No. 90533-9
SUPREME COURT OF THE STATE OF WASHINGTON



No. 69848-6-I
COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION 1

PREMERA, a Washington corporation; PREMERA BLUE CROSS, a Washington corporation; LIFEWISE HEALTH PLAN OF WASHINGTON, a Washington corporation; and WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST and its Trustee, F. BENTLEY LOVEJOY,

Petitioners,

v.

McCARTHY FINANCE, INC., a Washington corporation, McCARTHY RETAIL FINANCIAL SERVICES, LLC, a Washington limited liability company; HEMPHILL BROTHERS, INC., and its affiliates and subsidiaries; J.A. JACK & SONS, INC., a Washington corporation; LANE MT. SILICA CO., a Washington corporation; PUCKET & REDFORD, PLLC, a Washington professional limited liability company; and ANNETTE STEINER, a single person,

Respondents.



# MEMORANDUM SUPPORTING REVIEW BY AMICI CURIAE NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES AND PROPERTY CASUALTY INSURANCE ASSOCIATION OF AMERICA

Christian E. Mammen (WSBA 23493)
Hogan Lovells US LLP
3 Embarcadero Center, Suite 1500
San Francisco, CA 94111-4038
Tel: (415) 374-2325

Vanessa O. Wells (Cal. Bar No. 121279)
Hogan Lovells US LLP
4085 Campbell Avenue
Suite 100
Menlo Park, CA 94025
Tel: (650) 463-4000

*Attorneys for National Association of Mutual Insurance Companies and Property Casualty Insurance Association of America*

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## WHY THIS COURT SHOULD GRANT REVIEW

National Association of Mutual Insurance Companies ("NAMIC") and Property Casualty Insurers Association of America ("PCI") hereby submit this memorandum as *amici curiae* supporting review of the Court of Appeals' decision in this case.

NAMIC is a nationwide association of mutual insurers. A mutual insurance corporation is a specific organizational form without stockholders, and is managed for the benefit of policyholders. For almost 120 years, NAMIC has been serving the best interests of mutual insurance companies – large and small – across the country. NAMIC has approximately 1,400 property/casualty company members serving more than 135 million auto, home, and business policyholders. NAMIC members hold 50% of the auto/homeowners insurance market in the United States. Many of NAMIC's members write insurance in Washington, and are likely to be subject to regulation through civil actions as a result of the Court of Appeals' decision.

PCI is the property casualty industry's most diverse nationwide trade association. PCI has more than 1000 members, consisting of large and small companies in all 50 states. PCI's members represent every form of ownership: stock; mutual; risk retention group ("RRG"); and reciprocal. PCI's members write $195 billion in annual premiums and represent 46% of the United States auto market, 32 % of the homeowner's market, 37% of the commercial property and liability market, and 41% of the private workers compensation market.[1] Many of PCI's members write

[1] Memberships can overlap as between NAMIC and PCI.

insurance in Washington, and are likely to be subject to regulation through civil actions as a result of the Court of Appeals' decision.

NAMIC and PCI join petitioners in seeking review of a decision that would allow the courts – and each of them – to engage in ratemaking, including determinations regarding reasonable projections of losses and expenses, what constitutes a reasonable profit for an insurer writing a particular line of insurance, and how much capital is reasonable to support the insurance written by a particular insurer. These are not decisions courts are suited to make, nor are they judicial in character. Further, they are not decisions that can rationally or consistently be made by decentralized adjudication in the several trial courts throughout the state.

For these reasons, the various states throughout the country have concluded that the ***filed rate doctrine*** applies to resolve potentially overlapping powers of the regulator and the courts, when a plaintiff files a civil action that implicates rates. At its core, the doctrine precludes civil actions challenging price where industry members must file rates with a government agency charged with regulating that industry. While this common law doctrine "originated in the federal courts, 'it "has been held to apply equally to state agencies by every court to have considered the question."'"[2]

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[2] *MacKay v. Superior Court*, 188 Cal. App. 4th 1427, 1448-1449 (2010) *citing and quoting Commonwealth v. Anthem Ins. Cos., Inc.*, 8 S.W.3d 48, 52 (Ky. App. 1999); *see also Schermer v. State Farm Fire & Cas. Co.*, 721 N.W. 2d 307, 312-313 (Minn. 2006) (adopting filed rate doctrine and recognizing multiple rationales, including separation of powers, comity, legislative nature of ratemaking, technical expertise of regulator, and unforeseen consequences of potential court orders; noting that "most states have adopted the filed rate doctrine, and many apply it to insurance regulation."); *Am.*

In this case, the Court of Appeals correctly observed that healthcare coverage rates are strictly regulated, and correctly held that the filed rate doctrine applies. Nonetheless, the Court failed to apply the doctrine, as it should have after so concluding. If the plaintiff's theory is correct, the court will be required to determine whether the approved rates are inflated by fraud – i.e., excessive – and if so by how much. In order to do that, the court must examine the components of the rate – the projected losses and expenses, the projected investment income on reserves as well as surplus, and the rate of return – all factors which the regulator has determined to be reasonable in approving the rate. That is, the only way to prove or disprove the case presented by plaintiffs is for the court to embroil itself in the legislative function of ratemaking. The only way for the court to award the relief requested is to retroactively reduce the regulator's previously approved rates for the entirety of the putative class period. Adjudicating this case requires the court to make economic determinations requiring both the technical expertise of the regulator, and the legislative power to determine

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*Bankers Ins. Co. v. Wells*, 819 So. 2d 1196, 1205 (Miss. 2001) (noting that "the acceptance of the [filed rate] doctrine's basic applicability is near universal" and applying the doctrine to bar aspects of claim challenging insurance rates and terms); *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 963 (N.J. Super. Ct. App. Div. 2004) ("we also reject plaintiff's mistaken contention that the filed rate doctrine does not apply to the insurance industry not only because courts are not institutionally suited to regulate insurance premiums and benefit rates, but also because of the extensive regulation of this industry. We, thus, align our decision with the considerable weight of authority from other jurisdictions that have applied the filed rate doctrine to ratemaking in the insurance industry."); *Minihane v. Weissman*, 640 N.Y.S.2d 102, 103 (N.Y. App. Div. 1996) (holding that claim challenging filed rate as fraudulently obtained was barred by the filed rate doctrine; doctrine exists "to ensure that rates charged are stable and non-discriminatory, bearing in mind that the regulatory agencies presumably are most familiar with the workings of the regulated industry and are in the best position, due to experience and investigative capacity, to establish the proper rates.").

the state's economic public policy. It is in these circumstances that the filed rate doctrine applies to bar an ordinary civil action.

A decision that holds that the filed rate doctrine applies, but does not apply it, leaves Washington law in a state of confusion. The Court of Appeals' determination not to apply the doctrine to a case that directly challenges premiums, and which cannot be decided without re-examining and retroactively altering the rates at issue, is at odds with the settled law in other states across the country. The prospect of numerous piecemeal challenges that would engage the courts in the business of retroactively determining appropriate "non-fraudulent" rates as well as appropriate capitalization for the protection of policyholders threatens the stability and security of the insurance product in this state.

The Court of Appeals' decision allows rate regulation by courts, thereby creating the serious risks outlined here. In this respect, it is in conflict with the jurisprudence of the several states to consider the issue. For these reasons, this Court should review the Court of Appeals' decision.

## RATE REGULATION: A BRIEF PRIMER

Understanding the impact of a case such as this requires at least a rudimentary knowledge of insurance rate regulation.[3] *Amici* provide a brief synopsis here, and refer the Court to the discussion in the Petition (pp. 4-9).

The rates at issue here, generally, are subject to "prior approval"

[3] The defendants in this case are actually not insurers, they are Health Care Service Contractors ("HCSCs"). HCSCs, like insurers, are regulated by the Washington OIC in the same manner as disability insurers.

regulation. As the name suggests, rates must be approved before they can be charged. Approval may be by "deemer" – which occurs when the Office of the Insurance Commissioner ("OIC") does not disapprove the rates within a sixty day period after filing – or by affirmative approval. *See* RCW 48.18.110(2) (disability insurers); RCW 48.44.020(3) (HCSCs); WAC 284-43-920(1) (specifying that rate schedules must be filed with the commissioner before use, and every eighteen months). The standard for rate approval is that the rates must be reasonable in relation to the benefits provided in the policy. *See* RCW 48.18.110(2), RCW 48.44.020(3).

The OIC provides its own "primer" for consumers explaining rate review for individual and small group health plans. After listing "[f]actors that affect rates", the OIC goes on to describe "[w]hat we do". In that section, the OIC emphasizes that it scrutinizes the data for accuracy, examines the actuarial assumptions used to project future experience, and expressly considers "the company's current level of surplus" in assessing whether "[h]ow much the company expects to make" is reasonable. *See* http://www.insurance.wa.gov/your-insurance/health-insurance/health-rates/how-we-review-rates/. Once the rates are approved by the OIC, the applicant is required by law to charge that rate, and cannot change the rate without making a new rate filing. *See* WAC 284-43-920(1).

**THIS IS A RATE CASE**

The case at issue here is unabashedly a rate case. This is not argument. It is what the complaint pleads. In ¶¶ 9 – 15, the plaintiffs specifically air their grievances regarding their premium rates. Paragraph

22 details at length the gravamen of the claim, which is all about rates:

> The claims by the class representatives and on behalf of the class members are for excessive, unnecessary, unfair and deceptive overcharges for health insurance and as a result of such overcharges, over the 4-year period prior to the filing of this complaint, having and retaining at the present time as non-profit corporations, excessive surplus levels. During that period, [defendants have] . . . made profits by overcharging the plaintiffs and class members amounts for insurance that were far in excess of the cost . . . of providing the coverage . . . .

Plaintiffs clearly allege that they are challenging the approved rates as excessive. And it goes on. *See* Complaint ¶¶20, 28, 30, 65, and Prayer ¶2.

**THE FILED RATE DOCTRINE APPLIES TO THIS RATE CASE**

The Court of Appeals correctly held that Washington would adopt the filed rate doctrine, because the business at issue and specifically rates are subject to intense regulatory oversight and a strict prior approval regime. The Court, however, failed to recognize that the case presented in the complaint would embroil the court in a re-examination of rates and rate decisions – exactly the exercise barred by the filed rate doctrine.

Throughout the country, courts applying the filed rate doctrine in the insurance context look through form to substance to determine whether the doctrine applies. If the case pleaded by plaintiffs cannot be decided without re-examining the rate, it is barred by the filed rate doctrine. For example:

• In *Woodhams v. Allstate Fire and Cas. Co.*, 748 F. Supp. 2d 211 (S.D.N.Y. 2010), *aff'd* 453 Fed. Appx. 108 (2d Cir. 2012), the court held that the filed rate doctrine barred a claim that portions of approved fire policies were worthless and illegal, requiring a refund of a pro-rated portion of premiums charged for the policies. The court explained that: "Because

these policies and the premiums associated with them were approved by NYSID, Count I is a direct challenge to the reasonableness of the filed rates, and is therefore barred by the retroactive rate-setting strand of the filed rate doctrine." 748 F. Supp. 2d at 220. *Accord Sher v. Allstate Ins. Co.*, 947 F. Supp. 2d 370 (S.D.N.Y. 2013) (following *Woodhams* to hold that filed rate doctrine barred claim for premium refunds premised on alleged illusory coverage where premiums were approved by regulator).

• In *City of New York v. Aetna Cas. & Sur. Co.*, 693 N.Y.S.2d 139, 139 (N.Y. App. Div. 1999), the court held that the filed rate doctrine barred a cause of action asserted by the City and a putative class challenging auto rates as excessive because they did not drop when auto theft rates dropped.

• In *Rios v. State Farm Fire & Cas. Co.*, 469 F.Supp.2d 727, 735, 739 (S.D. Iowa 2007), the court held that the filed rate doctrine barred a claim which would involve the court in determining the amount of the premium attributable to the alleged illusory endorsement and require the court to "second guess" what rate the regulator would have allowed absent the alleged illusory endorsement.

• In *Stutts v. Travelers Indem. Co.*, 682 S.E.2d 769, 772-73 (N.C. Ct. App. 2009), the court held that a claim for breach of contract was barred by the filed rate doctrine where plaintiff could not prove breach of contract without the rates set by the regulator being questioned.

As can be discerned from this sampling, the touchstone is not the legal theory under which the claim is asserted. The determining factor is whether the action challenges the approved rates, and whether it is possible to

entertain the action without re-examining the approved rates. More fundamentally, the question is whether the case would require the courts to decide questions of economic public policy, which are essentially legislative in character. *See* cases cited in footnote 2.

Here, the complaint directly challenges the approved rates. The alleged fraud concerns the rates. It is not possible to either decide the issues or grant relief without re-examining the rates and "second guessing" what the rate should have been without the alleged fraud. If Washington accepts that the filed rate doctrine applies to insurance rates – and the Court of Appeals so held – then the doctrine applies here to bar this case.

**A NOTE ABOUT "SURPLUS"**

Plaintiffs in this case underscore that defendants have retained an amount of "surplus" they insist is "excessive." The complaint makes much of the Legislature's decision to withhold from the Commissioner the power to order disgorgement of surplus, or the power to reduce surplus by compelling rates subsidized by surplus. *See* Complaint ¶¶ 32-35 and n.4. The Court of Appeals seemed concerned by this limit on the Commissioner's power, and this concern appeared to be the Court's primary basis for finding that the filed rate doctrine does not apply.

At the threshold, the issue is a red herring. The complaint challenges the rates as excessive, and as unreasonable for the benefits provided under the policies. Thus, it calls for litigation revisiting past filed and approved rates. Not incidentally, the OIC expressly considers surplus levels in determining what constitutes a fair return for a particular filing. Because the

case engages the court in ratemaking, it is barred by the filed rate doctrine.

Further, the complaint appears to misunderstand the nature and purpose of "surplus". Despite a potentially unfortunate label, "surplus" is not extra money. *See State Farm Mut. Auto. Ins. Co. v. Superior Court*, 114 Cal. App. 4th 434, 441 (2003). "Surplus" is the insurer's capital base providing the security for the coverage written. *Id.* ("'[S]urplus provides a safety cushion to absorb adverse results and protects the policyholder and the company by helping maintain the company's solvency during periods of unfavorable operating results.'"). Such "unfavorable operating results" may occur when underwriting losses increase, when investment income on the invested assets decreases, due to catastrophes, or any other unforeseen event against which the company cannot reserve. *See id.* That is, surplus, far from being extra money, is what makes the insurance really insurance.

A state legislature – the holder of the police power – could decide to regulate maximum surplus. Generally states choose not to regulate surplus because insurance is safer when decisions about surplus are left to the business judgment of the company's management. As the court observed in *State Farm*, 114 Cal. App.4th at 441:

> The financial soundness of an insurance company "depends upon numerous factors that are difficult to quantify, and the insurance market is characterized by substantial diversity across insurers in types of business written, characteristics of customers, and methods of operation. It is impossible to specify the 'right' amount of [surplus] for most insurers through a formula." [citation omitted] Each insurance company has its own method for determining the amount of surplus it considers to be adequate.

Any decision by government to regulate surplus – rather than leaving

surplus level to the business judgment of management, where it resides absent exercise of the state's police power – rests with the Legislature.[4] Courts are not in the business of deciding either that the state should regulate surplus, or what the "right" amount of surplus should be. *Cf State Farm, id.* at 445, 449-451, 453 (business judgment rule applies to insulate determinations regarding surplus level from judicial scrutiny).

Thus, the inclusion in the complaint of allegations challenging the defendants' surplus as excessive is a further reason why the action is outside the judicial purview. It is not a reason for judicial involvement.

## CONCLUSION

Rates should not be regulated in the courts. The Court of Appeals' decision allows retroactive ratemaking by plaintiffs through civil actions. This decision is inconsistent with nationwide jurisprudence, and creates a threat to the stability and security of the insurance industry in this State. *Amici* respectfully request that this Court take review.

Respectfully submitted on this 19th day of September, 2014.

HOGAN LOVELLS US LLP

By: _____

Christian E. Mammen, WSBA 23493
Vanessa O. Wells, Cal. Bar No. 121279
*Attorneys for Amici NAMIC and PCI*

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[4] Moreover, the power to regulate surplus level is not part of the power to regulate rates. The power to regulate rates is held by the state where the rates are to be charged. Management of surplus is considered an aspect of a company's "internal affairs." *See State Farm, id.* at 442. Consequently, the state with authority to regulate surplus level – should it make that legislative decision – is the state where the insurer is domiciled.

CERTIFICATE OF SERVICE

I certify, under penalty of perjury under the laws of the United States and the State of California that, on September 19, 2014, I served a copy of the foregoing document on all counsel of record as indicated below:

Gwendolyn C. Payton
John R. Neeleman
Lane Powell PC
1420 Fifth Avenue, Suite 4200
Seattle, WA 98101-2338

Kathleen M. O'Sullivan
Eric Grayson Holmes
Perkins Coie LLP
1201 Third Avenue, Suite 4800
Seattle, WA 98101-3099

Frank Raymond Siderius
Raymond H. Siderius
Siderius Lonergan & Martin
500 Union Street, Suite 847
Seattle, WA 98101-2394

Joseph Colbert Brown , Jr.
J.C. Brown Law Office, PLLC
PO Box 384
Cashmere, WA 98815-0384

Randall Redford
Puckett & Redford, PLLC
901 Fifth Avenue, Suite 800
Seattle, WA 98164

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Ramona Altamirano