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

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; PUCKETT & REDFORD, PLLC, a Washington professional limited liability company; and ANNETTE STEINER, a single person,

Respondents

ON APPEAL FROM KING COUNTY SUPERIOR COURT

PETITION FOR REVIEW

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES AND COURT RULES

OTHER AUTHORITIES

I. IDENTITY OF PETITIONERS

Respondents Premera, Premera Blue Cross, LifeWise Health Plan of Washington (collectively "Premera") and Washington Alliance for Healthcare Insurance Trust and its Trustee F. Bentley Lovejoy (collectively "WAHIT") respectfully ask this Court to accept review of the Court of Appeals' decision. The decision is contrary to the filed rate doctrine as previously recognized by this Court and the Court of Appeals and, unless reversed, will disrupt the legislature's extensive scheme for regulating health insurance premium rates. *See* RAP 13.4(b)(1), (2) & (4).

II. COURT OF APPEALS' DECISION

Premera and WAHIT petition for review of the June 23, 2014 published decision (the "Decision") by Division I of the Court of Appeals. The Decision reversed the superior court's dismissal of Plaintiffs' claims. *McCarthy Finance, Inc. v. Premera*, --- P.3d ----, 2014 WL 2819025 (Wn. App. June 23, 2014). A copy of the Decision is attached to the Appendix.

III. ISSUES PRESENTED FOR REVIEW

Plaintiffs allege that misrepresentations by Premera and WAHIT resulted in their payment of excessive premiums and that they are entitled to reimbursement from allegedly excessive reserves held by Premera. The superior court properly dismissed Plaintiffs' claims based on the filed rate doctrine, primary jurisdiction, and failure to exhaust administrative remedies because, among other reasons, Plaintiffs' alleged damages can only be determined by reference to Premera's premium rates that are filed with and approved by the Office of the Insurance Commissioner ("OIC").

The filed rate doctrine provides that any "filed rate"—a rate filed with and approved by a regulatory agency—is per se reasonable and cannot be the subject of a private legal action. The Court of Appeals agreed that "[g]iven the extensive legislative and regulatory framework applicable to health insurance rates, the filed rate doctrine applies to health insurance," and that Plaintiffs here seek an "award measured by reference to premiums paid" pursuant to Premera's filed rates. The foregoing should have led the Court of Appeals to affirm the superior court's dismissal of Plaintiffs' complaint.

But the Decision holds that "an insurer is not insulated from CPA misrepresentation claims merely because a recovery may ultimately impact its rates." That conclusion rests upon a misreading of *Tenore v. AT & T Wireless Servs.*, 136 Wn.2d 322, 331, 962 P.2d 104 (1998)—a case in which the Court found the filed rate doctrine inapplicable because the case did not involve filed rates and the plaintiffs' request for damages did not "implicate rate adjustment." Instead, the court focused on whether the claims were preempted—a distinct issue from the filed rate doctrine. Thus, contrary to the Court of Appeals' conclusion, *Tenore* actually reinforces the applicability of the filed rate doctrine in cases like this one.

The Court of Appeals also held that the superior court erroneously dismissed Plaintiffs' complaint based on the related defenses of primary jurisdiction and failure to exhaust administrative remedies—even though the Court of Appeals correctly recognized that, "[w]hile the insurance commissioner cannot force a health carrier to use its surplus to lower its

rates, he can and does consider the size of the surplus to reject the carriers' request to raise rates." This is true with respect to large group as well as individual and small group rates, contrary to a conclusion by the Court of Appeals that the OIC does not review surplus for large groups. In effect, the Decision allows a court to adjudicate issues subject to exclusive and pervasive regulatory authority (insurance rate-making), and to award a remedy the legislature elected to specifically deny to the OIC (reduction in surplus), even though the Court of Appeals has determined that the scope and rigor of the OIC's review of Premera's rates triggers application of the filed rate doctrine. This violates an important separation of powers principle: With respect to application of the filed rate doctrine, the courts as well as the agency "are bound, not only by the ultimate purposes [the legislature] has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *MCI Telecomms. Corp. v. American Tel. & Tel. Co.*, 512 U.S. 218, 231 n.4 (1994).

The Decision raises the following issues warranting review:

1. Is a CPA claim alleging excessive, unnecessary, or unfair health insurance premium rates precluded by the filed rate doctrine?

2. Does the filed rate doctrine bar a CPA claim that alleges injury that can only be determined by reference to filed rates?

3. Does the filed rate doctrine apply to a challenge to a health insurer's alleged improper accumulation of surplus where the OIC considers surplus in approving or disapproving the insurer's filed rates?

4. Should courts defer to the OIC's primary jurisdiction with respect to a challenge to a health insurer's alleged improper accumulation of surplus where the OIC considers surplus in approving or disapproving the insurer's filed rates?

5. Is exhaustion of administrative remedies a prerequisite to a challenge to a health insurer's alleged improper accumulation of surplus where the OIC considers surplus in approving or disapproving the insurer's filed rates?

IV. STATEMENT OF THE CASE

A. Factual Background.

Premera is a "health care service contractor," which means it receives premiums from groups and individuals in return for which it provides health care services through a network of providers. RCW 48.44.010(9), RCW 48.44.020(1). Premera is required to file its individual and group contracts, and proposed premium rates, with the OIC for review and approval. RCW 48.44.020, 48.44.040, 48.44.070. The OIC, in turn, may "disapprove any individual or group contract" if it fails to comply with specific statutory and regulatory requirements. RCW 48.44.020(2) ("The commissioner may on examination, subject to the right of the health care service contractor to demand and receive a hearing under chapters 48.04 and 34.05 RCW, disapprove any individual or group contract form for any of the following grounds . . ."); *see also* RCW 48.44.110 (false or deceptive advertising by health care service contractors forbidden). The OIC reviews all proposed premium rates and must "disapprove any contract if the benefits provided therein are unreasonable in relation to the amount charged for the contract." RCW 48.44.020(3).

The OIC's approval process depends upon whether the proposed rate applies to individual and small group plans, on one hand, or large group plans, on the other. Under the Insurance Code's comprehensive

scheme, for individual and small group plans, Premera filed community-rated premiums and, for large group plans, it filed both its Large Group Rating Model and each individually negotiated large group rate (including those for WAHIT members).[1] RCW 48.44.017, 48.44.020, 48.44.040; WAC 284-43-920, 284-43-925, 284-43-930, 284-43-950; CP 344-48 (Blaine Decl.). The OIC then used its institutional expertise to review Premera's proposed rates, and ratings model, to ensure they complied with the Insurance Code's complex rate-setting methodology and, above all, were "reasonable" in relation to the plans' benefits. RCW 48.44.020, 48.44.021, 48.44.022, 48.44.023; WAC 284-43-915.

For individual, small group, and large group rates alike, the OIC was required to consider Premera's surplus—the same surplus Plaintiffs allege is excessive, *see* CP 10-11, 14-15, 17, 20-23 (¶¶ 22, 30, 34, 40-47)—in that review. WAC 284-43-915(2)(c) & (d); CP 323. For individual, small group and large group plans, the OIC reviews the proposed rates to determine whether they comply with these statutory and regulatory standards, as well as the general requirement that rates not be unreasonable in relation to a plan's benefits. RCW 48.44.020(3). The OIC has specifically enumerated criteria it must use to assess the

[1] WAHIT is a non-profit trust through which participating employers can obtain health benefit plans for their employees; WAHIT is not a Premera affiliate. CP 35, CP 234. During the period relevant to this case, Plaintiffs Hemphill Brothers, Inc., J.A. Jack & Sons, Inc., and Lane Mt. Silica Co., chose to purchase policies from Premera as part of their membership in WAHIT. *See* CP 2 (¶ 3).

reasonableness of Premera's rates, including accumulated surplus:

> (2) Benefits will be found not to be unreasonable if the projected earned premium for the rate renewal period is equal to the following:
>
> (a) An actuarially sound estimate of incurred claims associated with the filing for the rate renewal period, where the actuarial estimate of claims recognizes, as applicable, the savings and costs associated with managed care provisions of the plans included in the filing; plus
>
> (b) An actuarially sound estimate of prudently incurred expenses associated with the plans included in the filing for the rate renewal period, where the estimate is based on an equitable and consistent expense allocation or assignment methodology; plus
>
> **(c) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges, where the justification recognizes the carrier's investment earnings on assets other than those related to claim reserves or other similar liabilities; minus**
>
> **(d) An actuarially sound estimate of the forecasted investment earnings on assets related to claim reserves or other similar liabilities for the plans included in the filing for the rate renewal period.**
>
> **(3) The contribution to surplus, contingency charges, or risk charges in subsection (2)(c) of this section, will not be required to be less than zero.**

WAC 284-43-915 (emphasis added). Thus, contrary to a basic premise underlying Plaintiffs' claims in this case, in approving or disapproving proposed individual, small group and large group rates, the OIC specifically considers—in addition to estimated incurred claims and expenses—a health care service contractor's surplus levels and estimated investment earnings for the contract period. *Id.*

With respect to proposed individual and small group rates, in a

section on the OIC's website entitled "[h]ow we review health rates," the OIC describes its rate-approval process for small group and individual plans in similar terms. CP 323. The OIC specifically states that it determines the "reasonableness" of proposed rates in light of, among many things, "the company's current level of surplus":

> We also examine the following information to see if the rate is reasonable in relation to the plan's benefits:
>
> - That the premiums, claims and administrative costs are consistent with what the company reported in its financial statement.
> - The actual vs. projected medical and prescription drug costs.
> - The assumptions used to project the medical and prescription drug costs, including changes in these costs and in the benefit design.
> - The actual vs. projected administrative costs, including expenses such as agent commissions, taxes, salaries, case management activities, claims and appeals processing costs, customer services, etc.
> - **How much profit the company expects to make. This is generally called "contribution to surplus" or "projected profit." Whether this amount is considered reasonable depends on the company's current level of surplus, as well as the type of business.**
>
> If we believe the rate request is justified, state law requires us to approve the increase.
>
> If we don't believe the rate increase is justified we deny the increase. At this point, the insurer can revise its rate increase request or it can request a hearing.

Id. (emphasis added). This examination process is rigorous and thorough. As an example, the record contains several "Rate Request Decisions," which are publicly available on the OIC's website, in which the OIC

refused to approve Premera's proposed rate increases. CP 325-37. For example, in disapproving one proposed rate increase, the OIC explained as follows:

> **Our decision**
>
> * * *
>
> According to the company's financial statement, the company has $879.4 million in surplus – which is enough to pay 5.29 months of claims. Based on the company's significant profits on this block of business for the past few years, we believe its level of risk is low and have denied the 2.5% projected profit. Reducing the projected profit from 2.5% to 0% will change the rate projection and lower it from 4.7% to 1.9%. We do not have the authority to order a company to use surplus to subsidize or lower its rates. The approved 1.9% rate request will not require the company to use its surplus to lower rates, but will produce no projected profit for this block of business.

CP 333. In other words, while the OIC cannot force a health carrier to use a surplus to lower its rates, it can and does consider the size of the surplus to reject the carriers' request to raise rates. The OIC refused to allow Premera to contribute anything to surplus, and would approve only a rate that set Premera's contribution to surplus (i.e., "profit") at 0%. *Id.* Indeed, it works both ways. In another instance, the OIC noted concerns over respondent LifeWise's decline in surplus. CP 304-07.

With respect to large group rates, rate-setting and OIC approval for large groups is a multi-step process that involves negotiations between Premera and the large groups themselves, along with the group's underwriters, actuaries, brokers and other support professionals. CP 345 (Blaine Decl.) ¶ 6. Again, Washington law requires the OIC to consider "contribution to surplus" and "investment earnings" when reviewing and approving rates. RCW 48.44.020(3); WAC 284-43-915.

The undisputed record (and public filings) show that OIC approval is anything but passive; the OIC actively reviewed Premera's filings, asked for more information, rejected Premera's initial proposed rate, and required a lower rate before final approval. CP 325-37; CP 345-46 (Blaine Decl.), ¶¶ 7-9; CP 357-59; CP 537-43.

B. Plaintiffs' Allegations.

Plaintiffs filed a class action complaint in King County Superior Court in January 2012 against Premera, WAHIT, and WAHIT's trustee. CP 1-52; CP 35 (declaration of trust). Plaintiffs purported to represent putative classes comprised of plan members in three health insurance markets: the large group market (Class A); the small group market (Class B); and the individual market (Class C). CP 2-3, 6 (¶¶ 2-5, 16-18).

The sole cause of action alleged in Plaintiffs' complaint was for violation of the Consumer Protection Act ("CPA"), RCW 19.86.020. CP 7-11, 14-16. The focus of Plaintiffs' claims was an allegation that Premera had charged "excessive," "unnecessary," and "unfair" premium rates for its health plans and, as a result of these allegedly excessive rates, that Premera had accumulated a "massive" surplus inconsistent with its status as a non-profit corporation. *See* CP 4, 5, 10, 15, 17, 19-23 (¶¶ 12, 14, 22, 30(a) & (b), 34, 39, 40-47). As to WAHIT, Plaintiffs alleged that WAHIT's conduct, including purported false advertising, also increased their rates and led to the accumulation of that same allegedly excessive surplus. *See* CP 5, 7–10 (¶¶ 13, 14, 21, 30(d)). Plaintiffs alleged they were damaged in the sum "of the excess premiums paid to the

defendants," and asked that the "excess surplus ... be refunded to the subscribers who have paid the high premiums causing the excess." CP 15-16, 28 (¶¶ 30(d), 65, 66).

C. Decisions Below.

Premera moved to dismiss the Class B and Class C claims pursuant to CR 12(b)(6), and the Class A claims pursuant to CR 56. CP 97-113, 315-43, 160-80, 344-768. Premera argued that Plaintiffs' attack on its premium rates should be dismissed on three independent, but related, grounds: (1) the filed rate doctrine; (2) failure to exhaust administrative remedies; and (3) the primary jurisdiction doctrine. *Id.* The trial court granted Premera's motion to dismiss, dismissing the claims as to the proposed Class B and Class C subclasses. CP 157-59; 9/28/2012 Tr. at 31:11-32:22, 32:23-33:3. It also granted Premera's summary judgment motion, dismissing the proposed Class A claims. CP 273-75; 1/4/13 Tr. at 30:17-31:2, 34:22-35:23. Each ensuing order dismissed the claims on all three of the bases on which Premera sought dismissal. *Id.*

The Court of Appeals agreed that "[g]iven the extensive legislative and regulatory framework applicable to health insurance rates, the filed rate doctrine applies to health insurance." *McCarthy*, 2014 WL 2819025, at *3. It also recognized that the doctrine applies to CPA claims. *Id.* (citing *Hardy v. Claircom Commc'ns Group, Inc.*, 86 Wn. App. 488, 494-95, 937 P.2d 1128 (1997) ("the *Hardy* court held that the claims [including CPA claims] were barred by the filed rate doctrine")). Finally, the court also agreed that Plaintiffs sought an "award measured by reference to

premiums paid," because a "claim for damages caused by misrepresentation in marketing insurance ... warrants consideration of the amount paid for the policy." *Id.* at *4.

Notwithstanding the clear applicability of the filed rate doctrine, the Court of Appeals reversed. Citing to *Tenore*, 136 Wn.2d at 344–45, the court held that "an insurer is not insulated from CPA misrepresentation claims merely because a recovery may ultimately impact its rates." *McCarthy*, 2014 WL 2819025, at *4-*5. The court also reversed the dismissal on the alternative grounds of failure to exhaust administrative remedies and primary jurisdiction—even though here, too, the Decision recognized that the OIC "can and does consider the size of the surplus to reject the carriers' request to raise rates." *Id.* at *8.

V. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

A. The Filed Rate Doctrine Bars Plaintiffs' Claims.

1. The Filed Rate Doctrine Applies To Plaintiffs' CPA Claims Relating To Premera's Filed Premium Rates.

The filed rate doctrine provides that "any 'filed rate'—a rate filed with and approved by the governing regulatory agency—is per se reasonable and cannot be the subject of legal action against the private entity that filed it.'" *Id.* at *3 (quoting *Tenore*, 136 Wn.2d at 331 (citing *Wegoland Ltd. v. Nynex Corp.*, 27 F.3d 17 (2d Cir. 1994)))[2]. The Decision

[2] It is well-established that the filed-rate doctrine applies to claims alleging false advertising, fraud, concealment and violation of consumer protection acts, *Marcus v. AT&T Corp.*, 138 F.3d 46, 57-62 (2d Cir. 1998), including allegations that the insurer obtained approval for a rate through fraud on the agency. *See also In re Empire Blue Cross & Blue Shield Customer*

correctly holds that the doctrine bars claims against insurers where the allegations relate to the reasonableness of filed premium rates. *Id.* That holding is consistent with the weight of authority, including decisions from the Western District of Washington. *Blaylock v. First Am. Title Ins. Co.*, 504 F. Supp. 2d 1091, 1100 (W.D. Wash. 2007) ("[m]any courts, both state and federal, have concluded that the doctrine bars ... challenges to rates set by state agencies regulating insurance premiums"); *Heaphy v. State Farm Mut. Auto. Ins. Co.*, 2006 WL 278556, *2 (W.D. Wash. Feb. 2, 2006) ("it is clear to the court that any claims based on the reasonableness of the premiums charged are precluded by the filed rate doctrine").

The Decision also recognized that a prior decision had held that CPA claims are not immune from the filed rate doctrine. *McCarthy*, 2014 WL 2819025, at *3 (citing *Hardy v. Claircom Commc'ns Group, Inc.*, 86 Wn. App. 488, 937 P.2d 1128 (1997)). In *Hardy*, the plaintiff sued various companies for violation of the CPA and other claims based on the practice of "rounding up" telephone charges. 86 Wn. App. at 494–95. As the Decision correctly noted, "[c]oncluding that 'any court-imposed award of damages would by definition result in [plaintiffs] paying something other than the filed rate,' the *Hardy* court held that the claims were barred by the filed rate doctrine." *McCarthy*, 2014 WL 2819025, at *3.

Litig., 622 N.Y.S.2d 843, 164 Misc.2d 350 (N.Y. Sup. Ct. 1994), *aff'd sub nom. Minihane v. Weissman*, 640 N.Y.S.2d 102, 226 A.D.2d 152 (N.Y. App. Div. 1996); *Fersco v. Empire Blue Cross & Blue Shield*, No. 93 Civ. 4226 (JFK), 1994 WL 445730 (S.D.N.Y. Aug. 17, 1994).

This conclusion is not novel; the case law uniformly holds that, like a direct attack on the reasonableness of a rate, claims of fraud or false advertising are barred by the filed rate doctrine. This is so because "it is not the nature of the relief, nor the name of the cause of action, which triggers the doctrine," but whether "the damages sought by plaintiff for consumer fraud would require the court to ascertain what would be a reasonable rate absent the fraud." *Horwitz v. Bankers Life & Cas. Co.*, 745 N.E.2d 591, 605 (Ill. Ct. App. 2001) (internal citation and quotation marks omitted); *Clark v. Prudential Ins. Co. of Am.*, 736 F. Supp. 2d 902, 919-20 (D.N.J. 2010) (same); *In re Empire Blue Cross & Blue Shield Customer Litig.*, 622 N.Y.S.2d at 848 (same). In short, the filed rate doctrine applies, even to CPA claims, where a plaintiff seeks damages that would require a court to reconsider a filed and approved premium rate.

2. The Decision Erroneously Concludes That The Filed Rate Doctrine Does Not Bar Claims That Seek Damages Measured By Reference To Premera's "Filed" Rates.

Plaintiffs' CPA claim plainly falls within the filed rate doctrine's proscription: the only damages they seek are a refund of the allegedly excessive rates. CP 15-16, 28 (¶¶ 30(d), 65 & 66) (alleging damage in the sum "of **the excess premiums** paid to the defendants," and requesting that the "excess surplus ... be refunded to the subscribers who have paid the high premiums causing the excess") (emphasis added). Indeed, the Decision itself recognizes that Plaintiffs pray for an "award measured by reference to premiums paid". *McCarthy*, 2014 WL 2819025, at *4. In other words, the CPA damages Plaintiffs seek would necessarily conflict

with the OIC's finding that Premera's filed rates were reasonable and, worse yet, would require a court or jury to determine what a reasonable rate should have been. The filed rate doctrine forbids both.

The foregoing should have led to an affirmance. Instead, the Court of Appeals purported to apply a "nuanced approach, considering the specifics of the claim and the policy basis for the filed rate doctrine." *Id.* The Decision asserts that "[a]n award measured by reference to premiums paid ... does not amount to a court second guessing the health insurance rate approved by the [OIC] and does nothing to weaken the rate approval process" and, similarly, "an insurer is not insulated from CPA misrepresentation claims merely because a recovery may ultimately impact its rates." *McCarthy*, 2014 WL 2819025, at *4. The Decision's supposed "nuanced" approach to the filed rate doctrine is unsupported by either logic or precedent and, in fact, runs squarely against the very purpose of the doctrine.

The doctrine preserves the exclusive role of agencies in approving rates by keeping courts out of the rate-approval process. *Tenore*, 136 Wn.2d at 331-32. As the courts recognize, "regulatory bodies have institutional competence to address rate-making issues; ... courts lack the competence to set ... rates; and ... the interference of courts in the rate-making process would subvert the authority of rate-setting bodies and undermine the regulatory regime." *Marcus v. AT&T Corp.*, 138 F.3d 46, 62 (2d Cir. 1998). It is undisputed that OIC has plenary authority over health insurance rates and that the very same rates Plaintiffs allege were

excessive—*see* CP 3-5, 10-11, 15-17, 20 (¶¶ 8-15, 22, 30, 34 & 40)—were filed, reviewed, and approved by the OIC. All that the OIC cannot do is impose a remedy that Premera must use existing surplus to subsidize premiums. As discussed below, as a matter of law this does not preclude application of the filed rate doctrine.

The Decision tries to distinguish *Hardy* by asserting that "*Hardy* focused on the importance of efficient nationwide telephone and radio service." *McCarthy,* 2014 WL 2819025 at *3. But certainly, the state regulation of health insurance premiums is no less important in Washington and no less deserving of the doctrine's protection.

Nor can Plaintiffs avoid the filed rate doctrine by purporting to direct their attack toward Premera's surplus rather than its rates. Surplus and rates are inexorably linked. With respect to individual, large and small group rates, Premera's rates include a "contribution to surplus" component, which the OIC reviews for reasonableness. WAC 284-43-910(13), 284-43-915(2)(c). The Court of Appeals erroneously concluded that "[a]s to Class A (large group), the criteria the insurance commissioner must use to assess the reasonableness of Premera's rates do not include any reference to surplus or investment," even though the applicable statutes and regulations specifically direct the OIC to consider contribution to surplus in reviewing large group rates. *McCarthy,* 2014 WL 2819025 at *3; WAC 284-43-910(13), 284-43-915(2)(c).

A court could not find Premera's surplus to be excessive without also finding that its OIC-approved "contribution to surplus" was also

excessive. *See* V.M. Laughlin, *The Filed Rate Doctrine and the Insurance Arena*, 18 Conn. Ins. L.J. 373, 408 (2012) ("The accumulation of excessive reserves would necessarily involve rates because the remedy would likely be a recalculation of premium from which reserves are obtained."). Likewise, a court could not award Plaintiffs damages without recalculating what a reasonable "contribution to surplus" should have been. The Decision undermines the policy the doctrine seeks to preserve.

3. The Decision Is Based Upon A Misreading Of *Tenore*.

The Decision misreads *Tenore* in two ways. First, the Decision erroneously concludes that, in *Tenore*, the Court criticized the filed rate doctrine. *McCarthy* 2014 WL 2819025, at *3. Actually, the *Tenore* Court concluded that the filed rate doctrine did not apply for a more basic reason: that cellular telephone providers were "specifically exempted from tariff filing requirements by the FCC." *Tenore*, 136 Wn.2d at 332-34. The issue in *Tenore* was therefore whether the Federal Communications Act preempted the plaintiffs' claims. *Id.* at 335-54. And, contrary to the Decision's characterization, this Court did not criticize the filed rate doctrine; it recognized its breadth when contrasting the far more limited scope of preemption analysis. *Id.* at 332 ("Courts have construed the 'filed rate' doctrine broadly in dismissing lawsuits against telecommunications carriers involving direct or indirect challenges to the reasonableness of rates"). Therefore, rather than limiting or weakening the filed rate doctrine in Washington, *Tenore* actually reaffirmed the vitality and scope of the doctrine.

Worse yet, the Decision repeatedly cites *Tenore*'s preemption analysis to support its flawed understanding of the filed rate doctrine. Critically, however, in finding no federal preemption, *Tenore* distinguished filed rate doctrine cases, suggesting that if the issue at hand had involved the filed rate doctrine rather than preemption, the former doctrine would apply. *See Tenore*, 136 Wn.2d at 341-42 ("But in each of those cases, either the harsh rule of the 'filed rate' doctrine was implicated or the claims were found to be completely preempted by the regulatory agency's exclusive and plenary authority").[3] Thus, *Tenore*'s analysis establishes that where, as here, the rates at issue are filed and approved by regulators, and where, as here, calculation of damages "implicate rate adjustment," the claim is barred. *Id.* at 342.

4. The Insurance Commissioner's Inability To Require Premera To Use Surplus To Subsidize Premiums Does Not Limit the OIC's Rate Review or Render it Ineffective.

The Decision reasons that there is no concern that Plaintiffs' CPA claims will interfere with OIC's authority "in light of Insurance Commissioner Kreidler's public statements that he lacks meaningful control of the surpluses accumulated by nonprofit health insurers[.]" *McCarthy*, 2014 WL 2819025, at *6. The premise of the Court of

[3] *See also Tenore* at 342 ("Respondent now argues that cases have held that damages implicate rate adjustment and are tantamount to rate regulation; and even though those cases involved the 'filed rate' doctrine, that reasoning should be extended to dismiss claims requesting damages because, although there is no 'filed tariff'" federal law "preempts rate regulation").

Appeals' reasoning is wrong factually, and the reasoning misconstrues the purpose of the filed rate doctrine.

First, as the Decision itself recognizes, "[w]hile the insurance commissioner cannot force a health carrier to use its surplus to lower its rates, he can and does consider the size of the surplus to reject the carriers' request to raise rates." *Id.* at *8. Indeed, as the OIC itself proclaims: "**Whether [a premium rate] is considered reasonable depends on the company's current level of surplus as well as the type of business.**" CP 323 (emphasis added). Thus, contrary to the Decision's premise, the complaint is about the legislature's limitation, in a discrete respect, **of the remedy** that the OIC may grant, while there is no limitation on the OIC's ability to approve or disapprove rates. The theory of the seminal filed rate case, *Keogh v. Chicago & Northwestern Ry. Co.*, 260 U.S. 156 (1922), "was that the filed rates determine the rights between the customer and the utility and the Interstate Commerce Act had provided a remedy for injured shippers and consignees, so that it was improbable Congress intended to afford another remedy under the Sherman Act." *Feiner v. Orange & Rockland Utils., Inc.*, 862 F. Supp. 1084, 1088 (S.D.N.Y. 1994). Likewise, here the legislature has established the Plaintiffs' remedy—the OIC does consider Premera's surplus when approving rates, and does have authority to reject Premera's rates and proposed rate increases on the basis of accumulated surplus.

Second, and just as important, the fact that the legislature has carefully circumscribed the precise scope and limits of that regulatory

review—or, more precisely with respect to the issue at hand, the regulatory remedy or relief that the agency may grant—is a reason *for* application of the doctrine, not against it. The United States Supreme Court articulated this important separation of powers concept in *MCI Telecomms. Corp.*, in which it refused to allow the Federal Communications Commission to exempt nondominant long distance carriers from tariff filing requirements. First, the Court noted, "there is considerable debate in other forums about the wisdom of the filed rate doctrine," "[b]ut our estimations, and the Commission's estimations, of desirable policy cannot alter the meaning of the Federal Communications Act of 1934"; "such considerations address themselves to Congress, not to the courts." 512 U.S. at 231 (internal citations and quotation marks omitted). Then, the Court articulated the truism that both the courts and government agencies "are bound, not only by the ultimate purposes Congress [i.e., the legislature] has selected, **but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes**." *Id.* at 231 n.4 (emphasis added). Here, Plaintiffs complain not about the rigor or scope of review, but that the legislature has limited the remedy or relief that the agency may grant in a single discrete respect. Neither the agency nor the courts have the power to change that the legislature has specifically withheld the power of courts or the OIC to require insurers to use surplus to subsidize rates.

B. The Failure To Exhaust Administrative Remedies And The Primary Jurisdiction Defenses Also Bar Plaintiffs' Claims.

The Court of Appeals reversed the Superior Court's dismissal based on the failure to exhaust administrative remedies and the primary jurisdiction defenses exclusively because it concluded that the Insurance Commissioner's "public statements reveal that he is unable to effectively regulate the accumulation of surpluses." *McCarthy*, 2014 WL 2819025, at *6; *see also id.* at *7-8. In fact, the commissioner does have authority to consider surplus. For the same reasons that this reasoning does not preclude application of the filed rate doctrine, it does not save Plaintiffs' complaint from dismissal based on the failure to exhaust administrative remedies and the primary jurisdiction doctrine, and the Court of Appeals erred in not affirming the superior court on these grounds as well.

VI. CONCLUSION

For the foregoing reasons, this Court should grant review of the Decision of the Court of Appeals.

RESPECTFULLY SUBMITTED this 22nd day of July, 2014.

LANE POWELL PC

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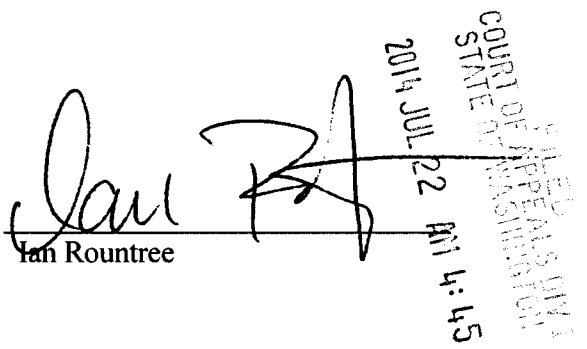

Ian Rountree

PETITIONER'S APPENDIX

Opinion filed in McCarthy Finance, Inc.. et al.. Appellants v. Premera, et al.. Respondents
CASE #: 69848-6-I
On Appeal from King County, Cause No. 12-2-01570-8.SEA

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

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, and 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.	No. 69848-6-I PUBLISHED OPINION FILED: June 23, 2014

VERELLEN, A.C.J. — Although the Office of the Insurance Commissioner has broad regulatory authority, the Insurance Code, ch. 48.44 RCW, and the Consumer Protection Act (CPA), ch. 19.86 RCW, anticipate that policyholders may litigate CPA claims against insurers and their agents. Especially where the insurance commissioner declares he is unable to effectively regulate surplus levels maintained by nonprofit insurers, the filed rate, primary jurisdiction, and exhaustion of remedies

doctrines do not necessarily bar CPA claims alleging misrepresentations by insurers or their agents that resulted in excessive surplus levels.

The Washington Alliance for Healthcare Insurance Trust (WAHIT), a nonprofit trust, sells insurance issued by nonprofit entities Premera, Premera Blue Cross, and LifeWise Health Plan of Washington[1] (collectively Premera). Despite its nonprofit status, Premera holds more than $1 billion in "surplus." The plaintiffs purchased Premera policies through WAHIT and seek damages, including refunds of premiums they have paid, alleging that Premera and WAHIT violated the CPA and the Insurance Code by making false claims on a web site, in advertising mailings, and in other public statements. They contend that Premera accumulated its large surplus, in part, based upon these misrepresentations.

The trial court dismissed the lawsuit in its entirety based on the filed rate, primary jurisdiction, and exhaustion of remedies doctrines. We conclude that several claims were erroneously dismissed.

The filed rate doctrine bars suits against regulated entities challenging the reasonableness of their filed rates. Claims alleging only excessive, unnecessary, or unfair rates are precluded by the filed rate doctrine. But the doctrine does not necessarily bar CPA claims based on fraud or misrepresentation, even though the court may be required to consider the premiums paid in computing damages. Such calculations do not amount to "rate setting" by the court.

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[1] WAHIT is a tax-exempt entity under the Internal Revenue Code, 26 U.S.C. § 501(c)(9). Premera is comprised of health care service contractors as defined in RCW 48.44.010(9). Premera was formed pursuant to the Washington Nonprofit Miscellaneous and Mutual Corporation Act, ch. 24.06 RCW. Premera Blue Cross and LifeWise Health Plan of Washington were formed pursuant to ch. 24.03 RCW, the Washington Nonprofit Corporation Act.

The primary jurisdiction doctrine is predicated on an attitude of judicial self-restraint and is applied when the court concludes that the dispute should be handled by an administrative agency created by the legislature to deal with such problems. The primary jurisdiction doctrine does not bar the CPA claims of misrepresentation and resulting excessive surplus because courts routinely address CPA misrepresentation claims and Insurance Commissioner Mike Kreidler has unequivocally stated that he lacks authority to effectively regulate such surpluses.

Litigants generally must exhaust available and adequate administrative remedies before seeking judicial intervention. Here, the exhaustion of remedies doctrine does not bar the policyholders' CPA claims because there is no showing that the insurance commissioner can provide an effective remedy.

Finally, the claims premised on selective underwriting were properly dismissed for failure to state a claim for relief to policyholders.

We affirm in part, reverse in part, and remand for further proceedings.

FACTS

Premera currently holds more than $1 billion in "surplus," approximately $250 million of which is profit from investments. "Surplus" refers to a company's total assets minus liabilities. As alleged by plaintiffs, "surplus" does not include the insurer's "claim reserves," defined by regulation as the total of unpaid reported claims plus reasonably expected claims not yet reported.[2]

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[2] WAC 284-43-910(8). Neither the statutes nor the regulations define "surplus." A rate decision issued by the insurance commissioner defines it as "[a] company's assets minus its liabilities." Clerk's Papers at 131. To the extent Premera contends that "surplus" includes or overlaps with claim reserves, that question does not change our ultimate conclusion in this appeal and may be further explored on remand.

In this putative class action, the plaintiffs represent proposed classes of individuals and groups that purchased Premera policies through WAHIT: "Class A," the "large group" class, is comprised of groups with more than 50 persons; "Class B," the "small group" class, consists of groups of at least 1 but not more than 50 employees; and "Class C" is comprised of individual purchasers. The policyholders allege that Premera and WAHIT violated the CPA and the Insurance Code by (a) falsely claiming on the WAHIT web site that it is an "employer governed trust," (b) falsely advertising in WAHIT mailings that it "negotiate[s]" to obtain high quality benefits at the "lowest possible cost" or "most affordable cost," and (c) falsely claiming WAHIT to be a "member governed group," allowing "selective underwriting" that contributed to the surplus.[3] They also allege that deceptive acts in the form of false statements to the public resulted in excessive surplus.[4]

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[3] Clerk's Papers at 7-9, 227.

[4] The 29-page complaint contains numerous allegations, but the plaintiffs' specific claims are set forth at paragraphs 21-22, consisting of (a) false assertions on the WAHIT web site that it is an "employer governed trust," (b) false advertising in WAHIT mailings that it "negotiate[s]" to obtain high quality benefits at the "lowest possible cost" or "most affordable cost," (c) false statements that WAHIT is a "member governed group," (d) claims that the insurers "falsely stated publicly that the reasons for the annual premium increases are because of increases in the cost of medical, hospital and health care" and "concealed from the plaintiffs and class members the fact that the percentage increases in those costs were not required to justify the increase in premiums," and (e) claims that the insurers "created [WAHIT]" in order to enable it to accumulate its surplus. Id. We do not read the complaint as asserting any claim regarding the surplus that is not, fundamentally, based on marketing misrepresentations or false statements to the public. Neither does the complaint state any claim that Premera's nonprofit status, in and of itself, or its statements to the public that it is a nonprofit provide a basis for any relief.

In Washington, statutes and administrative regulations provide for the insurance commissioner's review of all insurance premium rates.[5] The insurance commissioner may disapprove any individual or group contract if it is ambiguous or misleading or if the purchase of health care services is solicited by deceptive advertising.[6] The insurance commissioner may also disapprove any insurance contract if the benefits provided are "unreasonable in relation to the amount charged for the contract."[7]

Premera moved to dismiss the policyholders' claims pursuant to CR 12(b)(6) and CR 52, asserting that the filed rate doctrine, the insurance commissioner's primary jurisdiction, and the policyholders' failure to exhaust administrative remedies compelled dismissal. The trial court dismissed all claims brought by the "small group" Class B and the "individual" Class C plaintiffs pursuant to CR 12(b)(6) and dismissed all claims by the "large group" Class A plaintiffs on summary judgment.

The policyholders appeal.

DISCUSSION

Premera contends that the insurance commissioner's rate approval process would be adversely impacted by allowing a court to consider challenges related to Premera's accumulated surplus. Premera also contends that the doctrine of primary jurisdiction applies because the insurance commissioner is an expert in regulating

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[5] RCW 48.44.017(2), .020-.024, .040, .070, .110, .120, .180; WAC 284-43-901, -910 through -930, -945, -950.

[6] RCW 48.44.020(2), .110 ("No person shall knowingly make, publish, or disseminate any false, deceptive, or misleading representation or advertising in the conduct of the business of a health care service contractor, or relative to the business of a health care service contractor or to any person engaged therein.").

[7] RCW 48.44.020(3).

insurance companies' surpluses. Finally, Premera contends that the insurance commissioner's statutory authority to hold hearings and issue cease-and-desist orders were meaningful remedies available to the policyholders that they failed to exhaust.

Central to Premera's arguments is the premise that the insurance commissioner vigorously and effectively regulates the surplus maintained by the nonprofit insurers. However, Insurance Commissioner Mike Kreidler has publicly stated that surplus levels maintained by nonprofit insurers, including Premera, are excessive. Kreidler has also publicly asserted that he lacks the authority to effectively address or control the excessive surplus amassed by nonprofit insurers. He has unsuccessfully proposed legislation to more intensively address surpluses.[8]

This appeal is limited to whether the filed rate doctrine, primary jurisdiction, or failure to exhaust administrative remedies warrants dismissal of the policyholders' CPA claims of misrepresentation and the resulting excessive surplus. The parties have not briefed other questions as to the precise nature and nuances of those claims. This court reviews de novo a trial court's dismissal pursuant to CR 12(b)(6) and will affirm where no set of facts consistent with the complaint justify recovery.[9] This court reviews de novo an order granting summary judgment and will affirm

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[8] At a hearing in support of Senate Bill 5247, 62d Leg., Reg. Sess. (Wash. 2012), designed to allow the insurance commissioner to consider surpluses in reviewing rates, Kreidler testified that "there should be a mechanism in place to be able to make sure that [nonprofits] are responsible to the community." Clerk's Papers at 214.

[9] Lakey v. Puget Sound Energy, Inc., 176 Wn.2d 909, 922 n.9, 296 P.3d 860 (2013); FutureSelect Portfolio Mgmt., Inc., v. Tremont Grp. Holdings, Inc., 175 Wn. App. 840, 865, 309 P.3d 555 (2013), review granted, 179 Wn.2d 1008 (2014).

where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law.[10]

Filed Rate Doctrine

The policyholders assert that the trial court erred by dismissing their claims pursuant to the filed rate doctrine, a court-created rule barring suits against regulated entities challenging the reasonableness of their filed rates.[11] The doctrine "provides, in essence, that any 'filed rate'—a rate filed with and approved by the governing regulatory agency—is per se reasonable and cannot be the subject of legal action against the private entity that filed it."[12] Several policies are advanced by the filed rate doctrine, including (1) reinforcing the agency's authority to determine the reasonableness of rates, (2) deferring to the agency's expertise in a particular industry, (3) recognizing and preserving the legislature's determinations as to the regulatory scheme by allowing for enforcement by statutorily designated state officers, and (4) preventing lawsuits from disrupting the statutory and regulatory scheme for uniformity of rates.[13]

Whether to extend the filed rate doctrine to a claim involving health insurance is a question of first impression. The only case in which our Supreme Court has addressed the filed rate doctrine, Tenore v. AT&T Wireless Servs., provides limited

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[10] Lakey, 176 Wn.2d at 922.

[11] Tenore v. AT&T Wireless Services, 136 Wn.2d 322, 331, 962 P.2d 104 (1998).

[12] Id.

[13] See Wegoland Ltd v. NYNEX Corp., 27 F.3d 17, 18-21 (2d Cir. 1994); Edge v. State Farm Mut. Auto. Ins. Co., 366 S.C. 511, 623 S.E.2d 387, 391-92 (2005); Richardson v. Standard Guar. Ins. Co., 371 N.J. Super. 449, 853 A.2d 955, 963 (App. Div. 2004).

guidance on this issue.[14] In dicta, the Tenore court criticized judicial decisions from other jurisdictions that had applied the filed rate doctrine "rigidly, even to bar claims of a fraud or misrepresentation."[15] However, the court ultimately determined that the defendant, AT&T, was exempt from rate filing requirements and therefore the filed rate doctrine did not apply.[16]

By contrast, Hardy v. Claircom Communications Group, Inc., the only published opinion by this court considering the filed rate doctrine, appears on the surface to support a broader application of the doctrine.[17] There, a plaintiff sued telecommunications companies alleging negligent misrepresentation, fraud, breach of contract, and CPA violations based on the companies' practice of measuring air-to-ground telephone calls by rounding up the last fraction of a minute.[18] In determining whether to apply the doctrine, the Hardy court examined the nature of the claims and the effect of the remedies sought. Concluding that "any court-imposed award of damages would by definition result in [plaintiffs] paying something other than the filed rate," the Hardy court held that the claims were barred by the filed rate doctrine.[19] But

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[14] 136 Wn.2d 322, 962 P.2d 104 (1998).

[15] Id. at 332 (citing Kan. City S. Ry. Co. v. Carl, 227 U.S. 639, 653, 33 S. Ct. 391, 395, 57 L. Ed. 683 (1913) ("Neither the intentional nor accidental misstatement of the applicable published rate will bind the carrier or shipper"); Marco Supply Co. v. AT&T Commc'ns, Inc., 875 F.2d 434 (4th Cir. 1989) (doctrine precludes claim of price misrepresentation); Taffet v. S. Co., 967 F.2d 1483 (11th Cir. 1992) (allegedly overcharged or defrauded customers suffered no cognizable injury because of filed rate); Sw. Bell Tel. Co. v. Metro-Link Telecom, Inc., 919 S.W.2d 687 (Tex. App. 1996) (doctrine bars action for various allegedly anticompetitive practices committed by long distance provider)).

[16] Id. at 334-35.

[17] 86 Wn. App. 488, 937 P.2d 1128 (1997).

[18] Hardy, like Tenore, concerned federal regulation.

[19] Id. at 494-95.

Hardy has limited significance. As a federal court has noted, Hardy focused on the importance of efficient nationwide telephone and radio service, and the "application of the [filed rate] doctrine to a rate set by a federal agency in the telecommunications context does not mandate its application to a rate set by a state agency."[20]

We are not persuaded by the policyholders' argument that the filed rate doctrine does not apply to health insurance rates. The policyholders rely on Blaylock v. First American Title Insurance Co. in which the United States District Court for the Western District of Washington declined to extend the filed rate doctrine to a claim involving title insurance rates.[21] The Blaylock court emphasized that its determination applied only to title insurance rates, which are exempted from the more comprehensive regulations applicable to other categories of insurance.[22] Health insurance is more comprehensively regulated than title insurance. Given the extensive legislative and regulatory framework applicable to health insurance rates, the filed rate doctrine applies to health insurance.

We do agree with the policyholders that the filed rate doctrine has limitations consistent with the policy rationale for the doctrine, Washington's consumer protection statute, and insurance regulations. First, the CPA provides that consumers may bring claims against insurers. RCW 19.86.170 expressly allows CPA claims by private consumers in insurance-related disputes, including claims

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[20] Blaylock v. First Amer. Title Ins. Co., 504 F. Supp. 2d 1091, 1101 n.8 (W.D. Wash. 2007).

[21] 504 F. Supp. 2d 1091, 1101-03 (W.D. Wash. 2007).

[22] Id. at 1102-03.

based on misrepresentations prohibited by the Insurance Code.[23] The rigid filed rate standard Premera proposes would significantly undercut these provisions.

Second, our Supreme Court has recognized that CPA misrepresentation claims against sellers in a regulated industry context are not necessarily direct attacks on the rates charged by the sellers. A nuanced approach, considering the specifics of the claim and the policy basis for the filed rate doctrine, is appropriate and consistent with our Supreme Court's analysis in Tenore. Tenore relied in part on Nader v. Allegheny Airlines, Inc.,[24] in which the United States Supreme Court allowed a misrepresentation claim against an airline that overbooked its flights without disclosing its overbooking practices.[25] The Nader Court determined there was no irreconcilable conflict between the regulation of airline carrier rates and the "persistence of common-law remedies" because the claim it analyzed did not "turn on a determination of the reasonableness of a challenged practice" but only on the issue of disclosure of that practice.[26] The Nader Court also determined that "[t]he standards to be applied in an action for fraudulent misrepresentation are within the conventional competence of the courts."[27] The Tenore court reasoned that since

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[23] RCW 19.86.170 provides that "[n]othing in this chapter shall apply to actions or transactions otherwise permitted, prohibited or regulated under laws administered by the insurance commissioner of this state . . . PROVIDED, HOWEVER, That actions and transactions prohibited or regulated under the laws administered by the insurance commissioner shall be subject to the provisions of RCW 19.86.020 and all sections of chapter 216, Laws of 1961 and chapter 19.86 RCW which provide for the implementation and enforcement of RCW 19.86.020."

[24] 426 U.S. 290, 96 S. Ct. 1978, 48 L. Ed. 2d 643 (1976).

[25] Tenore, 136 Wn.2d at 342-44.

[26] Nader, 426 U.S. at 299, 305.

[27] Id. at 305.

"[a]ppellants do not attack the reasonableness of AT&T's practice of rounding up call charges" but "challenge only nondisclosure of the practice," "Nader addresses the precise issue now before this Court."[28]

Other states recognize similar limits to the filed rate doctrine. For example, in Spielholz v. Superior Court, plaintiffs alleged that defendants falsely advertised a "'seamless calling area.'"[29] The California Court of Appeal held that such claims were not a direct attack on rates and that the lawsuit's potential effect on rates would be "merely incidental."[30] Similarly, in Kellerman v. MCI Telecommunications Corp., the Illinois Supreme Court held that class action consumer fraud claims based on false advertising practices were "not preempted" where the claims did not "challenge the reasonableness" of the charged rates "but only the fact that its advertising did not disclose that . . . additional charges would be made."[31] Likewise, in Qwest Corp. v. Kelly, the Arizona Supreme Court held that the filed rate doctrine did not bar claims that a telecommunications company concealed material facts in marketing and selling its services.[32] As in those cases, we conclude the policyholders' claims alleging nondisclosures and misrepresentations by Premera and WAHIT are not direct challenges to the rates charged.[33]

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[28] Tenore, 136 Wn.2d at 344.

[29] 86 Cal. App. 4th 1366, 1369, 104 Cal. Rptr. 2d 197 (2001).

[30] Id. at 1375.

[31] 112 Ill. 2d 428, 436, 444, 493 N.E.2d 1045, 98 Ill. Dec. 24 (1986).

[32] 204 Ariz. 25, 36-37, 59 P.3d 789 (2002).

[33] See also Ciamaichelo v. Independence Blue Cross, 589 Pa. 415, 909 A.2d 1211, 1217-18 (2006) (Supreme Court of Pennsylvania determined that filed rate doctrine did not bar claims that an insurance seller accumulated excessive surplus funds dedicated to purposes inconsistent with nonprofit status).

Third, a court does not engage in "rate making" when considering the rates paid by policyholders as a measure of damages for a CPA misrepresentation claim. The Tenore court concluded that the plaintiffs' claims did not implicate rate setting and noted that awarding damages for misrepresentation was within the courts' competence:

> 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 . . . . 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.[34]

We agree with the Tenore court's observations that awarding damages for CPA misrepresentation claims does not require a court to substitute its judgment on the reasonableness of a rate. An award measured by reference to premiums paid, as a remedy for misrepresentation, does not amount to a court second guessing the health insurance rate approved by the insurance commissioner and does nothing to weaken the rate approval process.[35] A CPA claim for damages caused by

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[34] Tenore, 136 Wn.2d at 344-45 (quoting Nader, 426 U.S. at 299).

[35] Horwitz v. Banker's Life & Casualty Co., 319 Ill. App. 3d 390, 745 N.E.2d 591, 253 Ill. Dec. 468 (2001) and In re Empire Blue Cross & Blue Shield Customer Litigation, 164 Misc. 2d 350, 622 N.Y.S.2d 843 (Sup. Ct. 1994), cited by the insurers and WAHIT, are not persuasive in the context of the CPA claims at issue. Here, consistent with Tenore, the policyholders' request for an award of damages is not per se rate regulation. In Horwitz, the Illinois Appellate Court dismissed consumer fraud claims based on the filed rate doctrine where, in ascertaining damages, the court would be required to determine a reasonable rate absent the fraud. Horwitz, 745 N.E.2d at 605. In Empire Blue Cross, the New York Supreme Court dismissed consumer fraud claims based on the filed rate doctrine, concluding that "'[t]he fact that the remedy sought can be characterized as damages for fraud does not negate the fact that the court would be determining the reasonableness of rates.'" Empire Blue Cross, 622 N.Y.S.2d at 848 (emphasis omitted) (alteration in original) (quoting Wegoland, Ltd. v. NYNEX Corp., 806 F. Supp. 1112, 1119 (S.D.N.Y. 1992), *aff'd*, 27 F.3d 17).

misrepresentation in marketing insurance or in other public statements warrants consideration of the amount paid for the policy, and an insurer is not insulated from CPA misrepresentation claims merely because a recovery may ultimately impact its rates.

Fourth, Premera and WAHIT's other arguments are unpersuasive. Premera and WAHIT argue for a broad application of the filed rate doctrine that would bar claims based on false advertising, fraud, concealment, and violation of consumer protection acts. Premera relies on cases from other jurisdictions such as Clark v. Prudential Insurance Co. of America, in which the United States District Court for the District of New Jersey held that "[w]here fraud is present, the courts have left enforcement to the regulators, who are best situated to discover when regulated entities engage in fraud and to remedy fraud when it arises."[36] But Premera's argument would extend the filed rate doctrine to bar claims based on almost any business decision by the insurer because almost all such decisions ultimately implicate the rates charged to consumers. We conclude that such an interpretation of the filed rate doctrine is too broad.

Premera argues that a court could not find its surplus excessive without also finding that its insurance-commissioner-approved "contribution to surplus" was also excessive because Premera's rates include a "contribution to surplus" component which the insurance commissioner reviews for reasonableness. Premera cites to Lupton v. Blue Cross & Blue Shield of North Carolina to argue that the reasonableness of a rate cannot be litigated in the guise of an excessive surplus

[36] 736 F. Supp. 2d 902, 914 (D.N.J. 2010).

challenge.[37] There, plaintiffs alleged that an insurer charged excessive rates and exceeded the statutory limit on reserves. But Lupton is distinguishable because it did not involve consumer fraud or misrepresentation claims and, unlike Washington, North Carolina had a statutory limit to the amount of reserves an insurer could accumulate.[38] The Lupton court emphasized that "if Blue Cross accumulates a reserve in excess of the statutory limits, the Commissioner is authorized . . . to modify the rates, thereby affecting the amount of the reserve."[39] Premera does not assert that the Washington insurance commissioner has similar authority to modify Premera's rates to reduce existing surplus levels. Premera's reliance on Lupton is misplaced.

Finally, although claims alleging merely excessive, unnecessary, or unfair rates are precluded by the filed rate doctrine, CPA claims that a nonprofit company has accumulated a large surplus based on deceptive misrepresentations are not. Tenore provides guidance and is more germane than Hardy, which addressed rates set by a federal agency in the telecommunications context. Especially in light of Insurance Commissioner Kreidler's public statements that he lacks meaningful control of the surpluses accumulated by nonprofit health insurers, there is little basis for concern that allowing such CPA claims would interfere with the insurance commissioner's authority to regulate in this capacity.

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[37] 139 N.C. App. 421, 533 S.E.2d 270 (2000) (dismissing claims of inflated rates due to excessive reserves based on the filed rate doctrine).

[38] Id. at 271-72.

[39] Id. at 273.

We conclude that the filed rate doctrine does not preclude the policyholders' CPA claims based on (a) assertions on the WAHIT web site that it is an "employer governed trust," (b) advertising in WAHIT mailings that it "negotiate[s]" to obtain high quality benefits at the "lowest possible cost" or "most affordable cost," (c) assertions that WAHIT is a "member governed group," (d) allegations that the insurers "falsely stated publicly that the reasons for the annual premium increases are because of increases in the cost of medical, hospital and health care" and "concealed from the plaintiffs and class members the fact that the percentage increases in those costs were not required to justify the increase in premiums," and (e) allegations that the insurers "created [WAHIT]" in order to enable it to accumulate its surplus.[40]

Primary Jurisdiction

The policyholders assert that the trial court erred by dismissing their claims pursuant to the primary jurisdiction doctrine. Because the insurance commissioner's public statements reveal that he is unable to effectively regulate the accumulation of surpluses, we agree.

The doctrine of primary jurisdiction is "'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."[41] This court reviews a trial court's decision to apply the doctrine of primary jurisdiction for an abuse of discretion.[42]

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[40] Clerk's Papers at 7-11, 227.

[41] Kerr v. Dep't of Game, 14 Wn. App. 427, 429, 542 P.2d 467 (1975) (quoting 2 FRANK E. COOPER, STATE ADMINISTRATIVE LAW 564 (1965)).

[42] Id.

The insurance commissioner has publicly stated that he lacks authority through existing regulations and laws, or otherwise, to effectively regulate nonprofit health insurance companies' accumulation of excessive surpluses. These statements are compelling. Washington cases hold that in the context of insurance, "although a commissioner cannot bind the courts, the court appropriately defers to a commissioner's interpretation of insurance statutes and rules."[43] Given his acknowledged lack of authority, policies supporting deference to the primary jurisdiction of the insurance commissioner have little traction.

Moreover, the CPA expressly allows claims against insurers for matters subject to the insurance commissioner's regulation, provided the claim is not based on activity allowed by insurance statutes and regulations.[44] It would be anomalous, in light of this statutory authorization for CPA claims, to conclude that the insurance commissioner's primary jurisdiction acts as an absolute bar to such claims.[45]

We conclude that the trial court erred in dismissing the claims based on the primary jurisdiction of the insurance commissioner.

Exhaustion of Remedies

The policyholders contend that the trial court erred by dismissing their claims based on their failure to exhaust administrative remedies. We agree.

Generally, litigants must exhaust administrative remedies before seeking

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[43] Credit Gen. Ins. Co. v. Zewdu, 82 Wn. App. 620, 627, 919 P.2d 93 (1996).

[44] RCW 19.86.170.

[45] In general, multiple statutes can provide "synergies [of] multiple methods of regulation" consistent with each statute providing "its own mechanisms to enhance the protection of competitors and consumers." POM Wonderful LLC v. Coca-Cola Co., 2014 WL 2608859, at *9 (U.S. June 12, 2014).

judicial intervention when an agency has initial authority to evaluate and resolve a claim and the administrative remedy is adequate in relation to the relief sought.[46] But the requirement to exhaust administrative remedies does not apply if (a) the remedies would be patently inadequate, (b) the exhaustion of remedies would be futile, or (c) the grave, irreparable harm resulting from having to exhaust remedies clearly outweighs the policy requiring exhaustion of remedies.[47]

The policyholders assert that the courts should resolve their CPA claims that deceptive acts have resulted in an excessive surplus because (1) although the insurance commissioner considers ratepayers' contributions to surplus in reviewing and approving rates for Classes B and C, he does not evaluate whether there is an excessive surplus, (2) there is no regulation on point instructing the insurance commissioner how he is to address any excessive surplus, (3) there is no regulatory provision directing the insurance commissioner to consider a company's surplus in reviewing and approving the large group model for Class A, and (4) the insurance commissioner has expressly concluded that Premera has a grossly excessive surplus and that he has no authority to effectively address it.

As noted above, a litigant must exhaust administrative remedies only if an adequate administrative remedy is available. In addition to the insurance

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[46] McConnell v. City of Seattle, 44 Wn. App. 316, 323, 722 P.2d 121 (1986).

[47] State v. Tacoma-Pierce County Multiple Listing Serv., 95 Wn.2d 280, 283-84, 622 P.2d 1190 (1980) (because violations of the CPA "are not cognizable" by the relevant agencies "but rather by the courts," "[t]here is no remedy in either [agency] to be exhausted; the doctrine does not apply"); Buechler v. Wenatchee Valley Coll., 174 Wn. App. 141, 154, 298 P.3d 110 ("A court may relieve a petitioner of the exhaustion requirement if exhaustion would be futile."), review denied, 178 Wn.2d 1005 (2013); Estate of Friedman v. Pierce County, 112 Wn.2d 68, 74, 77, 768 P.2d 462 (1989) (whether administrative remedies are futile is a question for the court and can be demonstrated by factual circumstances); see also RCW 34.05.534.

commissioner's own public statements of his limited authority, the statutes and regulations provide no mechanism for him to actively regulate a nonprofit insurer's excessive surplus. RCW 48.04.010(1) and (3) allow the insurance commissioner to grant a hearing to an aggrieved person, but he has no authority to compel the insurers to disgorge the surplus allegedly accumulated as a result of marketing misrepresentations.

Notably, as to putative Classes B and C, the insurance commissioner is only allowed to deny new rate increases in consideration of an insurer's contribution to surplus—arguably an ineffective power in view of the large surplus already accumulated. As to Classes B (small group) and C (individual), the criteria the insurance commissioner must use to assess the reasonableness of Premera's rates refer to narrow consideration of surplus and investment:

> (c) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges, where the justification recognizes the carrier's investment earnings on assets other than those related to claim reserves or other similar liabilities; minus
>
> (d) An actuarially sound estimate of the forecasted investment earnings on assets related to claim reserves or other similar liabilities for the plans included in the filing for the rate renewal period.
>
> (3) *The contribution to surplus*, contingency charges, or risk charges . . . *will not be required to be less than zero.*[48]

The record contains several rate request decisions, one of which expressly refers to Premera's surplus level and investment income in refusing to approve a rate increase. Thus, while the insurance commissioner cannot force a health carrier to

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[48] WAC 284-43-915(2), (3) (emphasis added).

use its surplus to lower its rates, he can and does consider the size of the surplus to reject the carriers' request to raise rates.

As to Class A (large group), the criteria the insurance commissioner must use to assess the reasonableness of Premera's rates do not include any reference to surplus or investment. Premera contends that the insurance commissioner considers contribution to surplus as one factor in his approval process of the large group model.[49] However, the model refers only to control of "minimum reserve contributions." Premera provides no compelling evidence to the contrary. Premera asserts that the sealed large group rate file includes examples of individual instances where the insurance commissioner limited rates to a "zero contribution" to surplus. But these examples reveal only that the remedies available through the insurance commissioner have an extremely limited impact in regulating an already-existing surplus. These examples of regulation do not make apparent how the insurance commissioner's limited authority impacts the accumulation of a $1 billion surplus by a nonprofit entity as alleged in the complaint.

There is no showing that an adequate administrative remedy exists. Here, the policyholders are suing for an award of monetary damages, attorney fees, and costs. No statute or regulation allows the insurance commissioner to grant the relief plaintiffs seek. Exhaustion of remedies is not required in these circumstances.

Selective Underwriting

The policyholders allege that WAHIT misrepresented itself as a member-governed plan in order to exempt itself from the requirement that it cover all eligible

[49] Premera relies on form H-4. See Clerk's Papers at 449.

applicants without regard to their health status or claim history. By so doing, the policyholders allege WAHIT could "'selectively underwrite and refuse to cover eligible applicants based upon their health status and/or claim history.'"[50] The policyholders argue that the filed rate doctrine should not bar this claim because the denial of coverage meant that eligible applicants were not issued the coverage and not charged any rates.

We conclude that this purported claim fails, regardless of whether selective underwriting amounts to a direct challenge of the rates charged. The putative classes are defined as those who have purchased policies. The policyholders do not establish any relationship to any harm purportedly suffered by those who may have been wrongfully denied coverage. Standing is a common law doctrine that prohibits a litigant from raising another's legal right.[51] The claims of a plaintiff who lacks standing cannot be resolved on the merits and must fail.[52] There is no basis to grant relief to the policyholders for any injury suffered by nonpolicyholders. The trial court properly dismissed the selective underwriting claim.

CONCLUSION

This appeal is limited to the specific issues briefed—whether the filed rate, primary jurisdiction, and exhaustion of remedies doctrines support dismissal of the claims alleged. Those doctrines do not warrant dismissal of CPA claims based on

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[50] Br. of Appellants at 30.

[51] Grant County Fire Prot. Dist. No. 5 v. City of Moses Lake, 150 Wn.2d 791, 802, 83 P.3d 419 (2004); Berschauer Phillips Constr. Co. v. Mut. of Enumclaw Ins. Co., 175 Wn. App. 222, 226 n.5, 308 P.3d 681 (2013).

[52] Trinity Universal Ins. Co. v. Ohio Cas. Ins. Co., 176 Wn. App. 185, 198-99, 312 P.3d 976 (2013), review denied, 179 Wn.2d 1010 (2014).

alleged misrepresentations of WAHIT and false statements to the public by Premera. The selective underwriting claim was properly dismissed. We do not reach any other questions regarding the alleged claims.

Affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion.

WE CONCUR: