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No. 69848-6-I

COURT OF APPEALS, DIVISION I

OF THE STATE OF WASHINGTON

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

Appellants,

v.

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,**

Respondents.

BRIEF OF APPELLANTS

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Assignment of Error No. 1
Issues Related to Filed Rate Doctrine

(a) Should the court apply the filed rate doctrine on the disputed facts in this case of first impression in Washington.

(b) Does the plaintiffs' challenge to the amassment and retention of an enormous excess surplus in any event amount to a challenge to the rates within the purview of the filed rate doctrine?

(c) Plaintiffs contend that the defendants employed false advertising and false marketing practices of "increased buying power" and "a pooling of a large number of employers" and "the ability to negotiate high quality benefits at the lowest possible cost." These do not constitute a direct attack on rates. Did the trial court commit error in ignoring the precedents, including the Washington Supreme Court case of *Tenore v. AT&T Wireless Services,* 136 Wn.2d 322, 962 P.2d 104 (1998), *cert denied* 525 U.S. 1171, 119 S.Ct. 1096, 143 L.Ed.2d 95, holding that unless the allegation of false advertising constitutes a direct attack on rates, the filed rate doctrine does not apply?

(d) Is the claim in plaintiffs' complaint that the defendant trust WAHIT has illegally and falsely represented that it is a "member-governed" group, a false representation that has enabled it to "selectively underwrite" its coverages thereby contributing to the excess surplus – a claim that, as an underwriting claim, has nothing to do with filed rates or the filed rate doctrine?

(e) Should the filed rate doctrine be applied where, as the plaintiffs' complaint alleges, the defendant surplus levels have not been produced merely by the rates charged, but also by the profit from defendants' investments, a component of at least $250 million of the surplus presently held?

Assignment of Error No. 2
Re Primary Jurisdiction

(a) In view of the fact that all of the claims brought by the plaintiffs are for violation of the Washington Consumer Protection Act for unfair or deceptive acts or practices in trade or commerce, are these not issues within the conventional competence of the courts not requiring referral to an administrative agency?

(b) In the event that referral to administrative agency is necessary or desirable, should not the court retain jurisdiction to determine the issues after the completion of such a referral?

(c) In view of the fact that the Insurance Commissioner has publicly stated that the surplus levels maintained by the defendants are excessive and has proposed legislation unsuccessfully to correct this situation, is there any necessity to refer the issues here to the Commissioner?

(d) Do the court remedies sought by the plaintiffs in any way conflict with the administrative regulatory scheme?

Assignment of Error No. 3
Exhaustion of Remedies

(a) Does the exhaustion of remedies doctrine require that there be an effective remedy at the administrative level that plaintiffs could have pursued, i.e., money damages and attorney's fees?

(b) In view of the fact that the Washington Insurance Commissioner by statute has no authority to limit or control excessive surplus held by a health insurer, was any effective remedy available to the plaintiffs? If the only available remedy available to the plaintiffs would have been a hearing pursuant to the Administrative Procedure Act and by the express terms of that act if such hearing would be patently inadequate or futile, should exhaustion of remedies apply?

Assignment of Error No. 4
Issues of Fact

Did the trial court ignore or fail to recognize the existence of substantial material fact issues in the record, including (a) the issue whether the defendant, through their subsidiary WAHIT, by falsely advertising that it is a "member-governed" group engaged in a selective underwriting, thereby contributing to the excess surplus, and

(b) whether the defendants through WAHIT engaged in deceptive marketing practices described in the issues relating to the Filed Rate Doctrine above?

B. STATEMENT OF THE CASE

This is a class action filed in January, 2012 by the plaintiffs alleging violation of the Washington Consumer Protection Act, Chapter 19.86. The plaintiffs are four corporations, two limited liability companies and one individual. The individual plaintiff and all of the employees of the other plaintiffs during the four year period prior to the filing of this action were subscribers to health insurance coverage from the defendants. (Complaint, CP 2.) All of the defendants are owned or controlled by the parent corporation, PREMERA. (Exhibit B to Complaint, CP 52.) Two of the defendant corporations (PREMERA Blue Cross and Lifewise Health Plan of Washington) are health care service contractors as defined in RCW 48.44.010(9) selling health insurance policies to the public. The remaining two defendants are a trust, Washington Alliance for Health Insurance Trust (WAHIT) which was formed by PREMERA Blue Cross to sell PREMERA health insurance policies, and its individual trustee, F. Bentley Lovejoy. (Exhibit A to Fackler Declaration, CP 233-4.)

The defendant corporations are all non-profit entities. PREMERA was formed pursuant to RCW Ch. 24.06, the Washington Non-profit Miscellaneous & Mutual Corporations Act, and the other defendant corporations were formed pursuant to RCW Ch. 24.03, the Washington Non-profit Act. PREMERA Blue Cross maintains four subsidiaries, one of which has seven subsidiaries, including some for-profit entities. (CP 52 and CP 228.) The defendant trust (WAHIT) sells health insurance policies to the public and is a tax exempt entity pursuant to Internal Revenue Code 501(c)(9) (Exhibit A to Fackler Declaration, CP 233-4-5.)

Defendant PREMERA Blue Cross presently holds in excess of $1 billion in surplus (p. 6 of Fackler Declaration, CP 230) an amount that plaintiffs contend is far in excess of amounts necessary to maintain reasonable solvency, violating public policy for a corporation chartered as a Washington non-profit to amass and retain such an amount of surplus.[1] Plaintiffs' complaint points out that the

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[1] It is important to point out the difference between the terms "surplus" and "reserves." "Surplus" is defined as "a company's assets minus its liabilities," (CP 131.) "Reserves" are defined in WAC 284-43-910(8) as "claim reserves" means the "claims" that have been reported but not paid plus the 'claims' that have not been reported but may be reasonably expected."

Washington Insurance Commissioner, for years, has sponsored proposed legislation to limit retention by non-profit health insurers of excessive surplus and to give to the office of the Insurance Commissioner the right to consider in the rate approval process the amount of the health insurers surplus levels. (CP 17.)

Plaintiffs contend that the rates that have been charged by the defendants for health coverage have been invested in for-profit subsidiaries, a misuse of the premiums collected and a breach of duty to the subscribers. The surplus is excessive with a large component of the surplus, approximately $250 million, composed of investment profits, separate from the rates that have been charged. (Fackler Declaration, p. 5, CP 229 and 251-2.)

Plaintiffs contend that the conduct of the defendants in amassing the surplus has been unfair, deceptive and in violation of the provisions of the Washington Consumer Protection Act and the State Insurance Code, in the following particulars:

(a) Claiming on the website of the defendant trust (WAHIT) that it is an "employer governed trust." This advertisement is demonstrably false. The employers purchasing coverage for their employees from WAHIT have nothing to do with governing and

management of the trust. (Fackler Declaration, CP 233-4-5 and Luke Hemphill Declaration, CP 254.)

(b) That the defendant trust, a subsidiary of the PREMERA companies, falsely advertises that as a result of its "increased buying power" and a "pooling of a large number of employers," it is able to obtain coverage for purchasing employers at the "lowest possible cost," and that the trust is able to "negotiate" and obtain high quality benefits at the "most affordable cost." (CP 254, 259, 261.) These representations are all false. The only such price "negotiation" has been done by the PREMERA companies, and they do not, in obtaining provider agreements, negotiate any lower "cost" for the employer subscribers of the WAHIT trust. This is because the only health policies sold by WAHIT are PREMERA policies.

(c) A member-governed group (which the WAHIT trust claims to be but is not) is exempt from the Washington Insurance Code provisions relating to community rating and small group guaranteed issue laws. (Fackler Declaration, CP 227 and CP 240.) This statutory exemption, if available, permits selective underwriting in the offering of its health insurance coverages. (Fackler Declaration CP 227 and CP 240.) Selective underwriting allows a member-

governed group to select who it is willing to cover in the first instance and what modifications it is able to make to the coverages during the coverage period. Plaintiffs contend that by falsely claiming to be a "member governed group" the defendants, through their subsidiary WAHIT have unfairly, deceptively and wrongfully engaged in selective underwriting which has contributed to the excess surplus presently maintained by the defendant companies. (Complaint, CP 8-9.)

The case was originally filed in January of 2012. An approximate 5-month delay occurred as a result of the defendants' removal of the cause to the United States District Court for the Western District of Washington, assigned to the Honorable District Judge John Coughenour. (CP 53 through 73.) Plaintiffs filed a motion to remand to state court and on May 29, 2012, Judge Coughenour granted the motion to remand, identifying at p. 1 of his opinion plaintiffs' allegations in the following language (CP 78-9):

> Plaintiffs challenge the health insurance rates that the PREMERA defendants – non-profit corporations – have charged and their alleged accumulation of over $1 billion in excess surplus. Plaintiffs further claim that WAHIT misled customers through false marketing and served as a conduit for the PREMERA defendants' wrongful amassment of excess surplus.

Plaintiffs' complaint identified three putative classes, namely Class A, the "large group" involving the sale of health insurance policies to employer groups of more than 50 persons, Class B, the small group consisting of sales to employee groups of at least one but not more than 50 employees, and Class C, the individual group of purchasers, with the individual plaintiff, Annette Steiner, proposed as class representative. (CP 6.)

The defendants' first motion was presented to the Honorable Joan DuBuque as a CR 12(b)(6) motion seeking dismissal of all claims brought by the individual and small group classes B and C. (CP 97.) Three defenses were offered by the defendants in their joint motion, namely, the filed rate doctrine, primary jurisdiction and exhaustion of remedies. (CP 100 through 109.) After argument at the hearing on September 28, 2012, the court granted the defense motion, dismissing all of the claims of the B and C classes under all three of the defenses claimed. (CP 157. The 36-page transcript of this hearing is in the record of Clerk's papers under a single page number, CP 159.)

The trial court did not retain jurisdiction and did not refer the matter to the Office of Insurance Commissioner, as is frequently the case in primary jurisdiction rulings.

The defendants later presented a motion for summary judgment under CR 56 (CP 160) to dismiss the claims of Class A, the "large group" based upon the same three defenses, filed rate doctrine, primary jurisdiction and exhaustion of remedies, submitting briefs (CP 160 and 262) and receiving briefs and declarations in opposition from the plaintiffs. (CP 181 and 209, 225, 253.) The 40-page transcript of this hearing is in the record of Clerk's Papers under a single page number, CP 273.)

At the hearing on this second motion on January 4, 2013, for summary judgment, the trial court granted all three defenses dismissing finally all claims in the litigation. (CP 274.)

C. ARGUMENT

1. Filed Rate Doctrine Issue (a) Should the Doctrine be Applied to Health Insurance Rates?

It is not possible to predict with any certainty that this court or our Supreme Court will apply the Filed Rate Doctrine to health insurer rates. The decisions of our courts to date on filed rate were correctly

summarized by United States District Judge James L. Robart in *Blaylock v. First American Title Insurance Co.*, 504 F.Supp.2d 1091, 1101 (W.D. Wa. 2007) rejecting the doctrine in a case involving title insurance rates:

> Washington has little case law on the filed rate doctrine. The parties have not cited, nor is the court aware of a decision discussing the application of the doctrine to challenges to insurance rates, let alone title insurance rates, nor even rates set by a state regulatory agency. There is a single decision by the Washington Supreme Court discussing application of the doctrine. *Tenore v. AT&T Wireless Services.*

Unquestionably, since its inception in *Keogh v. Chicago & Northwestern Railway Co.*, 260 U.S. 156, 43 S.Ct. 47, 67 L.Ed. 183 (1922), the doctrine has been applied, with some limitations, to rates filed and established by federal agencies, such as the Interstate Commerce Commission (ICC) and Federal Communications Commission (FCC) but three issues are present here. Should the Washington Appellate Courts apply the doctrine to rates filed with a state, rather than a federal agency,[2] should the doctrine be applied to insurance rates in any event, and most importantly, in view of the

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[2] In *Knevelbard v. Kraft Foods, Inc., et al.*, 232 F.3d 979 (Ca. 9 2000) California rejected application of the doctrine to rates set by state regulatory agencies.

Insurance Commissioner's public statements that the amount of surplus held by the health insurers is excessive, and his legislative attempts to control surplus of health insurance, should the filed rate doctrine be applied to health insurance rates.

Unless the Washington courts apply a broad interpretation of the filed rate doctrine, it will not be applied to health care rates in Washington. Thus far, the only Washington Supreme Court decision has given the filed rate doctrine a narrow and restrictive interpretation.

Judge Robarts' description of *Tenore v. AT&T Wireless, supra* as a decision "discussing application of the filed rate doctrine," is an understatement. *Tenore* severely criticized how the doctrine has been "invoked rigidly even to bar claims of a fraud or misrepresentation" citing four decisions, including *Taffet v. Southern Co.*, 967 F.2d 1483 which held that the doctrine takes away all remedies available to "overcharged or defrauded customers." A decision like that deserves criticism.

And, at the time *Tenore* was decided, the only other Washington case involving the filed rate (or "filed tariff" doctrine) was an appellate decision in *Hardy v. Claircom Communications Group, Inc.*, 86 Wn. App. 488, 937 P.2d 1128 (1997). In that case in facts

similar to *Tenore* but involving rates filed with a Federal agency, the Court of Appeals ruled that all of the plaintiff's claims were barred by both the filed tariff doctrine and federal preemption. The *Tenore* trial court had decided that the *Hardy* decision was "controlling" and dismissed all the plaintiff's claims. The Supreme Court granted direct review of *Tenore*.

The *Tenore* decision ultimately ruled that (a) plaintiff's claim of damage from defendant's failure to disclose in its advertising its practice of "rounding up" telephone charges to the next full minute was merely an indirect attack on rates; (b) defendant's contention that plaintiffs' claim was merely a disguised form of an attack on the reasonableness of rates was rejected, and (c) since the case did not involve a direct challenge to the rates being charged, the competence of the administrative agency was not involved and all issues in the case were within the conventional competence of the courts to decide.

2. Filed Rate Doctrine Issue (b)
Plaintiffs' Challenge to Amassment of Excess Surplus Is Not a Challenge to Filed Rates

The issue whether a plaintiff's challenge to the amount of surplus held by a non-profit health insurer is a challenge of filed rates was directly involved in the Supreme Court of Pennsylvania in *Ciamaichelo v. Independence Blue Cross*, 909 A. 2d 1211 (Pa. 2006). It was a class action against defendant Independence Blue Cross, brought by a proposed class composed of the Blue Cross subscribers, policyholders and members. The complaint alleged that Independence Blue Cross had accumulated excess funds which were called surplus amounting to at least $349 million and perhaps as much as $438 million, that the surplus accumulated was excessive because the amount was not needed for Blue Cross' ongoing operations or financial solvency, and that the surplus was dedicated to purposes inconsistent with its non-profit status, including investments in for-profit subsidiaries. The matter was before the Supreme Court on an appeal from the Commonwealth Court of Pennsylvania, an intermediate appellate court, which had agreed with Blue Cross and applied the filed rate doctrine. The court described the doctrine as a rule that preserves the exclusive role of a regulatory

agency in approving rates. The Commonwealth Court had also ruled that any decision that Blue Cross was holding excessive reserves would necessarily require a recalculation of rates, that the Department had previously approved. The Commonwealth Court dismissed plaintiff's complaint.

On appeal to the Supreme Court, appellant Ciamaichelo contended that the Commonwealth Court had made two errors, namely that the complaint attempted to secure judicial regulation of rates and reserves and failed to recognize that the claims under the non-profit law were committed to the jurisdiction of the Court of Common Pleas. Blue Cross countered claiming that since the amount that an insurer holds in surplus is a function of the rates, the appellant's challenge to excess surplus is necessarily a challenge to the rates charged.

At p. 1217 of the opinion, the following appears:

> We agree with Appellants. At this juncture in the proceedings, on preliminary objections, we do not conclude that it is clear and free from doubt that Appellant's complaint amounts to nothing more than a request that the Court of Common Pleas second-guess an approved rate, as Independence Blue Cross argues, or that the court assume the Department's regulations of IBC's reserves or risk-based capital. (Citing cases.) Rather, we view the complaint as raising whether IBC

> violated the Non-Profit Law and committed breaches of contractual and fiduciary duties in amassing a fund designated as surplus that was in amount, over and above that necessary for IBC to operate properly, meet its legal obligations or secure its financial solvency, and in dedicating that fund to certain purposes.
>
> At p. 1218, the court also stated:
>
> Further, our view of the complaint leads us also to reject dismissal of the Complaint on the grounds that Appellants seek judicial review of an approved rate and the sweeping inference to be drawn from the Commonwealth Court's reasoning that allegations in a complaint that could lead to an adjustment of an insured's approved rate invariably amounted to a rate injury claim. As we discussed, the complaint does not allege a rate injury claim. Therefore, we hold that the Commonwealth Court erred in sustaining IBC's preliminary objections in the nature of a demurrer to the complaint under the filed rate doctrine.

The $348 million amount of surplus alleged by plaintiff Ciamaichelo was far less than the over $1 billion surplus plaintiffs have alleged that defendant PREMERA Blue Cross was holding at the time the instant case was filed.

3. Filed Rate Doctrine Issue (c)
Did the Trial Court Err by Ignoring *Tenore v. AT&T Wireless Services* and the Other False Advertising Cases Rejecting the Application of the Filed Rate Doctrine?

In *Spielholz v. Superior Court*, 86 Cal.App.4th 1366 (2001) plaintiff, a customer of Los Angeles Cellular Telephone Company filed

a class complaint against that company for false advertising, that the plaintiffs' and class members' telephone calling area had no dead zone, stating that the defendant provided a "seamless calling area." The defense moved to strike all claims for monetary relief based on the Federal Communications Act of 1934 that provided in part, "no state or local government may regulate the rates" charged by a wireless telephone service provider, but also provided that a state may "regulate the other terms and conditions of service."

The defendant contended that the presence or absence of the "seamless calling area" was a component of the rate charged and that plaintiffs' claim therefore was a direct attack on rates and not permitted.

The court conceded that an attack on any component of the rates, the so-called "billing increments" would be preempted as a direct attack on the rates. Thus, a "seamless calling area" would be a component of the billing and if the plaintiff were to attack the cost of the seamless calling area, it would be a rate attack and pre-empted. But, citing *Tenore*, the court ruled that plaintiffs were instead alleging that the defendants had falsely advertised that their services included a seamless calling area which was false. The court ruled that

accordingly, it was not a direct attack on rates and the effect on rates would be merely incidental. The court stated at p. 1375 as follows:

> *Ball v. GTE MobileNet of California, supra*, 81 Cal.App.4th 529, *In Re Comcast Cellular Telecom Litigation,* 949 F.Supp. 1193 and *Tenore v. AT&T Wireless Services, Inc.*, 962 P.2d 104 all involved the practice of billing in full minute increments, or rounding up to the next full minute, and other practices that resulted in charges for non communication time. The courts concluded that Section 332(c)(3)(A) preempts claims that directly challenge the rate charged by a wireless service provider (*Ball* at pp. 537-538, *Comcast* at p. 1201) but does not preempt claims alleging the failure to disclose a practice that affects the total amount charged (*Ball,* p. 543, *Comcast,* p. 1200, *Tenore*, p. 115.) They considered the billing increment to be an integral part of the rate and therefore held that direct challenges to the reasonableness or legality of the billing increment were preempted, *but claims based on the failure to disclose the billing increment were not preempted.* (Citing cases; emphasis supplied.)

Ball v. GTE MobileNet of California, supra is to the same effect. There the plaintiffs were suing the defendant for failing to disclose the "rounding up" practice which plaintiffs contended was not disclosed and that defendants accordingly were charging plaintiffs for unused time.

The plaintiffs asserted that the total rate had two components, the "rate" component and the "time" component, emphasizing that the

latter had nothing to do with the rate charged. The court agreed and held that the false advertising was not preempted.

In *Kellerman v. MCI Telecommunications Corporation*, 112 Ill.2d 428, 493 NE 2d 1045 (1986), *cert. denied*, 479 U.S. 949, 107 S.Ct. 434, 93 L.Ed.2d 384, customers of defendant communications company filed class action for violation in the Consumer Fraud and Deceptive Business Practices Act, alleging that the defendant's advertising practices constituted fraud. The defendant's ads compared their costs of billing practices with those of AT&T Wireless Services, asserting in the ads that AT&T Wireless Services charges its customers for uncompleted calls, such as when the party being called does not answer. According to the plaintiff the ads claimed that the defendant, unlike AT&T Wireless Services, does not bill for uncompleted calls. The plaintiff claimed that this ad was false because the defendant did in fact bill for all uncompleted calls.

The opinion pointed out at p. 436:

> Plaintiffs do not challenge the reasonableness of the additional charges imposed by defendant, but only the fact that its advertising did not disclose that the additional charges would be made.

Defendant asserted that by this allegation the plaintiff was "artfully emphasizing advertising and state law theories of liability," arguing that in reality the plaintiffs were attacking "charges, practices and tariffs" regulated by federal law and that the claims should be preempted.

The court ruled that "the better view is that plaintiff's actions are not preempted by the act."

Appellants contend the same distinction can be made here. WAHIT has made demonstrably false claims that by the "pooling of a large number of employers" and its "increased buying power" it is able to "negotiate" the cost of policies on an employer's behalf. The ability to so negotiate is obviously a component of the rates, a so-called "billing increment" but plaintiffs do not make a direct attack on the cost or benefit of negotiation. Plaintiffs' complaint is that defendants' advertising is false and that there is no such "negotiation." Such a billing component does not even exist. It is false advertising to claim that such negotiation occurs. Plaintiffs do not make a direct attack on rates. Rather, the attack is on false, deceptive, and misleading advertising and has only an incidental effect on the rates charged. The filed rate doctrine does not apply.

The Arizona Court of Appeals decided *Qwest v. Kelly*, 204 Ariz. 25, 59 P.3d 789 (2002). This was a class action filed against Qwest Corporation by Mark McMahon alleging fraud and misrepresentation. Qwest had sold him a maintenance service that he did not need. The claim included that Qwest concealed material facts regarding the need for the service and employed deceptive practices in marketing and selling it. Qwest moved to dismiss all claims asserting both that the Arizona Corporation Commission had exclusive jurisdiction and that the courts lacked jurisdiction and that the filed rate doctrine barred plaintiffs' claims.

At p. 800, the court cited a number of cases from around the country adopting the filed rate doctrine, stating the following:

> Although there is ample authority in favor of adopting the filed rate doctrine, there is persuasive authority to the contrary. (*Tenore v. AT&T Wireless Services, supra* is cited for this statement).

At p. 801 the following appears:

> Neither the anti-discrimination nor the non-justicability strand of the filed rate doctrine is implicated by McMahon's claims. First, the anti-discrimination strand is not implicated. There is no claim direct or otherwise that Qwest has charged rates in a discriminatory manner or given preferential treatment to different classes of consumers . . . McMahon and the putative class members are all tenants; all were allegedly sold

> the same wire maintenance service for the same rate. Neither the rate nor the quality of the service is at the heart of McMahon's complaint. Rather, it is the very fact that Qwest sold to the tenants through allegedly fraudulent and deceptive practices and material misrepresentations of fact, a wire maintenance service that Qwest knew or should have known tenants did not need.

The importance of the Supreme Court's decision in *Tenore v. AT&T Wireless Services*, *supra*, cannot be overemphasized. There, the plaintiffs filed a class action against AT&T Wireless Services under the Washington Consumer Protection Act alleging deceptive, fraudulent and misleading practices by not disclosing its practice of "rounding up" to a full minute, its billing for cellular time. AT&T Wireless Services invoked, as one of its defenses, the filed rate doctrine, also known as the "filed tariff doctrine." The court pointed out that the parent corporation, AT&T Wireless Services, along with all telecommunications common carriers, was required by Section 203 of the Federal Communications Act of 1934 to file tariffs with the FCC. The court pointed out early in the decision, that AT&T Wireless Services was a commercial, mobile radio service provider (so-called CMRS provider) and was thereby exempt from the tariff filing

requirement. The court ruled that accordingly, the claims involved did not implicate the filed rate doctrine.

Nevertheless, AT&T Wireless Services also contended that the doctrine of federal preemption applied, arguing that by federal statute, all CMRS providers were subject to Section 332 of the Federal Communications Act which provided in part:

> . . . no state or local government shall have authority to regulate the entry of or the rates charged by any commercial mobile service or any private mobile service, except this paragraph shall not prohibit a state from regulating the other terms and conditions of commercial mobile services.

Thus, though the filed rate doctrine was not specifically implicated, the same issue was presented, namely whether the challenge to the false advertising involved was a direct challenge to rates. If a direct challenge, it would be preempted by the statute, but if not it amounts to merely regulating the other terms and conditions of the services and has merely an incidental effect on the rates.

These issues were summarized in the *Tenore* decision at p. 338:

> Appellants assert they challenge only AT&T Wireless Services's inadequate disclosure practices in connection with billing, and do not contest the reasonableness or legality of the underlying rates.

> AT&T counters by stressing that appellant's claim is essentially a disguised form of attack on the reasonableness of its rates.

The *Tenore* decision at p. 344 citing *Nader v. Allegheny Airlines, Inc.*, 426 U.S. 290, 96 S.Ct. 1978, 48 L.Ed.2d 643 (1976) resolved the issue where the court stated:

> Appellants do not attack the reasonableness of AT&T's practice of rounding up call charges. They challenge only nondisclosure of the practice. *Nader* addresses the precise issue now before this Court. We consider it applicable authority. There is sufficient reliable authority for this Court to conclude that the state law claims brought by Appellants and the damages they seek do not implicate rate regulation prohibited by Section 332 of the FCA. The award of damages is not per se rate regulation, and as the United States Supreme Court has observed, does not require a court to 'substitute its judgment for the agency's on the reasonableness of a rate.' Any court is competent to determine an award of damages.

In the case at bar, at the end of the argument on the motion that was heard January 4, 2013, after all oral argument had been completed, the court concluded by saying to defense counsel at p. 39 of the report of the decision (CP 273.)

> I think the *Empire Blue Cross,* and the *Horwitz v. Banker's Life* in terms of out of state authority are the ones that I find compelling, so your motion is granted.

These two filed rate cases that the trial court found compelling were *Horwitz v. Banker's Life & Casualty Co.*, 319 Ill.App.3d 390, 745 NE 2d 591 (2001) and *Empire Blue Cross & Blue Shield Customer Litigation*, 164 Miss.2d 350, 622 NYS 2d 843 (1994). Both of these were filed rate cases, but neither involved false advertising which was the important basis for the court's decision in *Tenore v. AT&T Wireless Services, supra* and the cases we have cited that refer approvingly to *Tenore*.

In *Horwitz*, plaintiff on behalf of herself and a purported class of policy holders, sued the defendant insurer, Banker's Life & Casualty, claiming that they were allegedly injured by the manner in which the defendant insurance company calculated and applied its premium rates for individual health insurance policies. The plaintiff claimed violation of the Illinois Insurance Code and the Illinois Consumer Fraud & Deceptive Business Practices Act. Plaintiff also claimed a breach of contract. The plaintiff's claims in *Horwitz* were direct challenges to the rates that had been charged, the kind of claims that typically call for the defendant to assert the filed rate doctrine as a defense. The defendant did so, and not surprisingly, all of the challenges to the insurance rates were dismissed, with a single

exception involving plaintiff's allegation that the defendant had breached its contract by promising that "the premium for this policy is expected to increase each year." Plaintiff had contended that this language limited increases to one per year, asserting that in fact the plaintiff had been charged more than a single time each year. The court concluded that that language was ambiguous and on the contract claim alone, remanded for further proceedings. As stated, all of the challenges to the rates were dismissed based upon the filed rate doctrine. The case in no way involved the claims of false advertising similar to *Tenore* that are present in the case at bar.

The other case relied upon by the trial court is *Empire Blue Cross* which dismissed all claims under the filed rate doctrine. The plaintiffs had sought class certification and claimed that Empire Blue Cross made misrepresentations to the Superintendent of Insurance using two sets of books and that the books shown to the Superintendent of Insurance contained erroneous financial information leading to approval of a rate higher than justified. The case involved nothing more than a challenge to the filed rate and accordingly all claims were dismissed. As in *Horwitz* there was no claim of any kind relating to false advertising.

Thus the trial court committed serious error by completely ignoring WAHIT false advertising and expressly basing the filed rate decision on cases that did not even involve false advertising.

4. Filed Rate Doctrine Issue (d) Plaintiffs' Claim That the Defendants Illegally and Wrongfully Engaged in Selective Underwriting Thereby Contributing to Excess Surplus is Not a Challenge Barred by the Filed Rate Doctrine

Plaintiffs' complaint at paragraph 21(a) (CP 9) alleges that in accumulating the surplus, the defendants, through their subsidiary WAHIT claim "on its website and in its advertisements" that it was an employer governed trust. The complaint goes on to state that such a claim is false, that the employers purchasing coverage for their employees have nothing to do with the governing and the management of the trust, and the declaration of plaintiffs' expert, Curtis Fackler (CP 225, ff.) submitted by the plaintiffs in opposition to the motion for summary judgment, explains the details and the importance of this deception and how it is a method instead by which the defendants increase profits and surplus by illegally obtaining the ability to engage in selective underwriting. The Fackler explanation includes the following:

(a) At p. 2 (CP 226), a reference to the Internal Revenue Service form filed by defendant WAHIT (CP 235) answering questions relating to its "governing body and management" in which WAHIT responds that the number of members on WAHIT's governing body is "one."

(b) Exhibit B (CP 237-40) to the Fackler declaration is a four-page copy of a question from the National Association of Insurance Commissioners sent to all of the Insurance Commissioners across the United States and the response to one particular question from the Insurance Commissioner of the State of Washington. The question is: "why do some individuals and small employers purchase coverage through associations and out of state trusts rather than the traditional markets?" (WAHIT is such an association). The Washington Insurance Commissioner response to this question reads as follows:

> Because association or member-governed plans are exempt from Washington's community rating and small group guaranteed issue laws, association plans are able to design rating and underwriting criteria allowing for better selection of risk on both a health status as well as a minimum group size basis. Association plans therefore can alter the rate a small employer pays if an individual in the group has high utilization due to illness or injury.

To explain the response of the Washington Insurance Commissioner, "community rating laws" prohibit an insurer from considering health status or claim history in its underwriting practices. "Guaranteed issue laws" require insurance to cover all eligible applicants without regard to health status or claim history. Member governed plans are exempt from these requirements. The requirements themselves for insurers not eligible for the exemption are outlined in Exhibit C (CP 242-4) to Fackler's Declaration, RCW 48.44.023 (particularly subsections (3) and (6)). As the Insurance Commissioner's response continues: "Association plans (eligible for the exemption) are able to design rating and underwriting criteria allowing for better selection of risk on both a health status as well as a minimum group size basis." The point is that it is all *underwriting.* An association that is eligible for the exemption can, in Fackler's words, "selectively underwrite and refuse to cover eligible applicants based upon their health status and/or claim history." PREMERA's subsidiary, WAHIT, is not entitled to this exemption and should not be permitted to selectively underwrite.

It is easy to demonstrate why this does not involve a challenge to rates being charged. The eligible applicants who are denied this

coverage based on an illegal claim of the exemption are not issued the coverage and not charged any rates. The wrongful underwriting practices do not involve a claim of excessive rates being charged.

This point is not without precedent. A number of cases where insurers have attempted to dismiss plaintiffs' claims based on the filed rate doctrine, alleging that the plaintiffs' claims amount to nothing more than a claim that excessive rates have been charged point out that a challenge to wrongful underwriting practices does not involve the filed rate doctrine.

In *Donabedian v. Mercury Insurance Co.*, 116 Cal.App.4th 968, 11 Cal. Rptr.3d 45 (2004) plaintiff insured claimed that the defendant insurer had used the absence of his prior insurance in and of itself in accepting applicants for coverage and in determining rates in violation of statute. Defendant Mercury in its motion to dismiss, cited *Walker v. Allstate Indemnity Co.*, 77 Cal.App.4th 750, 753 (2000), a case that had dismissed similar plaintiff's claims because they were merely an attack on excessive rates. The *Donabedian* court opinion stated at p. 991:

> Mercury's reliance on *Walker, supra* is misplaced. There the insured's causes of action were each bottomed on the insurer's charging approved rates

> alleged nevertheless to be excessive. . . . Walker is inapposite. . . . Walker involved a challenge to approved rates. This case does not.

The *Donabedian* case was cited later in *Krumme v. Mercury Insurance Co.*, 123 Cal.App. 4th 924, 20 Cal.Rptr. 3d 484 (2004). There plaintiff Krumme sued the defendant insurers for selling car insurance through broker agents who were not appointed agents and for permitting them to charge broker fees. Mercury Insurance defended by again citing *Walker v. Allstate Indemnity Co.*, asserting that it was essentially a challenge to rates. The court responded, rejecting Mercury's contention at p. 937 in the following language:

> A judicial act constitutes rate regulation only if its principal purpose and direct effect are to control rates . . . In general, a claim that directly challenges a rate and seeks a remedy to limit or control the rate prospectively or retrospectively is an attempt to regulate rates but a claim that directly challenges some other activity, such as false advertising . . . is not rate regulation. (Citing cases including *Donabedian v. Mercury Insurance Company, supra.*)

In *MacKay v. Superior Court and 21st Century Ins. Co.*, 188 Cal.App.4th 1427, 115 Cal.Rptr. 3d 893 (2010) the court held that the Department of Insurance prior approval of a rate precluded a civil action challenging it, noting however the "limited nature" of the holding and stating at p. 911:

> Insurance Code Section 1860.1 protects from prosecution under laws outside the Insurance Code only 'acts done, actions taken and agreements made pursuant to the authority conferred by the rate-making chapter. It does not extend to insurer conduct not taken pursuant to that authority. . . . Cases which apparently reached a different result when the underlying conduct was not the charging of an approved rate are distinguishable on this basis. See *Donabedian v. Mercury Insurance Co., supra,* expressly acknowledging that the plaintiff 'contends the Insurance Commissioner did not approve Mercury's use of the lack of prior insurance to determine, for example, eligibility for the good driver discount or insurability.' Indeed, if the underlying conduct challenge was not the charging of an approved rate, but the application of an unapproved underwriting guideline, Insurance Code §1860.1 would not be applicable.

5. Primary Jurisdiction Discretionary Doctrine Inapplicable Where Agency Cannot Resolve Issue

Though the two defenses of exhaustion of remedies and primary jurisdiction are related, there are significant differences in the two, which should not be overlooked. These differences are:

The primary jurisdiction doctrine is discretionary. In applying the doctrine, the trial court must conclude that it should refrain from exercising jurisdiction until an administrative agency with special competence has resolved an issue arising in the proceeding before the court. *3 Davis, Administrative Law*, §19.01. See *Kerr v. Dept.*

of Game, 14 Wn.App. 427, 429, 542 P.2d 467 (1975) where the court stated:

> The doctrine of 'primary jurisdiction' does not involve jurisdiction in the technical sense. Rather, it is a doctrine 'predicated on an attitude of judicial self-restraint' and is applied when the court feels that the dispute should be handled by an administrative agency created by the legislature to deal with such problems. 2 F. Cooper, *State Administrative Law* 564 (1965). The application of the doctrine is not mandatory in any given case, but rather is within the sound discretion of the court.

If primary jurisdiction is applicable, the proper procedure is to stay the trial court's decision pending administrative exercise of its primary jurisdiction and not outright dismissal of the action. In determining whether to grant a stay based on primary jurisdiction, the court must "weigh the benefits of obtaining the agency's aid against the need to resolve the litigation expeditiously." Citing *Wagner & Brown v. A&R Pipeline Co.*, 837 F.2d 199, 201 (5th Cir., 1988).

In Re Real Estate Litigation, 95 Wn.2d 297, 301 and 302, 622 P.2d 1185 (1980) referring to the doctrine of primary jurisdiction, the court stated:

> The doctrine 'does not necessarily allocate power between courts and agencies, for it governs only the question whether court or agency will *initially* decide a

> particular issue, not the question whether court or agency will *finally* decide the issue.

The primary jurisdiction rule requires that: (1) the administrative agency has the authority to resolve the issues that would be referred to it by the court; (2) the agency has special competence over all or some part of the controversy which renders the agency better able than the court to resolve the issue; and (3) the claim before the court involves issues that fall within the scope of a pervasive regulatory scheme so that a danger exists that judicial action would conflict with the regulatory scheme. *Blaylock, supra* at 1103.

In the case at bar, during the court's ruling on primary jurisdiction at the hearing on the individual and small group cases, the court stated:

> . . . on the primary jurisdiction, I've been sitting here thinking about this all last night, saying, okay, so if this court decides that there is an excess surplus, what are the parameters that I decide is how much is okay, what's not good enough.
>
> We know that the Insurance Commissioner sets a minimum that a company has to have because we need to have these companies be in our state with financial health and not risk the policy holders not being able to get coverage, but that convinced me that this agency has the authority to resolve these issues, it has special

> competency in setting and addressing these issues, and the claim in front of the court involves issues within the scope of the pervasive regulatory scheme that the Insurance Commissioner has. *Transcript of Proceedings*, 9/28/2012, p. 33, 34 of CP 159.

With all due respect, appellants point out that the Insurance Commissioner has addressed these issues and has clearly and unambiguously stated, as appellants complain in this litigation, that the surplus maintained by the PREMERA companies is excessive beyond all issues of solvency and financial stability.

To quote from the statement of the Insurance Commissioner, Mike Kreidler, in support of Senate Bill 5247, at the Legislative hearing before the Senate Health and Longterm Health Care Committee on January 29, 2011 (pp. 6-7, Transcript, CP 214):

> What I have here is a proposal to limit the amount of surplus that insurance carriers continue to build. The insurance carriers have built up $2.4 billion of surplus in excess of what they need to pay the claims current – that they are currently experiencing. Of that $2.4 billion there is a significant share that it goes beyond what is the financial responsibility from the standpoint of solvency, of making sure that a health insurance company remains active in providing services.
>
> If you take a look at what the health insurers have done in the last few years relative to the amount of surplus that they have built up compared to the rate increases, that have even been higher, here are a couple of examples, the first one is one of – Group Health where

> you see that rate increases have been more than 122%, but you've seen the surplus increase threefold or tripled to $600 million.
>
> In the case of Regence you see that they are at 150% – at more than 150% in their premiums, but their surplus has more than doubled. Premera has gone from two – over 200% are rate increases – percent rate increases but their surplus has more than doubled. How much is enough is the real question you have to ask.

If there is a single person in the State of Washington who is an expert in the determination of excess surplus, it would be the Insurance Commissioner who has a fleet of actuaries at his disposal and who has analyzed the surplus held by Premera, and Regence and Group Health and found it to be grossly excessive:

> To continue with Mr. Kreidler's statements:
>
> If they don't need it for solvency but it continues to grow, there should be a mechanism in place to be able to make sure that the returning investment for the non-profit health insurers that operate in the State of Washington. Non-profits, by their very chartering papers that – that they are responsible to the community. Not to stockholders, to the community. The 'community' being the people that hold the policies.
>
> And at p. 11 of CP 214:
>
> We very much want to make sure that these companies have reserves. But how much is enough? In this case, $2.4 billion is what they have in aggregate. This is nearly a billion dollars that is above what is required

> from the standpoint of solvency in order to protect the integrity of those companies.

Appellants submit that there is no need to consider a referral of this matter to the Insurance Commissioner for assistance under the doctrine of primary jurisdiction. The Commissioner's position is a given – the surplus is excessive and the Commissioner has tried legislatively for years to correct it. Other states have given this authority to the agency.[3] Judicial action in this case does not conflict with the existing regulatory scheme.

See also on the primary jurisdiction issue, the Supreme Court's analysis in *Tenore v. AT&T Wireless Services, supra*. There the trial court had decided that the plaintiff's claims were required to be referred to the FCC. This ruling was reversed with the *Tenore* court citing the United States Supreme Court decision in *Nader v. Allegheny Airlines, Inc., supra.* stating at p. 346:

> The action brought by petitioner does not turn on a determination of the reasonableness of a challenged

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[3] For example, Oregon Code Section 743.018(5) reads as follows: ". . . in order to determine whether the proposed premium rates for a health benefit plan for small employers or for an individual health benefit plan are reasonable and not excessive, inadequate or unfairly discriminatory, the Director may consider: (a) the insurer's financial position, *including but not limited to profitability, surplus, reserves, and investment savings.*" (Emphasis supplied.)

> practice – a determination that could be facilitated by an informed evaluation of the economics or technology of the regulated industry. The standards to be applied in an action for fraudulent misrepresentation are within the conventional competence of the courts, and the judgment of a technically expert body is not likely to be helpful in the application of these standards to the facts of this case.

The *Tenore* decision continues at p. 347:

> Similarly, in this case there is no conflict between the authority of the FCC and that of a court in deciding whether AT&T's advertising practices are misleading. As in *Nader,* Appellants in this case do not challenge the reasonableness of AT&T's underlying practice of rounding its call charges. Also, although the FCC enacted the preemption provision in Section 332 to promote uniformity, it did so primarily to prevent burdensome and unnecessary state regulatory practices, and not to subject the CMRS infrastructure to rigid control. Nor does the FCC have exclusive authority over advertising and billing practices, if at all.

Finally, on the issue of procedure, the trial court here did not enter any order referring this case to the office of the Insurance Commissioner. The doctrine of primary jurisdiction as substantially all the cases hold, governs the question of whether the court will initially decide a particular issue, not the question of whether the court will finally decide the issue. Here the trial court erred in not retaining jurisdiction if there was any real intent to refer the matter to the Insurance Commissioner's office for such an initial determination.

6. Exhaustion of Remedies
Absence of Remedy at Agency Level Precludes Exhaustion

The prerequisite to compelling the litigant to exhaust administrative remedies is availability of a remedy at the administrative level. Plaintiffs are suing for an award of monetary damages, attorneys fees and costs. The Insurance Commissioner has no authority to grant such relief. The only relief provided by statute states that a person aggrieved by an act (or threatened act) is entitled to demand a hearing before the OIC which relief is waived, unless the demand is made within 90 days. RCW 48.04.010(1) and (3).

In *State v. Multiple Listing Service*, 95 Wn.2d 280, 622 P.2d 1190 (1980) the Washington Attorney General filed actions against 3 real estate broker associations, alleging violations of the Consumer Protection Act for denying independent brokers who were not members of the broker association's access to the Multiple Listing Service. The defendant associations asserted first that the State had not exhausted remedies and, prior to filing the consumer action, should have complained to the Real Estate Commission and State Department of Licensing . The trial court granted summary judgment

of dismissal of plaintiff's complaint, in part based on exhaustion of remedies. The Supreme Court reversed at p. 284 describing under what circumstances the exhaustion doctrine is to be applied:

> . . . when the agency's authority 'establishes clearly defined machinery for the submission, evaluation and resolution of complaints by aggrieved parties' and *when the 'relief sought ...can be obtained by resort to an exclusive or adequate administrative remedy. . . .'* (Emphasis supplied.)

The Supreme Court noted the case was an action under RCW Ch. 19.86 involving violation of the Consumer Protection Act. Such violations are not cognizable by either the Department of Licensing or the Real Estate Commission. Thus the exhaustion doctrine was held not to apply. In the present action, there is no authority given OIC to grant the relief plaintiffs seek.

Credit General Insurance Co. v. Zewdu, 82 Wn. App. 620, 626, 919 P.2d 93 (1996) explains what is meant by an "adequate administrative remedy" sufficient to require exhaustion, citing *State v. Multiple Listing Service*, *supra.* If plaintiff's complaint objects merely to the defendant engaging in what plaintiffs contend to be illegal activity, an agency's power to issue a cease and desist order is an adequate remedy and exhaustion is required. *Retail Store*

Employees Union Local 1001 v. Washington Surveying & Rating Bureau, 87 Wn.2d 887, 558 P.2d 215 (1976).[4] In *State v. Multiple Listing Service, supra,* where the agency has no power to assess penalties either generally or with reference to violations of the Consumer Protection Act, the remedy is not adequate and exhaustion of remedies is not required.

Any "appeal" from OIC action following an administrative hearing is judicial review pursuant to RCW Ch. 34.05, the Administrative Procedures Act. The authority of the court is limited to relief provided by RCW 34.05.570 and .574.

PREMERA fails to point out that RCW 34.05.534 specifies when exhaustion of remedies is *not* required:

> (3) The court may relieve a petitioner of the requirement to exhaust any or all administrative remedies upon a showing that: (a) The remedies would be patently inadequate; (b) The exhaustion of remedies would be futile; or (c) The grave irreparable harm that would result from having to exhaust administrative

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[4] The *Retail Store Employee's* case cited by PREMERA demonstrates the point. If the relief sought by the plaintiff can be obtained at the agency level, with the statutes governing the agency empowering it to grant the relief plaintiffs' request, exhaustion applies. Here, however, the plaintiffs are claiming money damages, relief that the Insurance Commissioner has no statutory authority to award and there is accordingly no exhaustion of remedies possible.

> remedies would clearly outweigh the public policy requiring exhaustion of administrative remedies.

Clearly, plaintiffs satisfy these requirements. There is no adequate remedy at the OIC level for plaintiffs; a hearing before OIC would be "futile" given the Commissioner's own interpretation of his statutory authority, and; public policy is not served by requiring plaintiffs to first proceed before OIC.

Finally, on the exhaustion of remedies issue PREMERA has cited *South Hollywood Hills Citizens v. King County*, 101 Wn.2d 68, 677 P.2d 114 (1984), *Spokane County Fire Protection Dist. v. Review Board,* 97 Wn.2d 922, 652 P.2d 1356 (1982) and *Lauer v. Pierce County*, 273 Wn.2d 242, 267 P.3d 988 (2011). These cases are readily distinguishable. In *South Hollywood Hills*, application to the court for review of action by the King County Council was dismissed because the applicant had been notified in writing that the decision would be "final and conclusive" unless any aggrieved party obtained a writ of review from the Superior Court "within 20 days." No such writ was obtained and the applicant accordingly failed to exhaust administrative remedies. In *Spokane Fire Protection*, County residents had petitioned the City to annex an area. The City

evaluated the petition and issued a threshold determination from which the fire protection district did not appeal. The City thereafter decided to annex the territory and the fire district filed a Superior Court action. The case was dismissed with the court pointing out that it is not possible to challenge an agency action if the challenger had not appealed the threshold decision. *Lauer v. Pierce County* involved an invalid petition, but even so, the court stated at p. 256 of the opinion that "Lauer and De Tienne fully participated in every step of administrative review relating to the case and exhausted all remedies." These three cases have little to do with the case at bar.

There is no adequate administrative remedy to exhaust. Exhaustion would be futile. PREMERA'S claim of failure to exhaust remedies should be denied.

D. CONCLUSION

Appellants agree with a single conclusion announced by the trial court – that the best agency to decide whether the level of surplus held by the health insurer is excessive is the Washington State Insurance Commissioner, Mr. Mike Kreidler. However, the Insurance Commissioner has reached that decision and repeatedly informed the public and the legislature that those levels of surplus are grossly

excessive, beyond all solvency requirements, and something should be done to correct it.

The issues in this case involve false advertising and unfair and deceptive marketing practices. The *Tenore* decision emphasized that unless false advertising involves a direct attack on the rate component itself, and its cost, the effect on rates is incidental and the filed rate doctrine does not apply.

The record establishes excessive surplus beyond any reasonable necessity – a surplus that was obtained by false and misleading representations by the subsidiary WAHIT, thereby contributing to the excess surplus. WAHIT falsely advertised that it is employer-governed and that it negotiates with other insurers to obtain the most favorable cost. These falsehoods are not an attack on the amount of rates charged. There is no claim relating to process or cost of negotiating. The appellants claim is that there is no negotiation and accordingly it is not an attack on rates and the filed rate doctrine is not involved.

Finally, *Tenore* pointed out that issues such as unfair and deceptive marketing practices, false advertising and damages are within the usual competence of the courts and there should be no

need to resort to primary jurisdiction or exhaustion of remedies. Appellants request reversal and remand for trial.

Respectfully submitted this 24th day of May, 2013.

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Declaration of Service

The undersigned declares under penalty of perjury under the laws of the State of Washington that on the below date I mailed via U.S. Mail, first class, postage pre-paid and/or sent by legal messenger and/or electronic mail, a true copy of this document to:

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Dated this 24 day of May, 2013.

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