69848-6

69848-6

No. 69848-6-I

DIVISION I, COURT OF APPEALS
OF THE STATE OF WASHINGTON

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,

Plaintiffs-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,

Defendants-Respondents

ON APPEAL FROM KING COUNTY SUPERIOR COURT

BRIEF OF RESPONDENT

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I. INTRODUCTION

The Superior Court correctly dismissed all claims against defendants 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"). The Superior Court found that the Plaintiffs' claims failed as a matter of law and of fact under three distinct but interrelated theories: the filed rate doctrine, the primary jurisdiction doctrine and failure to exhaust administrative remedies doctrine.

This Court should affirm. The insurance rates at issue in this case were all filed, reviewed and approved by the Office of Insurance Commissioner ("OIC") pursuant to a rigorous regulatory scheme under Washington's Insurance Code. This Court should refuse to second-guess the judgments of the OIC and the legislature that established the authority of the OIC, and should affirm the trial court's decision under the filed rate doctrine, the primary jurisdiction doctrine and failure to exhaust administrative remedies doctrine

II. COUNTERSTATEMENT OF THE ISSUES

1. Did the trial court properly dismiss Plaintiffs' claims based on the filed rate doctrine because those claims challenged Premera's filed premium rates, which the OIC rigorously reviewed and approved? **Yes.**

2. Did the trial court properly dismiss Plaintiffs' claims because Plaintiffs failed to exhaust administrative remedies pursuant to RCW 48.04.010 before challenging Premera's rates in the Superior Court? **Yes.**

3. Did the trial court properly exercise its discretion when it determined that the OIC has primary jurisdiction over Plaintiffs' complaints regarding Premera's rates and other regulated practices? **Yes.**

III. COUNTERSTATEMENT OF THE CASE

A. Factual and Statutory Background.

Premera is a "health care service contractor," which means it has health plan contracts with groups and individuals in which it agrees to provide health care services to plan members through a provider network and, in exchange, members agree to pay premiums. RCW 48.44.010(9); RCW 48.44.020(1); *Ketcham v. King Cnty. Med. Serv. Corp.*, 81 Wn.2d 565, 567, 502 P.2d 1197 (1973). 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, among other things:

> (a) ... it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses ...; or
>
> (b) ... it has any title, heading, or other indication of its provisions which is misleading; or
>
> (c) ... purchase of health care services thereunder is being solicited by deceptive advertising; or ...
>
> (e) ... it violates any provision of this chapter; ....

RCW 48.44.020(2); *also* RCW 48.44.110 (false or deceptive advertising by health care service contractors forbidden). Further, and especially relevant here, 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).

WAHIT is a non-profit trust created to obtain and hold insurance policies on behalf of participating employers; WAHIT is not a subsidiary of Premera. 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 coverage from Premera as part of their membership in WAHIT. *See* CP 2 (¶ 3).

Premera's rate-making and the concomitant OIC-approval process vary depending upon whether the proposed rate applies to small group and individual plans, on one hand, or large group plans, on the other.

Small Group and Individual Plans. For small group and individual plans, Premera must file proposed rates that comply with a comprehensive statutory and regulatory scheme. *See* RCW 48.44.017(2), 48.44.021, 48.44.022, 48.44.023. The OIC has promulgated detailed rules that specify precisely what Premera must submit to support its proposed rates, *see* WAC 284-43-901, 284-43-925, 284-43-930, 284-43-945, which include—among dozens of other factors—the "methodology, justification and calculations used to determine contribution to surplus." WAC 284-43-930(3).

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). With respect to the latter, the OIC has specifically-enumerated criteria it must use to assess the reasonableness of Premera's rates:

> (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 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.*

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.

These OIC rate disapprovals confirm that the OIC does in fact consider Premera's investment income (*see* CP 329) and surplus levels when assessing the reasonableness of the proposed rate. For example, in disapproving one proposed rate increase, the OIC explained:

> **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. In Premera's case, 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.

Large Group Plans. Rate-setting for large group plans is likewise rigorous, although the process differs. Unlike small group and individual plans, which are pooled together and community-rated, *see supra*, large group rates are negotiated group by group and rated for each group. CP 346 (Blaine Decl.) ¶ 10. Premera is required to file both its large group rate-setting methodology and the actual proposed rates for each group with the OIC for review and approval. *See* RCW 48.44.020(2), 48.44.040; WAC 284-43-920, 284-43-925, 284-43-950. The large group rating process also applies to associations such as WAHIT. RCW 48.44.024.

Washington law requires the OIC to review Premera's proposed large group rates to ensure they are reasonable relative to the benefits provided—a review that considers "contribution to surplus" and "investment earnings." RCW 48.44.020(3); WAC 284-43-915.

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. For large groups, Premera develops a Large Group Rating Model, which it is required to file with the OIC for review and approval. *Id.* The model weighs numerous factors, including the individual group's prior claims experience, its demographics, the benefits it wants to include, geographic factors, the

provider network to be included, the group's industry, tax issues, changes in the law (such as coverage mandates), and administrative expenses. *Id.* The model Premera provides to the OIC expressly sets forth for OIC review and approval the contribution to surplus Premera proposes for every large group member. CP 496 (Table H-4).

Premera files the Large Group Rating Model with the OIC within 30 days of the effective date. Parts of the filing are publicly available, and other parts are not for public disclosure because they contain Premera's proprietary and confidential trade secrets. CP 345 (Blaine Decl.) ¶ 7; *see, e.g.*, CP 352-514 (2011 non-public filing (sealed)); CP 532-691 (2012 non-public filing (sealed)).[1] The OIC then reviews the Model and either approves it or sends "Objections" to Premera. CP 345 (Blaine Decl.) ¶ 7; *see also* WAC 284-44A-090. Premera must respond to these Objections. CP 345-46 (Blaine Decl.) ¶¶ 7-9. The confidential filings in the record contain several examples of this back-and-forth objections process between Premera and the OIC. *See, e.g.*, CP 357-59 (objection and response); CP 537-43 (same).

[1] The public version of these large group filings are available from the OIC at https://fortress.wa.gov/Search.aspx. This site contains the general large group rate filing based on the Large Group Rating Model, as well as each large group rate filing.

The OIC's approval of the Large Group Rating Model is only the starting point. From there, large group rates are negotiated group by group, often with the participation of professional insurance brokers representing the large group. CP 346 (Blaine Decl.) ¶ 10. The large group market is very competitive, and Premera faces aggressive competition from other health carriers; Premera's underwriters may vary the final rate to address these competitive demands. *Id.* After the rate for any particular group is negotiated and agreed upon, Premera then files the actual large group contract with the OIC. CP 347 (Blaine Decl.) ¶ 11; *see* CP 714-22 (short form filing for Plaintiff McCarthy Finance rate).

B. Procedural Background.

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 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"). CP 7-11, 14-16. Although described as various "deceptive acts or practices," the entire focus of Plaintiffs' claims was an allegation that, during the class period,

Premera had charged "excessive," "unnecessary," and "unfair" premium rates for its health plans and, as a result of these alleged overcharges and the investment income thereon, 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). Plaintiffs alleged they were damaged in the sum "of the excess premiums paid to the defendants," and further asked that the "excess surplus … be refunded to the subscribers who have paid the high premiums causing the excess." CP 28 (¶¶ 65, 66); *also* CP 15-16 (¶ 30(d)).

Premera first moved under CR 12(b)(6) to dismiss Plaintiffs' claims asserted on behalf of small group (Class B) and individual (Class C) plan members. CP 97-113; 315-43. Premera argued that Plaintiffs' attack on premium rates should be dismissed based on three independent, but related, theories: (1) the filed rate doctrine; (2) failure to exhaust administrative remedies; and (3) the primary jurisdiction doctrine. *Id.* Premera showed that the OIC reviewed and approved the very rates Plaintiffs claimed were excessive and, as part of its review, considered Premera's surplus levels. Premera also showed that insureds have an administrative means of challenging OIC-approved rate increases, and that any insured who fails to do so waives the right to challenge the rate. *Id.*

WAHIT and its Trustee (collectively "WAHIT") joined in Premera's motion. CP 276-78.

The trial court granted Premera's motion, dismissing the claims as to the proposed Class B and Class C subclasses. CP 157-59. At the hearing on the motion, the trial court explained its decision:

> I am granting the defendants' motion to dismiss … on all three grounds. And that is because I am very firmly convinced, by the record that you presented to the Court, that the insurance commissioner has a very comprehensive scheme for regulating the basis of premiums and setting the rates for premiums. [¶] And what plaintiff seeks to do really goes to the heart of the intertwined and complexity of the factors that the insurance commissioner indeed considers in setting those premiums …
>
> Additionally, on the primary jurisdiction, … I'd been sitting here thinking … "Okay. So if this Court decides that there is an excess surplus, what are the parameters that I decide how much is okay? What's not good enough?" … [¶] 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 pervasive regulatory scheme that the commissioner has. [¶] And I think there's a very real danger that judicial intervention without that expertise, without the broad base of knowledge, could in fact conflict with the regulatory scheme.

9/28/2012 Tr. at 31:11-32:22. Finally, the court found that Plaintiffs had failed to exhaust their administrative remedies, noting that "there was a remedy that was available to request review through the insurance commissioner" and "[t]hat remedy was not sought." *Id.* at 32:23-33:3.

Premera then moved for summary judgment on Plaintiffs' remaining claim asserted on behalf of large group (Class A) members. CP 160-80. The basis for Premera's motion was the same as its motion to dismiss: filed rate doctrine; failure to exhaust administrative remedies; and primary jurisdiction. *Id.* Premera submitted an extensive declaration from the manager responsible for developing large group rates explaining the process by which OIC reviews and approves both Premera's Large Group Rating Model and each individual large group contract. CP 344-768. The declaration attached the confidential (sealed) large group rate information Premera filed with the OIC regarding WAHIT and its employer groups. *Id.* WAHIT again joined in Premera's motion. CP 291-92.

The trial court granted Premera's motion for summary judgment. CP 273-75. In announcing its decision, the court rejected Plaintiffs' effort to re-characterize the nature of their allegations:

> But when I look at your complaint, and I go to what your relief … you've requested, basically the relief that you've requested in your damages and prayer for relief is the sum of the excess premiums paid over the period of four years immediately prior to the filing of this complaint. And then you say that the amount of excess surplus should be refunded to the subscribers who have paid the high premiums, causing the excess. So whatever we call it, you're inextricably getting back to the rate setting of the insurance agency …
>
> * * *

> … We can color it any way we want. But at the heart, what the plaintiffs are seeking are a refund of [premiums] that they said were excessively charged against them. And while they have referenced the surplus, we have to look at the rate-setting process that's engaged in by the Office of the Insurance Commissioner. [¶] … We have special expertise within the industry and within the Office of Insurance Commissioner. Those rates have been approved. And I don't believe this Court should be second-guessing it and going through a different route to get those premiums returned.

1/4/13 Tr. at 30:17-31:2; 34:25-35:23. As with the motion to dismiss the Class B and Class C claims, the trial court granted Premera's motion for summary judgment of the Class A claims on all three grounds. *Id.* at 34:22-25. Plaintiffs filed a timely notice of appeal. CP 308-14.

IV. ARGUMENT

This Court reviews de novo a trial court's decision to grant a motion to dismiss, and will affirm the decision where it appears beyond doubt that the plaintiff can prove no set of facts, consistent with the complaint, which would justify recovery. *Lakey v. Puget Sound Energy, Inc.*, 176 Wn.2d 909, 922 & n.9, 296 P.3d 860 (2013) (internal quotation marks and citation omitted). This Court also reviews de novo a trial court's decision to grant summary judgment, and will affirm an order of summary judgment when "there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." *Id.* As discussed below, this Court reviews a trial court's decision to apply the

doctrine of "primary jurisdiction" for abuse of discretion only. *See Kerr v. Dep't of Game*, 14 Wn. App. 427, 429, 542 P.2d 467 (1975).

A. The Filed Rate Doctrine Bars Plaintiffs' Claims.

1. The Filed Rate Doctrine Applies To Claims Challenging Insurance Rates Filed With And Approved By The OIC.

The filed rate doctrine bars claims against regulated entities where the allegations relate to the reasonableness of a filed rate. *Tenore v. AT & T Wireless Servs.*, 136 Wn.2d 322, 331, 962 P.2d 104 (1998) (*citing Wegoland Ltd. v. Nynex Corp.*, 27 F.3d 17 (2d Cir. 1994)). The 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 claim against the entity that filed it. *Id.* Courts construe the doctrine broadly to require dismissal of both direct and indirect challenges to the reasonableness of rates, including claims based on fraud, deceptive acts and practices, false advertising, and other theories. *Id.* at 332-33 & n.41; *Hardy v. Claircom Comms. Group, Inc.*, 86 Wn. App. 488, 492-93, 937 P.2d 1128 (1997). Where a court is asked to award damages by calculating what the "correct" rate should have been – a rate that would never have been filed or approved by the applicable regulatory agency – the filed rate doctrine applies with equal force. *Tenore*, 136 Wn.2d at 333;

Hardy, 86 Wn. App. at 493-94 (citing *Ark. La. Gas Co. v. Hall*, 453 U.S. 571 (1981)).

Although the filed rate doctrine was originally applied to rates filed with federal regulatory agencies, *see Keogh v. Chicago & Northwestern Railway Co.*, 260 U.S. 156 (1922) (Interstate Commerce Commission); *Montana-Dakota Utilities Co. v. Northwestern Public Service Co.*, 341 U.S. 246 (1951) (Federal Power Commission), it is now understood as applying with equal force to rates filed with state agencies. *Wegoland*, 27 F.3d at 20 ("courts have uniformly held, and we agree, that the rationales underlying the filed rate doctrine apply equally strongly to regulation by state agencies"). Both federal and state courts have overwhelmingly applied the doctrine to insurance rates filed with state agencies and, indeed, the district court for the Western District of Washington relied on the doctrine to dismiss claims related to the reasonableness of rates filed with the OIC. *See Blaylock v. First Am. Title Ins. Co.*, 504 F. Supp. 2d 1091, 1100 (W.D. Wash. 2007) ("Many courts, both state and federal, have concluded that the doctrine bars . . . challenges to rates set by state agencies regulating insurance premiums" (citing extensive authority)); *see also Heaphy v. State Farm Mut. Auto. Ins. Co.*, 2006 WL 278556, at *2 (W.D. Wash. Feb. 2, 2006) ("[I]t is clear to the court that any claims based on the reasonableness of the [insurance] premiums charged are precluded

by the filed rate doctrine. There is ample authority in this and other jurisdictions to the effect that the reasonableness of a rate cannot be challenged where that rate was required to be (and was) filed with a regulatory agency authorized to review it").[2]

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[2] *See, e.g.*, *Coll v. First Am. Title Ins. Co.*, 642 F.3d 876 (10th Cir. 2011) (filed rate doctrine precluded insureds' claims against title insurers seeking damages and similar relief for allegedly excessive amounts that insurers charged for title insurance premiums); *Clark v. Prudential Ins. Co. of Am.*, 736 F. Supp. 2d 902, 919 (D.N.J. 2010) (Plaintiff's "claims for compensatory damages or refund based on insurance premiums he paid in previous years are barred by the filed rate doctrine"); *Roussin v. AARP*, 664 F. Supp. 2d 412 (S.D.N.Y. 2009) *aff'd*, 379 Fed. Appx. 30 (2d Cir. 2010) (filed rate doctrine barred claims styled as claims for breach of fiduciary duties and gross negligence, where claims essentially challenged as unreasonable a portion of insurance premiums which were on file with and approved by the New York State Department of Insurance ("NYSDI") and determination of the issue would involve the court in rate-making process that NYSDI was more competent to perform); *Fersco v. Empire Blue Cross & Blue Shield*, 1994 WL 445730, at *2 (S.D.N.Y. Aug. 17, 1994) (dismissing the case including RICO, state consumer fraud statute, and common law fraud causes of action alleging inflated insurance rates because "'any "filed rate"—that is, one approved by the governing regulatory agency—is per se reasonable and unassailable in judicial proceedings brought by ratepayers'" (citing *Wegoland*, 27 F.3d at 18)); *Horwitz v. Bankers Life & Cas. Co.*, 745 N.E.2d 591, 605 (Ill. Ct. App. 2001) (filed rate doctrine barred a private right of action for breach of contract or violation of the Illinois Consumer Fraud and Deceptive Business Practices Act where the plaintiff alleged excessive health insurance rates); *Commonwealth ex rel. Chandler v. Anthem Ins. Cos.*, 8 S.W.3d 48 (Ky. Ct. App. 1999); ("The legislative polices embodied in the insurance code and the administrative apparatus called into being to carry out those policies are sufficiently comprehensive to remove health insurance regulation from the common law in Kentucky and to invoke the filed rate doctrine."); *Lupton v. Blue Cross & Blue Shield of N.C.*, 533 S.E.2d 270 (N.C. Ct. App. 2000) (dismissing claims of inflated rates due to excessive reserves based on the filed rate doctrine).

There is no merit to Plaintiffs' argument that Washington courts have rejected the filed rate doctrine or would do so in the context of insurance. Washington courts have applied the doctrine to dismiss claims related to rates filed with federal agencies. *Hardy*, 86 Wn. App. at 493-94. And in *Tenore*, the Washington Supreme Court did not—as Plaintiffs erroneously claim—criticize the filed rate doctrine, nor did it find the doctrine inapplicable to claims for false advertising. Opening Br. at 13-14, 23-25. Indeed, the primary issue in *Tenore* was whether the Federal Communications Act preempted the plaintiffs' claims. 136 Wn.2d at 335-45. In a relatively brief discussion of the filed rate doctrine, the Court conceded the breadth of the doctrine, but found it inapplicable—not because the plaintiffs' claims alleged false advertising—but because cellular telephone providers were "specifically exempted from tariff filing requirements by the FCC." 136 Wn.2d at 332-34. In short, the filed rate doctrine did not apply in *Tenore* because there was no filed rate.

Similarly, the court in *Blaylock v. First American Title Insurance Co.*, 504 F. Supp. 2d 1091 (W.D. Wash. 2007), did not "reject" the doctrine because the case involved insurance. Opening Br. at 12. Again, just the opposite. Based on its reading of *Tenore* and *Hardy*, the court assumed the doctrine would apply to rates filed with the OIC, depending "on the specifics of the underlying regulatory scheme of the agency." *Id.*

at 1100, 1102. And, like *Tenore*, it was the scheme itself that ultimately rendered the doctrine inapplicable; unlike "regular insurance rates," such as those at issue in this case, title insurance rates are not subject to OIC review and approval. The trial court thereby recognized that the filed rate doctrine would apply to insurance rates that are actually reviewed by the OIC, as opposed to title insurance rates, which are not subject to review:

> [W]hile the regulatory scheme under the Insurance Code is generally quite comprehensive with respect to insurance rates, title insurance is exempted from this comprehensive scheme. By contrast, title insurance rates are subjected only to superficial regulation—while the rates must be submitted to the OIC, the Code does not mandate that they receive any review by the Commissioner. While the Code does provide for a waiting period before the conclusion of which rates cannot go into effect, this waiting period is even shorter for title insurance rates than it is for regular insurance rates, indicating that review of the rates is not actually anticipated.

Id. at 1102-03 (emphasis added). Thus, the filed rate doctrine controls here.

2. Plaintiffs' Challenge To Premera's OIC-Approved Rates Triggers Application Of The Filed Rate Doctrine.

The filed rate doctrine has two purposes. *Tenore*, 136 Wn.2d at 331-32; *Hardy*, 86 Wn. App. at 491-92. First, the doctrine preserves the exclusive role of agencies in approving reasonable rates by keeping courts out of the rate-approval process. Second, the doctrine prevents price discrimination between ratepayers. *Marcus v. AT & T Corp.*, 138 F.3d 46, 58 (2d Cir. 1998); *Wegoland*, 27 F.3d at 19-21; *Tenore*, 136 Wn.2d at 331-

32; *Hardy*, 86 Wn. App. at 491-92; *Marcus*, 138 F.3d at 58; *Blaylock*, 504 F. Supp. 2d at 1102 (same).

Plaintiffs' claims here fail under the filed rate doctrine for the policy reasons emphasized by the courts. As the courts have long recognized, "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*, 138 F.3d at 62. Unlike the rates in *Tenore* or *Blaylock*, Premera's health plan rates—the 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. Pursuant to the Insurance Code's comprehensive scheme, for small group and individual plans, Premera was required to and did file 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 and its employer-members. 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 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.

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. Although filed rates are deemed approved if not rejected within sixty days, *see* RCW 48.44.020(3), 48.44.023(3)(i), 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 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.

The trial court properly rejected Plaintiffs' central claim—that Premera's rates (including those for WAHIT's employer-members) were excessive, and that they were entitled to a refund equal to the allegedly excessive portion of the rates. Simply put, any finding that Premera's rates were excessive and any calculation of damages necessarily would require a court to second-guess the OIC's determination that Premera's rates were reasonable and conflict with the OIC's oversight of the Code's comprehensive rate-making regime. *Coll v. First Am. Title Ins. Co.*, 642 F.3d 876, 890 (10th Cir. 2011) ("The dispositive question, then, is whether … the court's determination will impact the agency's rate determinations.

If so, the 'filed rate' doctrine will bar the claim."); *Wegoland*, 27 F.3d at 21 ("Courts are simply ill-suited to systematically second guess the regulators' decisions and overlay their own resolution.").

Plaintiffs' argument that this case is really an attack on Premera's surplus, not its rates, *see* Opening Br. at 15-17, 28-33, ignores their own allegations and, in the end, does not change the analysis. Surplus and rates are inexorably linked. 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). Thus, a court could not find Premera's surplus to be excessive without also finding that its OIC-approved "contribution to surplus" was also excessive. At the same time, a court could not award Plaintiffs the damages they seek without recalculating what a reasonable "contribution to surplus" should have been. *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."). As the trial court correctly noted, "We can color it any way we want. But at the heart, what the plaintiffs are seeking are refund of [premiums]. … And while they have referenced the surplus, we have to look at the rate-setting process that's engaged in by the [OIC]." Tr. 1/4/13 at 34:25-35:6.

The decision in *Lupton v. Blue Cross & Blue Shield of North Carolina*, 533 S.E.2d 270 (N.C. Ct. App. 2000), is particularly instructive. The plaintiffs alleged that Blue Cross had charged excessive rates and had accumulated reserves in excess of a statutory limit on such reserves. *Id.* at 271-72. In an effort to avoid the filed rate doctrine, the plaintiffs filed an amended complaint that focused solely on the reserve issue, and removed all references to the allegedly excessive rates. *Id.* at 273 n.2. Nevertheless, the appellate court affirmed the trial court on filed rate grounds:

> In the case at bar, plaintiffs contend that they are not seeking a redetermination of their insurance rates but rather a declaration that Blue Cross's reserve is statutorily excessive. Plaintiffs argue that the "manner and method in which [Blue Cross] accumulated the reserves is irrelevant to the issue of whether the filed rate doctrine is applicable." We disagree.
>
> In approving the rates, the Commissioner considers Blue Cross's reserve amount. Thereafter, Blue Cross's collection of premiums, based on these rates, determines the accumulation of the ... reserve. Thus, 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. Any allegation that Blue Cross accumulated an excessive reserve requires the recalculation of approved rates ....

Id. at 273. That rationale applies equally here. Plaintiffs cannot avoid the filed rate doctrine by claiming their challenge is confined to Premera's surplus when the surplus is a product of OIC-approved rates. As in *Lupton*, the OIC considers surplus and can find a proposed rate increase

unreasonable in light of existing surplus—which it has done in Premera's case. CP 333.[3]

There is no legitimate dispute that the OIC considers surplus when reviewing rates. WAC 284-43-915. The fact that the legislature has enacted some statutory-based limitations on the scope of the OIC's authority when reviewing rates does not preclude the filed rate doctrine from barring the claim. To the contrary: there will always be some limitation on the agency's power. For example, in *In re Wheat Rail Freight Rate Antitrust Litigation*, 759 F.2d 1305 (7th Cir. 1985), the applicable statute limited the regulatory agency's review of a railroad's rates unless it first found the railroad at issue had market dominance. *Id.*

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[3] Plaintiffs cite *Ciamaichelo v. Independence Blue Cross*, 909 A.2d 1218 (Pa. 2006), for the opposite result, *see* Opening Br. at 15-17, but that case is easily distinguishable. The decision was based entirely on an alleged breach of Pennsylvania's Non-Profit Corporation Law, which is different from Washington's Non-profit law on the key issue, not based on the filed rate doctrine. Even then, the court concluded that the Director of Insurance had primary jurisdiction over the dispute. *Id.* at 1218-19. Moreover, unlike here, the plaintiffs in *Ciamaichelo* did not allege that their rates were excessive, nor did they seek compensatory damages. *Id.* at 1213-14. Plaintiffs also assert with no authority that Washington non-profit law imposes limits on how much surplus non-profits can accumulate. This is simply false. Premera Blue Cross and LifeWise are organized under RCW 24.03, Washington's Non-Profit statute, which does not impose any limits on how much profit can be made or how much surplus can be accumulated. Non-profit corporations under RCW 24.03 are specifically empowered to "invest and reinvest funds" including investments in subsidiaries, "whether for profit or not". RCW 24.03.035(7) & (9).

at 1311. Despite this limited review, the court rejected plaintiffs' argument that the filed rate doctrine did not apply, and instead held that the doctrine barred the plaintiffs' claims. *Id.* Thus, as long as the agency has the power to review and challenge a filed rate, it is unnecessary to consider the parameters of that power. *Id.*

Plaintiffs' claims also run afoul of the filed rate doctrine's prohibition against discrimination between rate-payers of one regulated entity over others. The courts recognize that awarding damages to plaintiffs, while leaving others to pay filed rates, leads to discriminatory results and interferes with a uniform regulatory scheme. *Wegoland*, 27 F.3d at 21. Plaintiffs claim that all Washington carriers—not just Premera—have charged excessive rates to accumulate unnecessarily large surplus levels. Opening Br. at 36-37 (quoting CP 214). The Washington legislature has spoken clearly on the role of surplus in the rate review process. Thus, a refund of rates or surplus in this case would not only require a recalculation of OIC-approved rates, but would result in different treatment for Premera and its ratepayers. The filed rate doctrine applies to bar Plaintiffs' claims for this reason as well.

3. The Filed Rate Doctrine Applies Equally To Plaintiffs' Claims Alleging False And Deceptive Advertising.

This Court should reject Plaintiffs' argument that the filed rate doctrine does not apply because their claims are, purportedly, not a "direct attack on rates," but rather allege "false, deceptive, and misleading advertising." Opening Br. at 21. Plaintiffs' claim of false advertising is mere window-dressing for a direct challenge to Premera's OIC-approved rates—at which the complaint takes square aim. CP 4-5, 10-11 & 15 (¶¶ 12, 14, 22 & 30: rates were "excessive," "unnecessary," "unfair" and "overcharges"). Indeed, Plaintiffs did not allege and do not articulate how Premera's or WAHIT's allegedly false advertising damaged Plaintiffs, other than to increase their rates. CP 7-11, 15-16 (¶¶ 21, 22 & 30). Regardless, even if Plaintiffs' claims really were only about advertising, the doctrine would still apply.

It is well-established that the filed rate doctrine applies to claims alleging false advertising, fraud, concealment and violation of consumer protection acts. *Marcus*, 138 F.3d at 57-62. In the insurance context, numerous courts have applied the doctrine to dismiss claims that an insurer fraudulently induced insureds to purchase a policy and/or made false or deceptive statements regarding the filed rates. *Clark v. Prudential Ins. Co. of Am.*, 736 F. Supp. 2d 902, 919-20 (D.N.J. 2010) ("[T]here is no

fraud exception to the filed rate doctrine. . . . Where 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.") (internal quotation marks and citations omitted); *Horwitz v. Bankers Life & Cas. Co.*, 745 N.E.2d 591, 605 (Ill. Ct. App. 2001) (case dismissed based on the filed rate doctrine because "the damages sought by plaintiff for consumer fraud would require the court to ascertain what would be a reasonable [health insurance] rate absent the [alleged] fraud"); *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 967 (N.J. Super. Ct. App. 2004) (filed rate doctrine "precludes fraud claims because it operates on the presumption that the plaintiff had knowledge of the filed rates and, thus, could not reasonably rely upon the regulated entity's misrepresentations or omissions of material facts"). It even applies to allegations that the insurer obtained approval for a rate through fraud on the agency. *Fersco v. Empire Blue Cross & Blue Shield*, 1994 WL 445730, at *2 (S.D.N.Y. Aug. 17, 1994) (dismissing claims alleging fraud on the agency because "'any "filed rate"—that is, one approved by the governing regulatory agency—is per se reasonable and unassailable in judicial proceedings brought by ratepayers'" (citing *Wegoland*, 27 F.3d at 18));; *In re Empire Blue Cross & Blue Shield Customer Litig.*, 622 N.Y.S.2d 843, 848, 164 Misc. 2d 350, 358 (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) ("[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.' . . . The ascertaining of damages and the determination of a reasonable rate are 'hopelessly intertwined.") (internal quotations omitted).

These cases agree that, like a direct attack on the reasonableness of a rate, claims of false advertising or even fraud that requires a reevaluation of an approved rate is still 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 [alleged] fraud." *Horwitz*, 745 N.E.2d at 605 (internal quotation marks and citation omitted); *Clark*, 736 F. Supp. 2d at 919 (same); *Empire Blue Cross,* 164 Misc. 2d at 358 (same). Here too, Plaintiffs cannot escape their own complaint: the only damages they seek are a refund of the allegedly excessive rates. CP 15-16, 28 (¶¶ 30(d), 65 & 66). For all the same reasons discussed above, any such award would conflict with the OIC's finding that Premera's rates were reasonable and, worse yet, require a court or jury to determine what a reasonable rate should have been. The filed rate doctrine forbids both.

Although the complaint does not allege "selective underwriting," *see* CP 1-29, Plaintiffs now attempt to create a claim under this name by asserting that WAHIT really does not qualify as an Association and that the OIC should not have allowed WAHIT to be rated as a large group. *See* Opening Br. at 8-9, 28-31; CP 226-28 (Fackler Decl.) ¶¶ 3-11. This is really just a claim of fraud on the regulator in the rate making process, a claim that is also barred by the filed rate doctrine. *See, e.g.*, *Empire*, 622 N.Y.S.2d at 848; *Clark*, 736 F. Supp. 2d at 919-20. This "selective underwriting" theory, like plaintiffs' other earlier articulated theories, violates the central tenet of the filed-rate doctrine – it would require a court to second-guess the OIC in its rate review process, and ultimately require a recalculation of the OIC approved rate.[4]

None of the cases cited by Plaintiffs recognize a false advertising or fraud exception to the filed rate doctrine; most have nothing to do with the doctrine. The primary issue in *Spielholz v. Superior Court*, 86 Cal. App. 4th 1366, 104 Cal. Rptr. 2d 197 (2001), *Ball v. GTE Mobilnet of Cal.*, 81 Cal. App. 4th 529, 96 Cal. Rptr. 2d 801 (2000), and *Kellerman v.*

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[4] Plaintiffs cite two cases for the proposition that "a challenge to wrongful underwriting practices does not involve the filed rate doctrine," Opening Br. at 31-32, but both cases—*Donabedian v. Mercury Ins. Co.*, 116 Cal. App. 4th 968, 11 Cal. Rptr. 3d 45 (2004) and *Krumme v. Mercury Ins. Co.*, 123 Cal. App. 4th 924, 20 Cal. Rptr. 3d 484 (2004)—were decided on the basis of California's unique Unfair Competition Law and other statutes without any reference to the filed rate doctrine.

MCI Telecomm. Corp., 112 Ill. 2d 428, 493 N.E.2d 1045 (Ill. 1986), like the Washington Supreme Court's decision in *Tenore*, was whether the plaintiffs' state law claims were preempted by the Federal Communications Act—not whether they were precluded by the filed rate doctrine; neither *Ball* nor *Kellerman* even mention the doctrine. *Spielholz* mentions it, but, just like the *Tenore* court, concluded that the filed rate doctrine was obviously inapplicable because "wireless telephone service providers … are exempt from the tariff filing requirement." 86 Cal. App. 4th at 1380.

Plaintiffs' reliance on *Qwest Corp. v. Kelly*, 59 P.3d 789 (Ariz. Ct. App. 2002), is similarly misguided. Plaintiffs alleged that Qwest engaged in deceptive practices in selling a wire maintenance service that it knew plaintiffs (as residential tenants rather than homeowners) did not need. *Id.* at 790. The Court rejected Qwest's filed rate defense because "the claims have nothing to do with the reasonableness of the rate charged for the … kinds of services offered and sold …." *Id.* at 801. Plaintiffs did not allege they overpaid for the service or that it was different than advertised, just that they didn't need it. Thus, unlike here, plaintiffs' claim would not require a court to second-guess agency approval of the filed utility rate nor recalculate that rate to award plaintiffs damages. *Id.*; *see also Crumley v. Time Warner Cable, Inc.*, 554 F. Supp. 2d 933, 942 (D. Minn. 2008)

(distinguishing *Qwest* on the grounds that the "case involved a question about whether the tenants should have been charged *at all*, rather than what charge was appropriate" (emphasis in original)).

Finally, it is important to note that application of the filed rate doctrine to OIC-approved rates would not leave ratepayers helpless to challenge the reasonableness of rates. As discussed below, ratepayers have an administrative means to challenge the OIC's approval of allegedly excessive rates, which includes an opportunity for judicial review. *See* RCW 48.04.010. That Plaintiffs admittedly failed to avail themselves of this opportunity should not weigh against application of the filed rate doctrine in this case, but simply provides another reason why their claims were properly dismissed.

B. Plaintiffs Failed To Exhaust Administrative Remedies.

Under settled Washington law, when the OIC can redress a claim in the first instance, the administrative remedy must be exhausted before a plaintiff can bring suit; failure to exhaust requires dismissal. *See Taylor v. Bankers Life & Cas. Co.*, 2008 U.S. Dist. LEXIS 108102, at *4 (W.D. Wash. Aug. 29, 2008); *Retail Store Employees Union v. Wash. Surveying & Ratings Bureau*, 87 Wn.2d 887, 906-07, 558 P.2d 215 (1976); *Credit Gen. Ins. Co. v. Zewdu*, 82 Wn. App. 620, 625, 919 P.2d 93 (Wn. App. 1996). Like the filed rate doctrine, the exhaustion requirement is based on

the principle that the judiciary should give deference to an agency's expertise in an area outside the conventional experiences of judges. *Retail Store*, 87 Wn.2d at 906.[5]

As a second and related basis for dismissal, the trial court found that Plaintiffs failed to exhaust their administrative remedies. 9/28/2012 Tr. at 32:23-33:3; 1/4/13 Tr. at 36:11-13. This too was correct as a matter of law. For all the same reasons detailed above, Plaintiffs' claims are subsumed by the Insurance Code's comprehensive regulatory scheme and the OIC's plenary authority over the rates health care service contractors charge their members. That scheme requires the OIC to review Premera's proposed rates, including those for WAHIT's employer-members, and its surplus levels, to determine whether the rates comply with the Code's rate-setting methodology, and to disapprove those rates that are "unreasonable." RCW 48.44.017, 48.44.020, 48.44.021, 48.44.022, 48.44.023, 48.44.040; WAC 284-43-915, 284-43-925, 284-43-930, 284-

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[5] Plaintiffs' citation to the Administrative Procedure Act (APA) is inapposite. Opening Br. at 42-43 (quoting RCW 34.05.534). As this Court has recognized, the APA applies only when a person appeals an adverse agency order to superior court. *Zewdu*, 82 Wn. App. at 628 n.2. Because Plaintiffs did not ask for a hearing to administratively challenge the OIC's approval of Premera's rates under RCW 48.04.010, or appeal any order resulting from such a hearing, the APA and its exhaustion standard is irrelevant. *Id.* And, even if it applied by analogy, for the same reasons explained below, Plaintiffs' remedies were not "patently inadequate" nor was the exhaustion requirement "futile" in this case.

43-950; CP 323; 333. The OIC also has authority to issue cease-and-desist orders to enjoin violations of the Code, including false and deceptive advertising. RCW 48.02.080, 48.44.110.

Just as important for purposes of exhaustion, the Insurance Code gave Plaintiffs an administrative means of challenging Premera's rates. The Code provides that the OIC "shall" hold a hearing upon receipt of a written demand "made by any person aggrieved by any act …, or failure of the commissioner to act …." RCW 48.04.010(1). If a person fails to demand that hearing within 90 days of notice of OIC approval, "the right to such a hearing shall conclusively be deemed to have been waived." RCW 48.04.010(3). This remedy is mandatory and, thus, plan members disputing the reasonableness of a health care service contractor's rate must first administratively challenge the OIC's approval of that rate. *Taylor*, 2008 U.S. Dist. LEXIS 108102, at *4-16; *Retail Store*, 87 Wn.2d at 906-07; 1963 Op. Att'y Gen. No. 59, 1963 WL 65456, at *7 ("insured affected by an increase … in his insurance rates may demand a full hearing before the [OIC] pursuant to RCW 48.04.010").[6] Plaintiffs did not do so. The trial court properly dismissed Plaintiffs' claims on this basis too.

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[6] In the trial court, Plaintiffs argued that the statute upon which the Attorney General's opinion relied was repealed and, thus, the opinion no longer reflected Washington law. CP 197-98. This is incorrect. The Opinion relied on RCW 48.04.010 for the proposition that insureds must

The Supreme Court's decision in *Retail Store Employees Union* controls here. Plaintiffs alleged, among other things, that an insurance rating bureau to which they subscribed had set and filed "improperly high" premium rates with the OIC. 87 Wn.2d at 889-91. In dismissing plaintiffs' claims on exhaustion grounds, the Court held that the plaintiffs had to administratively challenge the rates before filing suit:

> The complaint of the union and its members alleges improper rating of plaintiff-owned buildings resulting in unlawfully high fire insurance rates, caused by improper management of the [rating] Bureau. The administrative remedy of RCW 48.19.310 and RCW 48.04 establishes clearly defined machinery for the submission, evaluation and resolution of complaints by aggrieved parties. ... Exhaustion of the administrative remedy is a jurisdictional prerequisite to resort to the courts. Thus, if the union and member plaintiffs desire to pursue their other claims, they must first utilize the procedures provided in RCW 48.19.310 and RCW 48.04.

Id. at 906-07 (quotation marks and citation omitted). More recently, the district court for the Western District of Washington dismissed a class action lawsuit challenging an insurer's allegedly excessive rates for failure

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request a hearing with the OIC to challenge rate increases. 1963 WL 65456, at *7. That statute is the same today as it was in 1963. The Opinion went on to say that if the insured was unhappy with the OIC's decision after such a hearing, he or she could "appeal to the superior court ... pursuant to RCW 48.04.100." RCW 48.04.100 was repealed with the adoption of the APA, currently codified in RCW 34.05 *et seq.* That change did not affect RCW 48.04.010 and, in any event, Plaintiffs' administrative appeal rights are wholly irrelevant here. Plaintiffs did not demand a hearing from the OIC, did not receive an order from the OIC and, thus, did not file an appeal of any agency action in superior court under the APA or otherwise.

to exhaust administrative remedies because, like here, the insureds did not challenge the OIC's approval of those rates. *Taylor*, 2008 U.S. Dist. LEXIS 108102, at *14-15. Many state and federal courts have similarly dismissed challenges to agency-approved insurance rates on this basis.[7]

Plaintiffs concede that RCW 48.04.010 provided them a means to challenge Premera's rate increases, but argue that their failure to exhaust that remedy is excused because the OIC has no authority to award money damages. Opening Br. at 40-43. This claim fails as a matter of law. Even when an administrative remedy is not the precise relief sought, or will not afford "complete relief," the remedy may be adequate to require exhaustion. *Zewdu*, 82 Wn. App. at 625 (*citing Dioxin/Organochlorine Ctr. v. Dep't of Ecology*, 119 Wn.2d 761, 777, 837 P.2d 1007 (1992)). Critically, "the adequacy of the remedy must be measured from the time the administrative remedy was available." *Id.* at 627. Thus, the issue is not whether the OIC has authority to order Premera to pay damages for rates it charged in the past, but whether the OIC had the authority to prevent Premera from increasing those rates in the first instance.

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[7] *See, e.g.*, *Melder v. Allstate Corp.*, 404 F.3d 328 (5th Cir. 2005); *McLiechey v. Bristol W. Ins. Co.*, 408 F. Supp. 2d 516 (W.D. Mich. 2006); *Allen v. State Farm Fire and Cas. Co.*, 59 F. Supp. 2d 1217 (S.D. Ala. 1999); *Ex parte Cincinnati Ins. Co.*, 51 So. 3d 298 (Ala. 2010); *State Farm Mut. Auto. v. Gibbons*, 860 So. 2d 1050 (Fla. Ct. App. 2003); *D.A.X., Inc. v. Employers Ins. of Wausau*, 659 N.E.2d 1150 (Ind. Ct. App. 1996); *Prentiss v. Allstate Ins. Co.*, 548 S.E.2d 557 (N.C. Ct. App. 2001).

The OIC unquestionably had that authority, including the authority to reject proposed rate increases after considering Premera's surplus—which it has done. RCW 48.44.020; WAC 284-43-915; CP 333. Had Plaintiffs challenged the rates when they were originally approved, as they were entitled to do, and succeeded in convincing the OIC to disapprove them, then there never would have been any allegedly unreasonable rates in the first place, nor any accumulation of allegedly excessive surplus; the administrative remedies would have been more than "adequate." Simply put, Plaintiffs cannot exploit their own failure to exhaust administrative remedies in years past to argue that the remedies are inadequate or futile now; any other result would reward Plaintiffs for sleeping on their rights.[8]

The district court's decision in *Taylor* is on point. There, as here, plaintiffs brought a class action lawsuit against their insurer alleging they were harmed by an increase in insurance rates; there, like here, the OIC

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[8] In contrast, *State v. Tacoma-Pierce County Multiple Listing Service*, 95 Wn.2d 280, 622 P.2d 1190 (1980), relied upon by Plaintiffs, provides a good example of when administrative remedies are not adequate. There, the State brought an action under the CPA alleging that several realtor groups engaged in a conspiracy to exclude competition when they denied non-members access to the Multiple Listing Service directory of house listings. The realtors argued that the State should have sought an administrative decision from the Real Estate Commission or Department of Licensing first. The Court easily rejected that argument because the Commission and the Department had no authority to regulate multiple listing associations, much less enjoin the challenged behavior. *Id.* at 284. Here, the OIC does have authority over rate-setting and can (and does) disapprove Premera's proposed rates.

approved those rates under its comprehensive regulatory authority; and there, like here, plaintiffs failed to exhaust administrative remedies to challenge the OIC's approval. In addressing, and rejecting, the very same arguments Plaintiffs make here, the court concluded as follows:

> This leads to Plaintiffs' final argument, which is that their CPA and civil damages are not subject to exhaustion because the Commissioner is powerless to grant relief on these claims. While there can be no doubt that the OIC is not empowered to simply stand in the place of a state or federal court, this fact alone does not obviate the exhaustion requirement. …
>
> The Insurance Code both prohibits the precise behavior Plaintiffs allege and extensively regulates the particular contractual relationship at issue between the parties. These are matters over which the Commissioner's enforcement authority plainly extends. Furthermore, the ultimate harm Plaintiffs complain of is the result of the 2007 premium rate increase, the propriety of which is solely within the discretion of the OIC, which even has authority to revisit prior rate-setting decisions. … And as Defendant observes, Plaintiffs' "damages" came to fruition precisely because they did not engage [in] the administrative process before the new rates took effect. To the extent it is uncertain what that process might have yielded, it was Plaintiffs' obligation to find out. In sum, Plaintiffs are not excused from exhausting their administrative remedies for lack of any adequate remedy.

Taylor, 2008 U.S. Dist. LEXIS 108102, at *14-15. The same is true in this case; Plaintiffs cannot speculate that administrative remedies would have been futile or inadequate; it was their obligation to find out. For this reason too, Plaintiffs' claims must be dismissed as a matter of law.

C. The OIC Has "Primary Jurisdiction" Over Plaintiffs' Claims.

When both a court and an administrative agency have jurisdiction over an issue, the doctrine of primary jurisdiction is applied to determine whether the court should decide the issues or defer them to the agency for resolution. *Vogt v. Seattle–First Nat'l Bank*, 117 Wn.2d 541, 554, 817 P.2d 1364 (1991). "The court will usually defer to agency jurisdiction if enforcement of a private claim involves a factual question requiring expertise that the courts do not have or involves an area where a uniform determination is desirable." *Id.* Application of the doctrine lies within the sound discretion of the trial court, which this Court reviews for abuse of discretion. *Kerr v. Dep't of Game*, 14 Wn. App. 427, 429, 542 P.2d 467 (1975).[9] An abuse of discretion occurs only where the trial court's decision is arbitrary or rests on untenable grounds or reasons. *In re Marriage of Littlefield*, 133 Wn.2d 39, 46–47, 940 P.2d 1362 (1997).

As a third and final grounds for dismissal, the trial court found that—to the extent the OIC did not have exclusive jurisdiction over

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[9] Plaintiffs argue that where primary jurisdiction is applicable, the "proper procedure is to stay the trial court's decision … and not outright dismissal of the action." Opening Br. at 34, 39. Not so. While the doctrine permits a trial court to retain jurisdiction pending agency review, the trial court also has discretion to dismiss the claims outright. *Dioxin/Organochlorine Ctr. v. Dep't of Ecology*, 119 Wn.2d 761, 837 P.2d 1007 (1992) (affirming trial court dismissal); *Miller v. U.S. Bank of Wash.*, 72 Wn. App. 416, 865 P.2d 536 (1994) (same).

Plaintiffs' claims—the OIC should have "primary jurisdiction" over them. 9/28/2012 Tr. at 32:2-22; 1/4/13 Tr. at 35:24-36:10. Although no fixed formula exists, *Vogt*, 117 Wn.2d at 554, the Supreme Court identified three factors that favor a finding of primary jurisdiction: (1) the agency has authority to solve the issue, (2) the agency has special competence over all or some part of the controversy, and (3) the issues before the court fall within the scope of a pervasive regulatory scheme so that a danger exists that judicial action would conflict with the regulatory scheme. *In re Real Estate Brokerage Antitrust Litigation*, 95 Wn.2d 297, 302-03, 622 P.2d 1185 (1980). Because all three factors are present here, the trial court did not abuse its discretion in finding that the doctrine of primary jurisdiction provided another basis for denial of Plaintiffs' claims.

For the same reasons discussed above, Plaintiffs' claims are an attack on Premera's OIC-approved rates, including those for WAHIT employer-members; without those rates, there would be no allegedly excess surplus. Indeed, as the trial court recognized, even if this case were only about Premera's surplus or advertising, the court could not award damages without itself determining what a reasonable rate would have been. 1/4/13 Tr. at 30:23-31:2. The OIC has the special expertise to assess the reasonableness of rates based on complicated regulatory, financial, actuarial and market factors, including surplus levels and

investment earnings. The complex factors that go into rate-setting methodology are not within the ordinary experience of the courts, and the trial court properly exercised its discretion in refusing to second-guess the OIC on the issue. *Cf. Dioxin/Organochlorine*, 119 Wn.2d at 775-76 (Pollution Control Hearings Board has special expertise to resolve environmental issues under State Environmental Policy Act); *Jaramillo v. Morris*, 50 Wn. App. 822, 831-32, 750 P.2d 1301 (1988) (State Podiatry Board better equipped to decide medical issues).

By the same token, judicial action risks significant disruption to the OIC's pervasive regulation of rates. Any ruling that Premera's rates were excessive would necessarily conflict with the OIC's determination that those rates were reasonable, including the amount the OIC approved for contribution to surplus. *Cf. D.J. Hopkins, Inc. v. GTE Nw., Inc.*, 89 Wn. App. 1, 9, 947 P.2d 1220 (1997) (primary jurisdiction appropriate where allegedly deceptive label in phone bill "was originally approved by the WUTC").

For similar reasons, Plaintiffs' effort to dress up their attack on Premera's rates as a challenge to Premera's and/or WAHIT's allegedly false advertising does not remove this dispute from the Insurance Code's pervasive regulatory scheme. Opening Br. at 7-9. In granting Premera's motion for summary judgment, the trial court stated as follows:

> Claims have been made about deceptive advertising that results in selective underwriting. Well, that's precisely why we have an insurance commissioner, to look at the agencies, to look at the regulations, to look at whether they are providing misleading information. And for the Court to interpose itself in this would, I think, take away from the ability to have a comprehensive, studied, thorough analysis of the issues that need to be addressed.

1/4/13 Tr. at 36:2-10. As the trial court emphasized, in addition to rates, the OIC has jurisdiction over claims of false, deceptive or misleading advertising, and misrepresentation of the terms and benefits of contracts. RCW 48.44.020(2)(c), 48.44.110, 48.44.120. Further, the OIC has powers to enforce these provisions through adjudicative proceedings, cease-and-desist orders, or by filing suit. RCW 44.02.080, 48.04.010, 48.44.180. In short, whether cast as a challenge to rates, surplus or advertising, the trial court was well within its discretion in deferring the matter to the authority and special competence of the OIC.

V. CONCLUSION

Plaintiffs' challenge to Premera's rates is foreclosed as a matter of law by the filed rate doctrine and for failure to exhaust administrative remedies. At a minimum, it was well within the trial court's discretion to recognize the OIC's primary jurisdiction over this dispute. To the extent Plaintiffs are unsatisfied with the OIC's authority to regulate rates or surplus, their answer lies with the legislature, not the courts.

RESPECTFULLY SUBMITTED this 24th day of July, 2013.

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CERTIFICATE OF SERVICE

I certify, under penalty of perjury under the laws of the United States and the State of Washington, that on July 24, 2013, I served a copy of the foregoing document on all counsel of record as indicated below:

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