestion, yet failed to explain how "individualized"

investigations into providers' personal characteristics could be performed, especially for high-volume PIP and MedPay claims. Resp. at 6.

The *amici* confirm that Liberty is correct. Mitchell, a leading claims-management company with several decades of experience reviewing medical bills, explains that the information that Division I's decision would require insurers to consider "is neither publicly available nor verifiable." Mitchell Br. at 4. Insurers often do not know from a facility's bills who provided each service (especially when treatments are performed by nurses or other staff), and are not informed about the providers' education, experience, credentials, or other personal characteristics. *Id.* Even if insurers had a reliable source for this information, "there is no evidence" that it would provide objective insights into the reasonableness of charges for routine treatments.[2] *Id*. at 7. As Mitchell notes, this is particularly true

[2] This observation, which is based on Mitchell's decades of experience, is echoed by the undisputed expert testimony that

for the types of treatments most commonly covered under PIP and MedPay, which "are not unusual or difficult to perform." *Id.* at 6-7.

APCIA also warns of the impossible predicament that insurers will face if they are prohibited from relying on computerized databases like FAIR Health. APCIA Br. at 3-4. The Insurance Code requires that insurers pay *only* a "reasonable" amount for PIP-covered treatment. RCW 48.22.095(1)(a); RCW 48.22.005(7). Thus, the Washington legislature clearly intended for insurers to investigate the reasonableness of providers' billed fees by comparing them to the fees charged by other providers. *Id.* But those investigations must be efficient because payment must be prompt. WAC 284-30-360(1); WAC 284-30-370. As APCIA notes, Division I's decision "puts insurers in an untenable situation," forcing them

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academic studies have not identified a connection between a provider's personal background and reasonable value of the health care services rendered. CP 3538.

to perform thousands, if not millions, of investigations in a short timeframe, yet prohibiting them from relying on computerized processes that make such review possible. APCIA Br. at 8.

Dr. Schiff offers nothing to address these concerns. He denigrates the data-driven approach taken by Liberty and other insurers as "arbitrary and automatic," but he makes no effort to show that personalized investigations are even possible, much less preferable, in this context. Resp. at 2. Division I erred in ignoring the undisputed expert testimony on this issue, and this Court should not ignore the *amici's* insights.

(2) Insurers' Use of Computerized Databases like FAIR Health Is Widespread.

Unable to defend Division I's decision on the merits, Dr. Schiff attempts to minimize its potential impact by claiming that most insurers will be unaffected because they "do not use a database to pay claims … and instead individually investigate the reasonableness of bills." Resp. at 6. This claim is unsupported by the record. The only "evidence" Dr. Schiff cites is

mischaracterized deposition testimony from more than a decade ago. CP 5878. To be clear, there is *no evidence* in the record that even a single insurer in Washington routinely investigates the reasonableness of PIP and MedPay bills by assessing the personal background of medical providers.

The *amici* confirm that Dr. Schiff's characterization of insurers' practices is also factually inaccurate. Mitchell notes that more than 30 Washington insurers currently use its computerized bill-review software, which is responsible for the processing of millions of PIP and MedPay claims.[3] Mitchell Br. at 2. Similarly, APCIA confirms that use of FAIR Health is "standard practice across the United States" and "commonly relied on to assess the reasonableness of medical bills in high-volume claims[.]"

[3] Mitchell's brief is also a powerful rejection of Dr. Schiff's assertion that FAIR Health licensing agreements indicate that Liberty is misusing the database. Resp. at 15 n.7. As the entity that licenses FAIR Health data on insurers' behalf, Mitchell's support as an amicus curiae echoes its testimony in the trial court confirming that Liberty uses the database exactly as it was intended. CP 3513-19.

APCIA Br. at 1-2. APCIA's confirmation of the "industry-wide" use of computerized databases, *id.* at 3, is particularly compelling in light of Dr. Schiff's unfounded suggestion that Liberty's practices harm other insurers and "unfairly" give Liberty "a competitive advantage." Resp. at 16. Obviously, if this were true, the insurers' trade association would not be supporting Liberty.

(3) Policyholders and Providers Will Be Harmed if the Decision Stands.

The *amici* also demonstrate that the negative effects of Division I's "unworkable" decision will not be limited to insurers. They will be felt by policyholders, too. The *amici* validate Liberty's observation that the end result of Division I's decision will be that insurers will pay most bills in full without any effective investigation to ensure that the charges are reasonable. Pet. at 13-14; Mitchell Br. at 8. As Mitchell explains, "the resulting impact on policyholders would be profound, in two ways." Mitchell Br. at 8. In the short term, policy benefits will be prematurely exhausted by outlier provider charges. *Id.* In the

longer-term, providers will inevitably increase their charges on the realization that Washington insurers cannot effectively investigate or challenge them, no matter how unreasonably high they are. *Id.* at 9. Surely this was not the result intended by the State's promulgation of rules that require insurers to "adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies," WAC 284-30-330(3), and barring them from "[r]effusing to pay claims without conducting a reasonable investigation." WAC 284-30-330(4).

As Mitchell further explains, Division I's decision will also harm providers. *Id.* at 9-10. The "individualized" investigations that Division I has mandated will "significantly delay payment" because they will "dramatically slow down the process" of reviewing and paying claims. *Id.* at 9. For the majority of providers, who receive full payment of their billed charges under Liberty's current practices, the delay will not be offset by higher payments. Moreover, there is no guarantee that "individualized" investigations into providers' "personal

characteristics" will consistently yield increased payments. An examination of a provider's background might reveal information—negative patient reviews, board discipline, etc.—that might support a lower payment. Thus, if Division I's decision stands, the highest-billing providers in Washington might be paid in full more frequently, but all other providers will be forced to wait longer for the full payments they already receive—and some will end up being paid less.

(4) The Decision Makes Washington an Outlier in PIP and MedPay and Will Undermine the State's Broader Health Care Policies.

The *amici* also effectively show that Division I's decision stands in stark opposition to the decisions of other states' courts and regulators. APCIA Br. at 12. For example, the Delaware Supreme Court recently considered nearly identical claims by a plaintiff who argued that GEICO breached its obligation to pay "reasonable" fees for PIP-covered treatments when it reduced provider payments to the 80th percentile of charges in the geographic area, as determined by a computerized database.

GEICO Gen. Ins. Co. v. Green, 276 A.3d 462, 2022 WL 1052195, at *8 (Del. Apr. 8, 2022). The court rejected the plaintiff's argument that a "reasonable" investigation required consideration of "factors such as time, skill level of the provider, or the cost of operating the provider's practice." *Id.* Similarly, New Jersey regulations *require* insurers to consider computerized databases, including FAIR Health, in determining the reasonableness of PIP bills. N. J. Admin. Code 11:3–29.4(e)(1). In other words, Division I's decision effectively classifies as "unreasonable" claims-handling practices that are expressly approved—and even required—in other states.

The *amici* also highlight the potential negative spill-over effects of Division I's decision. The use of medical databases is not limited to PIP and MedPay. Insurers in other contexts and other types of health care payors rely on them to determine reasonable payments. APCIA notes that the Washington Legislature directed the Office of Financial Management to create the Washington State All Payer Claims Database to

support transparency and contain health care costs. APCIA Br. at 10-11. Division I's decision undermines this policy by embracing Dr. Schiff's baseless attacks on the use of medical claims databases. *Id.*

(5) Division I's *Folweiler* Decision Should Not Consign Washington to Bad Public Policy.

Division I did not examine any of the policy considerations that the *amici* address. This was because it considered itself bound by its prior decision in *Folweiler v. American Family Insurance Company*, 5 Wn. App. 2d 829, 429 P.3d 813 (2018). Op. at 12. But Division I refused to assign any significance to the procedural posture of *Folweiler*. *Id.* at n.8. Following its lead, Dr. Schiff argues that "*Folweiler*'s holding was not dependent on its 12(b)(6) posture or on taking the plaintiff's allegations as true." Resp. at 15.

This argument flatly contradicts what Dr. Schiff's counsel told this Court in response to American Family's petition for review in *Folweiler*. There, the provider relied heavily on the CR

12(b)(6) posture, arguing that it limited the Court's analysis on the merits of FAIR Health:

> On Am. Fam.'s 12(b)(6) motion, … [t]he court had to accept as true Folweiler's allegation that the [FAIR Health] database … has incomplete and inaccurate charge data and does not collect data on providers."

CP 4868-69.

In that respect, Dr. Schiff's counsel was correct: *Folweiler* was not the right case for this Court to address the merits of FAIR Health or computerized bill review. *This is the right case*. Unlike in *Folweiler*, the parties here have conducted full discovery and compiled a full summary judgment record, and the *amici* have now shared their insights based on decades of relevant experience. This evidence and experience informs the questions of what constitutes a "reasonable" fee and a "reasonable" investigation in the PIP and MedPay context. It should not be ignored. Insurers, policyholders, and medical providers should not be forced to suffer the negative consequences of an "unworkable" framework merely because Division I viewed

itself as bound by a few unnecessarily broad statements in its CR 12(b)(6) decision in *Folweiler*.

C. THE AMICI'S ARGUMENTS ARE RELEVANT TO THE CPA ISSUES RAISED IN LIBERTY'S PETITION FOR REVIEW.

The *amici's* discussion of the benefits of computerized bill review, the problems with "individualized" investigations into "personal characteristics," and the impact on policyholders and providers is also relevant to the CPA issues presented in Liberty's Petition. Pet. at 18-22. Refusing to address the consumer impact of Liberty's practices or any public interest considerations beyond application of the Insurance Code and WAC regulations, Division I did not distinguish Dr. Schiff's claim from a *per se* CPA claim, which medical providers lack standing to bring. *Tank v. State Farm & Cas. Co.*, 105 Wn.2d 381, 394, 715 P.2d 1133 (1986).

Even if Dr. Schiff could establish the "unfair practice" element of his CPA claim solely by showing a violation of the Insurance Code or WAC insurance regulations, neither he nor

Division I can point to any evidence that Liberty's use of computerized bill review instead of personalized investigations caused him a legally cognizable injury—a point that *amici* emphasize in explaining how Liberty's practices benefit providers generally. Mitchell Br. at 9-10. Dr. Schiff argues that a showing of injury is not required for his CPA claim because Liberty did not conduct a "reasonable" investigation, Resp. at 17, but no precedent supports his argument (or Division I's misguided suggestion) that satisfying the "unfair practice" element of a CPA claim alleviates the need to satisfy the separate elements of causation and injury. Op. at 13. Review is thus necessary so that Division I's decision does not undermine this Court's longstanding CPA precedents. Pet. at 18-22.

D. THE AMICI PROVIDE FURTHER SUPPORT FOR THE OIC'S REGULATORY APPROVAL OF LIBERTY'S PRACTICES.

The *amici*'s insights and experience also demonstrate the wisdom of the OIC's regulatory approval of Liberty's practices.

Contrary to Dr. Schiff's suggestion, that approval is relevant and cannot be ignored for two reasons.

First, the OIC's approvals reflect the studied opinion of the state agency entrusted to protect consumers and must therefore be afforded substantial deference. APCIA Br. at 13. The specificity and clarity of the agency's approval of Liberty's practices is unambiguous. The OIC first considered the propriety of Liberty's use of a computer database to determine the reasonableness of provider bills *more than fifteen years ago.* In 2006, the OIC affirmatively approved policy language stating that Liberty would not pay more than what it determined to be customary based on a database-driven geographic analysis. CP 4934. In 2016, Liberty specifically requested the agency's legal opinion on its use of FAIR Health's 80th percentile benchmark, and the OIC expressly approved that practice through it forms-approval process. CP 4889-90. In 2020, the OIC submitted a declaration in support of Liberty's practices in this case. CP 4885-86.

Dr. Schiff cites this Court's decision in *Durant v. State Farm Mutual Insurance Company*, 191 Wn.2d 1, 419 P.3d 400 (2018), but the regulatory record here is decidedly different. Unlike in *Durant*, the OIC did not issue any advisories stating that the practices at issue here are illegal. *Id.* at 13. Moreover, in *Durant*, the OIC submitted an amicus brief in this Court *against the insurer*. *Id.* No such brief has been filed here, and the OIC's trial court testimony leaves no doubt about its position on these issues. In short, this is not a record of regulatory inaction or equivocation. As *Durant* confirms, the agency's long-held, considered, and consistent determinations that Liberty's practices are legal deserve the engagement of this Court, not the disregard shown by Division I. *Id.* at 13 (courts must give OIC determinations "substantial weight").

Second, as APCIA explains, Division I's rejection of Liberty's "safe harbor" defense misunderstands the process and the legal significance of the OIC's review of insurers' proposed policy language. APCIA Br. at 13-14. Dr. Schiff amplifies this

misunderstanding by suggesting that the OIC approval is based on regulatory inaction. Resp. at 22. But the Insurance Code and this Court's precedent clearly impose on the OIC an affirmative obligation to review the proposed policy language to determine if it "complies with applicable Washington law and administrative regulations." RCW 48.18.100(1). If the policy does not comply, the OIC must reject it. RCW 48.18.110(a). *Progressive Cas. Ins. Co. v. Jester*, 102 Wn.2d 78, 82 n.2, 683 P.2d 180 (1984); *Credit Gen. Ins. Co. v. Zewdu*, 82 Wn. App. 620, 625, 919 P.2d 93 (1996), *review denied*, 130 Wn.2d 1022 (1997) (noting OIC obligation "to determine whether policy provisions are consistent with Washington's insurance laws"). The undisputed evidence in this case is that the OIC takes these obligations seriously, assigning highly experienced staff to carefully review proposed policy language. CP 4885-86.

Moreover, as APCIA explains, insurers rely on the OIC's determination on the legality of the practices described in their

policy forms.[4] APCIA Br. at 13. Division I's rejection of "safe harbor" protection in this case—and its suggestion that the OIC's policy forms approval process might *never* support "safe harbor" protection—negates these reliance interests and usurps the regulatory authority of the OIC. *Id.* The Court's review is essential to restore that authority and to provide guidance to insurers regarding which they can rely the OIC's actions to protect themselves from CPA liability.

E. CONCLUSION

Liberty respectfully requests that the Court grant review.

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[4] In *Durant*, State Farm was told by the OIC that, despite its earlier approval of its forms, the agency now considered State Farm's practices to be unlawful. 191 Wn.2d at 13-14. State Farm refused to stop the practices or to submit new policy forms consistent with the OIC's changed view. *Id.* Nothing of the sort happened here. Liberty was entitled to rely in good faith on the OIC's 2006 and 2016 approvals of its use of a computerize database in determining the reasonableness of Schiff's bills. Division I's conclusion this last November that the practice is unlawful in no way defeats Liberty's good faith and safe harbor defenses for its approved conduct for the fifteen years that preceded that ruling.

This document contains 2,934 words, excluding the parts of the document exempted from the word count by RAP 18.17.

DATED this 21st day of March, 2023.

Respectfully submitted,

/s/ *Philip A. Talmadge*
Philip A. Talmadge, WSBA #6973
Talmadge/Fitzpatrick
2775 Harbor Avenue SW
Third Floor, Suite C
Seattle, WA 98126
(206) 574-6661

John M. Silk, WSBA #15035
Wilson Smith Cochran Dickerson
901 Fifth Avenue, Suite 1700
Seattle, WA 98164
(206) 623-4100

James A. Morsch
Saul Ewing Arnstein & Lehr
161 N. Clark St., Suite 4200
Chicago, IL 60601
(312) 876-7100

Marc A. Fuller
Jackson Walker LLP
2323 Ross Avenue, Suite 600
Dallas, TX 75201
(214) 953-6000

Counsel for Petitioners Liberty Mutual Fire Insurance Company and Liberty Mutual Insurance Company

DECLARATION OF SERVICE

On said day below, I electronically served a true and accurate copy of the ***Answer to Amici Briefs*** in Supreme Court Cause No. 101576-3 to the following:

David E. Breskin
Cindy Heidelberg
Breskin Johnson & Townsend
1000 Second Avenue, Suite 3670
Seattle, WA 98101

John M. Silk
Wilson Smith Cochran Dickerson
1000 Second Avenue, Suite 2050
Seattle, WA 98104

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Clerk's Office

I declare under penalty of perjury under the laws of the State of Washington and the United States that the foregoing is true and correct.

DATED: March 21, 2023 at Seattle, Washington.

/s/ Brad Roberts
Brad Roberts, Legal Assistant
Talmadge/Fitzpatrick

TALMADGE/FITZPATRICK

March 21, 2023 - 11:01 AM

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Appellate Court Case Title:	Stan Schiff, M.D., Ph.D. v. Liberty Mutual Fire Insurance Co. et ano.

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- prevost@carneylaw.com
- shin@carneylaw.com
- trang.la@morganlewis.com

Comments:

Answer to Amici Briefs

Sender Name: Brad Roberts - Email: brad@tal-fitzlaw.com
Filing on Behalf of: Philip Albert Talmadge - Email: phil@tal-fitzlaw.com (Alternate Email: matt@tal-fitzlaw.com)

Address:
2775 Harbor Avenue SW
Third Floor Ste C
Seattle, WA, 98126
Phone: (206) 574-6661

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