

RECEIVED  
SUPREME COURT  
STATE OF WASHINGTON  
Jan 06, 2012, 1:33 pm  
BY RONALD R. CARPENTER  
CLERK

No. 86647-3

RECEIVED BY E-MAIL

---

IN THE SUPREME COURT OF  
THE STATE OF WASHINGTON

---

WASHINGTON STATE MEDICAL ASSOCIATION, a Washington  
nonprofit corporation, and WASHINGTON CHAPTER OF THE  
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, a  
Washington nonprofit corporation,

Petitioners,

v.

MIKE KREIDLER, Washington State Insurance Commissioner,

Respondent.

---

PETITIONERS' OPENING BRIEF

---

BRIAN W. GRIMM  
WSBA No. 29619  
Bennett Bigelow & Leedom, P.S.  
1700 Seventh Avenue, Suite 1900  
Seattle, Washington 98101  
(T) 206-622-5511  
(F) 206-622-8986

Attorneys for Petitioners,  
Washington State Medical  
Association and Washington Chapter  
of the American College of  
Emergency Physicians

**FILED**  
JAN 03 2012  
CLERK OF THE SUPREME COURT  
STATE OF WASHINGTON

**ORIGINAL**

## TABLE OF CONTENTS

I. INTRODUCTION .....	1
II. NOTE REGARDING BRIEFING DEADLINES .....	2
III. STATEMENT OF ISSUES .....	2
IV. STATEMENT OF THE CASE.....	3
A. HEALTH INSURERS IN WASHINGTON MUST COVER EMERGENCY SERVICES. ....	3
B. HISTORICALLY, THE INSURANCE COMMISSIONER INTERPRETED AND ENFORCED RCW 48.43.093 CONSISTENTLY WITH ITS PLAIN LANGUAGE. ....	4
C. THE INSURANCE COMMISSIONER’S CURRENT INTERPRETATION OF THE STATUTE IS INCONSISTENT WITH ITS PLAIN LANGUAGE.....	7
D. THE INSURANCE COMMISSIONER’S NEW INTERPRETATION OF THE STATUTE HARMS BOTH PATIENTS AND PHYSICIANS. ....	9
E. PETITIONERS SOUGHT A DECLARATORY JUDGMENT AND A WRIT OF MANDAMUS FROM THE SUPERIOR COURT.....	10
F. THE SUPERIOR COURT AWARDED SUMMARY JUDGMENT IN FAVOR OF THE INSURANCE COMMISSIONER ON BOTH CLAIMS. ....	11
G. PETITIONERS SEEK DIRECT REVIEW OF THE TRIAL COURT’S DECISION. ....	12
V. STANDARD OF REVIEW .....	13
VI. ARGUMENT .....	14
A. HEALTH INSURERS ARE NOT NECESSARY PARTIES TO PETITIONERS’ DECLARATORY-JUDGMENT CLAIM AGAINST THE INSURANCE COMMISSIONER. ....	14
B. PETITIONERS ARE ENTITLED TO SUMMARY JUDGMENT ON THEIR DECLARATORY-JUDGMENT CLAIM. ....	18

C. PETITIONERS' MANDAMUS CLAIM IS NOT CONTINGENT  
UPON THEIR DECLARATORY JUDGMENT CLAIM.....22

D. PETITIONERS ARE ENTITLED TO SUMMARY JUDGMENT ON  
THEIR MANDAMUS CLAIM.....23

VII. CONCLUSION.....24

## TABLE OF AUTHORITIES

### Cases

<i>Bainbridge Citizens United v. Washington State Department of Natural Resources</i> , 147 Wn. App. 365, 198 P.3d 1033 (2008).....	15
<i>Barber v. Peringer</i> , 75 Wn. App. 248, 877 P.2d 223 (1994).....	13
<i>Cockle v. Department of Labor and Industries</i> , 142 Wn.2d 801, 16 P.3d 583 (2001).....	18, 23
<i>Glasebrook v. Mutual of Omaha Insurance Co.</i> , 100 Wn. App. 538, 997 P.2d 981 (2000).....	16
<i>Hodge v. Raab</i> , 151 Wn.2d 351, 88 P.3d 959 (2004).....	17
<i>Horan v. Marquardt</i> , 29 Wn. App. 801, 630 P.2d 947 (1981).....	17
<i>Kelley v. Centennial Contractors Enterprises, Inc.</i> , 169 Wn.2d 381, 236 P.3d 197 (2010).....	13
<i>Land Title of Walla Walla, Inc. v. Martin</i> , 117 Wn. App. 286, 70 P.3d 978 (2003).....	22, 23
<i>Sheikh v. Choe</i> , 156 Wn.2d 441, 128 P.3d 574 (2006).....	13
<i>State Health Insurance Pool v. Health Care Authority</i> , 129 Wn.2d 504, 919 P.2d 62 (1996).....	13
<i>State v. Hirschfelder</i> , 170 Wn.2d 536, 242 P.3d 876 (2010).....	19
<i>Veit ex rel. Nelson v. Burlington Northern Santa Fe Corp.</i> , 171 Wn.2d 88, 249 P.3d 607 (2011).....	20

**Statutes**

RCW 48.02.060 ..... 15, 23  
RCW 48.43.093 ..... passim  
RCW 7.24.020 ..... 14  
RCW 7.24.110 ..... 12, 14, 22  
RCW 7.24.120 ..... 14

**Rules**

CR 12 ..... 11  
CR 56 ..... 11, 13  
RAP 4.2 ..... 13

## I. INTRODUCTION

The Washington Insurance Code requires health plans to pay for emergency medical services when a prudent layperson acting reasonably would have believed that an emergency medical condition existed. After nearly a decade of interpreting the applicable statute, RCW 48.43.093, to mean that health plans must pay the full, billed charges of “out-of-network” emergency providers (*i.e.*, those with whom the health plans have not negotiated discounted rates), the Insurance Commissioner now interprets the statute to mean that health plans must pay only a portion of such charges, equivalent to what they would pay to their “in-network” providers, leaving patients liable for the difference.

The Insurance Commissioner’s new interpretation of RCW 48.43.093 is indefensible, given the language of the statute and the applicable rules of statutory interpretation. Indeed, the Insurance Commissioner’s actions directly undermine the very policy goal which the statute was adopted to promote. Petitioners, the Washington State Medical Association (“WSMA”) and the Washington Chapter of the American College of Emergency Physicians, seek a declaratory judgment stating, with certainty and finality, how RCW 48.43.093 should be interpreted, and a writ of mandamus compelling the Insurance

Commissioner to enforce the statute consistently with the correct interpretation.

## II. NOTE REGARDING BRIEFING DEADLINES

On November 29, 2011, the Court stayed the due date for filing Petitioners' opening brief until the Court Commissioner has ruled on Respondent's motion to limit the scope of review. See Letter from Supreme Court Clerk to Counsel of Record, dated November 29, 2011, at 2. Petitioners appreciate this extension, but are nevertheless filing their opening brief at this time to ensure that this appeal proceeds as expeditiously as possible. Petitioners understand that Respondent's brief will not be due until thirty days after the Court Commissioner has ruled on the pending motion.

## III. STATEMENT OF ISSUES

This appeal presents the following issues:

1. Did the trial court err by dismissing Petitioners' declaratory-judgment claim on the ground that Petitioners sought a declaratory judgment, interpreting RCW 48.43.093, against the Insurance Commissioner alone, and did not also join health plans as parties?

2. What is the correct interpretation of RCW 48.43.093?

3. Did the trial court err by dismissing Petitioners' mandamus claim based on its determination that Petitioners' mandamus claim was contingent upon Petitioners' declaratory-judgment claim?

4. Should the Court issue a writ of mandamus compelling the Insurance Commissioner to enforce the statute consistently with the correct interpretation?

#### IV. STATEMENT OF THE CASE

##### A. Health Insurers in Washington Must Cover Emergency Services.

Under RCW 48.43.093, health insurers must "cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed." RCW 48.43.093(1)(a). The statute requires that the insurer cover emergency services even if obtained from a physician with whom the insurer does not have a contract (*i.e.*, an "out-of-network" or "nonparticipating" provider), so long as "a prudent layperson would have reasonably believed that use of a participating hospital emergency department would result in a delay that would worsen the emergency" or certain other circumstances exist. RCW 48.43.093(1)(a). The statute recognizes that an out-of-network provider's billed charges for such services are likely to be higher than the allowed charges the insurer has negotiated with its in-network providers, and provides that the insurer

may shift a maximum of \$50 of the differential to the policyholder. *See* RCW 48.43.093(1)(c). A copy of the statute is attached as an appendix to this brief.

B. Historically, the Insurance Commissioner Interpreted and Enforced RCW 48.43.093 Consistently with its Plain Language.

There really should be no dispute regarding what RCW 48.43.093 means. The language of the statute is plain. Insurers “shall cover” emergency services; they “shall cover” such services even when obtained “from a nonparticipating provider”; and they may shift only \$50 of the additional cost associated with the nonparticipating provider to the policyholder. *See* RCW 48.43.093(1)(a) & (c).

Historically, the Office of the Insurance Commissioner (“OIC”) interpreted and enforced the statute consistently with this plain meaning. Deborah Senn, the Insurance Commissioner from 1993-2001, engaged in enforcement, rulemaking, and a statewide informational campaign, all of which were consistent with the plain-language interpretation of the statute. CP 459-70.

Mike Kreidler succeeded Ms. Senn as Insurance Commissioner in 2001. However, OIC’s interpretation of RCW 48.43.093 was no different (at least for a time) under Commissioner Kreidler than it had been under Commissioner Senn. Pursuant to a public records request, WSMA

obtained internal OIC documents which confirm that OIC interpreted the statute at that time exactly as WSMA asks the Court interpret it now.

For example, in a 2002 letter to Premera Blue Cross, OIC informed the insurer as follows:

All emergency claims will be paid at *the billed charges* of a non-contracted provider.

CP 585 (emphasis added). Premera agreed to do so. CP 588.

In 2005, another insurer, Regence, contacted OIC to determine what rates it would have to pay for services at a new freestanding emergency room being built by Swedish Medical Center in Issaquah, in the event that Regence did not enter into a contract with Swedish with respect to that new facility. Deputy Insurance Commissioner Elizabeth Berendt sought advice from another OIC employee, Charles Brown, who informed her on January 6, 2005, as follows:

[I]f Regence does not contract with the new facility and if a Regence enrollee goes to the facility due to circumstances beyond his/her control or if a reasonably prudent layperson would have thought it would create a serious health risk to take the additional time to go to a network ER, under RCW 48.43.093(1)(c), I believe Regence will be required to pay the new facility *at the facility's normal billed rate* and at a reimbursement percentage level that does not leave the enrollee with an ER bill that is any more than \$50 bigger than it would have been if the enrollee had gone to a participating ER.

CP 598-99.

Also in 2005, OIC considered the implications of the anticipated termination of Premera's contract with Evergreen Hospital in Kirkland. Deputy Commissioner Berendt asked Mr. Brown and others for clarification regarding what rates Evergreen would have to pay for emergency services at Evergreen if Evergreen were no longer within Premera's participating-provider network. Ms. Berendt asked:

Can the health plan limit[] their exposure by paying their fee schedule at the in network benefit level and leave the patient holding the bag[?]

CP 604-05.

Consistent with the internal OIC discussions regarding Regence in early 2005, as well as OIC's longstanding interpretation of the statute, Mr. Brown responded to this question as follows:

I read the statute to mean that the cost to the enrollee of going to a non-par[ticipating] ER cannot be more than fifty dollars over what it would have been if the enrollee had gone to a contracted ER. I[t] appears to me this \$50 differential limit includes whatever amount is balance billed as well as any coinsurance or deductible liability on the part of the enrollee, so that the enrollee's deductible, copay, and balance bill are all added up and compared to the total that the enrollee would have paid at a par[ticipating] ER, with the enrollee paying a maximum of that amount plus \$50 and *the*

*carrier paying the rest of the non-par[ticipating] ER's billed charges.*

CP 604 (emphasis added).

Obviously OIC's internal discussions are not determinative of the correct interpretation of RCW 48.43.093. That is a legal question for the Court alone. However, this correspondence is noteworthy at least because it demonstrates that in OIC's 2002 communications with Premera, OIC's 2005 internal discussions regarding what rates Regence would have to pay for services at Swedish's ER in Issaquah, if out of network, and OIC's 2005 internal discussions regarding what rates Premera would have to pay for emergency services at Evergreen Hospital in Kirkland, if out of network, OIC interpreted RCW 48.43.093 exactly as WSMA asks the Court to interpret the statute today: for emergency services provided by nonparticipating providers, insurers must pay the full billed charges, except for the \$50 maximum which they are allowed to shift to patients.

C. The Insurance Commissioner's Current Interpretation of the Statute is Inconsistent with its Plain Language.

Sometime between 2005 and 2006, OIC changed its interpretation of RCW 48.43.093. Currently, OIC takes the position that under RCW 48.43.093, insurers only must pay out-of-network providers the same rates they have negotiated with their in-network providers, and patients are liable for the difference between this amount and the providers' billed

charges. CP 477 (out-of-network providers "have the option of seeking payment directly from the patient, or 'balance billing,' for the difference between what the health carrier will pay, and what the physician charges").

OIC's change of interpretation is reflected in another internal OIC e-mail exchange, obtained by WSMA pursuant to its public records request. In 2006, the following situation was brought to the attention of Deputy Commissioner Berendt:

Previously [Premera Blue Cross] had been paying *billed charges* for claims involving out of network ER providers. As of 3/1/06, the guidelines only allow for payment for ER claims incurred with out of network providers based on *the company's allowable charges*.

Ms. Berendt responded as follows:

Yes – this is the *new position* [of OIC].

CP 607 (emphasis added).

In her declaration in support of OIC's motion to dismiss below, Ms. Berendt provided further explanation regarding OIC's change of position. According to Ms. Berendt, OIC had been requiring Premera to pay billed charges in order to incentivize Premera to establish an adequate network of participating providers, and that the change in OIC's

interpretation of RCW 48.43.093 occurred after Premera established an adequate participating-provider network:

[A]fter the carrier [Premera] developed an adequate provider network, it challenged the requirement to pay billed charges. Subsequently, the Commissioner agreed that RCW 48.43.093 permits health carriers to pay the same allowed fee schedule for both contracted and non-contracted emergency service providers.

CP 497.

OIC's explanation is a *non sequitur*. Either RCW 48.43.093 requires health insurers to pay billed charges for emergency services provided by out-of-network providers or it does not require health insurers to pay billed charges for emergency services provided by out-of-network providers. The language of the statute has not changed, and the meaning of the statute cannot be contingent upon the activities of a single insurance company.

D. The Insurance Commissioner's New Interpretation of the Statute Harms Both Patients and Physicians.

The Insurance Commissioner's new interpretation of RCW 48.43.093 not only is wrong as a matter of law (discussed below), it harms both patients and physicians. If patients obtain treatment from an emergency room pre-approved by their insurers, in lieu of the closest emergency room, the delay may, as the Legislature recognized, "worsen

the emergency.” RCW 48.43.093(1)(a). If patients instead obtain treatment from the closest emergency room, and it happens to be an out-of-network facility, the patients are responsible for whatever portion of the billed charges their insurer does not “allow,” in direct contradiction to the plain language of the statute which permits insurers to shift only \$50 of the differential cost to patients. The Insurance Commissioner’s change of interpretation also harms emergency physicians because instead of receiving full payment from insurers, as the statute contemplates, physicians instead receive only partial payment and must “balance-bill” their patients, attempt to collect on those bills, and try not to harm the doctor-patient relationship in doing so, or else not receive full payment. CP 438-39.

E. Petitioners Sought a Declaratory Judgment and a Writ of Mandamus From the Superior Court.

On December 9, 2010, WSMA filed a petition for a writ of mandamus in this Court. CP 223-252. On March 1, 2011, Commissioner Goff transferred the action to Thurston County Superior Court, which would have original jurisdiction not only over the mandamus petition, but also over a declaratory-judgment claim. CP 5-8. On August 25, 2011, Petitioners amended their complaint in Thurston County Superior Court to add a declaratory-judgment claim. CP 431-43.

F. The Superior Court Awarded Summary Judgment in Favor of the Insurance Commissioner on Both Claims.

On September 2, 2011, the Insurance Commissioner moved to dismiss both of Petitioners' claims. CP 473-92. In support of his motion, the Insurance Commissioner presented a declaration from Deputy Commissioner Berendt, with additional attached exhibits. CP 494-546. On September 19, 2011, Petitioners filed a brief in opposition to the Insurance Commissioner's motion. CP 547-79. Petitioners also presented a declaration in support of their opposition to the motion, with additional attached exhibits. CP 581-607. On September 26, 2011, the Insurance Commissioner filed a reply brief in support of his motion. CP 608-17. The trial court heard oral argument and issued its decision on September 30, 2011. CP 618-19.

"Because matters outside the pleading were presented to and not excluded by the Court," specifically the declarations and exhibits presented by both parties, the trial court treated the Insurance Commissioner's motion "as a CR 56 motion" for summary judgment. CP 618; *see also* RP 21 ("whether it was initially a CR 12 motion, the presence of those declarations converts it to a CR 56" motion).

Viewing all facts and inferences in the light most favorable to Petitioners, the trial court nevertheless determined that Petitioners had not

pled a claim under the Uniform Declaratory Judgments Act, RCW Chapter 7.24 (the "UDJA"). Specifically, the trial court determined that Petitioners had not joined a required party under RCW 7.24.110. CP 618; *see also* RP 22; RCW 7.24.110 ("When declaratory relief is sought, all persons shall be made parties who have or claim any interest which would be affected by the declaration, and no declaration shall prejudice the rights of persons not parties to the proceeding."). The trial court determined that Petitioners must join at least one health insurer as a party, even though Petitioners sought no relief whatsoever from any health insurer, and only sought to resolve a dispute between Petitioners and *the Insurance Commissioner* regarding the interpretation of a statute which *the Insurance Commissioner* is required to enforce, where *the Insurance Commissioner's* misinterpretation and consequent lack of enforcement of the statute harms Petitioners. The trial court further determined that Petitioners' mandamus claim was contingent upon its declaratory-judgment claim. CP 618; *see also* RP 24. Accordingly, the trial court awarded summary judgment in favor of the Insurance Commissioner and dismissed both claims. CP 618-19.

G. Petitioners Seek Direct Review of the Trial Court's Decision.

Petitioners timely sought direct review by this Court. CP 620-24. In their Statement of Grounds, Petitioners explained that the Court should

grant direct review pursuant to RAP 4.2(a)(4), because this case impacts the public health and the scope of coverage that health insurers must provide in Washington, and pursuant to RAP 4.2(a)(5), because this is a mandamus action against a state officer. See Petitioners' Statement of Grounds for Direct Review, filed November 14, 2011, at 9-14.

#### V. STANDARD OF REVIEW

The Court reviews an order of summary judgment *de novo*. See *Sheikh v. Choe*, 156 Wn.2d 441, 447, 128 P.3d 574 (2006). The same standard of review applies regardless of whether the trial court order is entered on a motion originally filed as a motion for summary judgment or on a motion originally filed as a motion to dismiss which was treated as a motion for summary judgment because matters outside the pleading were presented to and not excluded by the trial court. See *Kelley v. Centennial Contractors Enterprises, Inc.*, 169 Wn.2d 381, 385-86, 236 P.3d 197 (2010). Summary judgment is appropriate where "there is no genuine issue as to any material fact" and "the moving party is entitled to judgment as a matter of law." CR 56(c). The Court may grant summary judgment to either the moving or the non-moving party. See *State Health Ins. Pool v. Health Care Auth.*, 129 Wn.2d 504, 507, 919 P.2d 62 (1996) (affirming trial court's *sua sponte* award of summary judgment to non-moving party); *cf. Barber v. Peringer*, 75 Wn. App. 248, 255, 877 P.2d 223 (1994)

(remanding for summary judgment to be entered in favor of non-moving party).

## VI. ARGUMENT

### A. Health Insurers Are Not Necessary Parties to Petitioners' Declaratory-Judgment Claim Against the Insurance Commissioner.

Under the UDJA, the Court may issue a declaratory judgment “determin[ing] any question of construction or validity arising under ... [a] statute.” RCW 7.24.020. Because the purpose of the UDJA “is to settle and to afford relief from uncertainty and insecurity” it “is to be liberally construed and administered.” RCW 7.24.120.

The trial court dismissed Petitioners' declaratory-judgment claim because it determined that Petitioners had not joined a required party under RCW 7.24.110. CP 623. That provision of the UDJA provides as follows: “When declaratory relief is sought, all persons shall be made parties who have or claim any interest which would be affected by the declaration, and no declaration shall prejudice the rights of persons not parties to the proceeding.” RCW 7.24.110. For this provision to apply, the non-party must meet three requirements:

- (1) The trial court cannot make a complete determination of the controversy without that party's presence; *and*
- (2) The party's ability to protect its interest in the subject matter of the litigation would be impeded by a judgment in the case; *and*

(3) Judgment in the case necessarily would affect the party's interest.

See *Bainbridge Citizens United v. Wash. State Dep't of Natural Res.*, 147 Wn. App. 365, 372, 198 P.3d 1033 (2008).

The trial court determined that “a health carrier” is a required party to Petitioners’ declaratory-judgment claim against the Insurance Commissioner. CP 623. The trial court did not determine that a specific health carrier is a required party, but rather that Petitioners must sue at least one health carrier along with the Insurance Commissioner. CP 623; see also RP 23 (explaining that the trial court “do[es] not believe that [it] is necessary” to “join every single insurer”).

There is no reason that the Court “cannot make a complete determination of the controversy” at issue in this matter—i.e., the interpretation of RCW 48.43.093—without the presence of one or more health insurers as parties. Petitioners simply are asking the Court to resolve a dispute between Petitioners and the Insurance Commissioner regarding the correct interpretation of a statute which the Insurance Commissioner is required to enforce. See RCW 48.02.060(2).

*Bainbridge Citizens United*, cited by the Insurance Commissioner and apparently relied upon by the trial court, see RP 22, is inapposite. In that case the petitioner sought “an order declaring that” certain non-parties

were “in violation of” certain regulations and that the agency had a duty to take specific enforcement actions against the non-parties. *Bainbridge Citizens United*, 147 Wn. App. at 372-73. Because the non-parties were the only persons who could rebut the petitioner’s factual allegations that they had violated the regulations at issue and the declaration would be that the non-parties had violated the regulations, the court determined that they were necessary parties. *See id.* at 373-74. The present case is not analogous. Here, Petitioners do not seek a declaration that any insurer violated RCW 48.43.093 or that the Insurance Commissioner is required to take specific enforcement action against any insurer. Petitioners simply are seeking the interpretation of a statute.

It is true that the Court’s interpretation of RCW 48.43.093 has the potential to affect persons other than the Insurance Commissioner and Petitioners. Indeed, it has the potential to affect every health insurer and every person with health insurance in Washington. However, it does not follow that the Court “cannot make a complete determination of the controversy” without joining such persons as parties. Washington courts have issued declaratory judgments interpreting various provisions of the Insurance Code, as well as other statutes, without joining as a party every person to whom those statutes apply. *See, e.g., Glasebrook v. Mut. of Omaha Ins. Co.*, 100 Wn. App. 538, 544, 997 P.2d 981 (2000)

(interpreting Insurance Code provision relating to health insurance, without requiring all health insurance companies be joined as parties, even though statute applicable to “all health carriers”); *see also Hodge v. Raab*, 151 Wn.2d 351, 358, 88 P.3d 959 (2004) (interpreting Insurance Code provision relating to motor vehicle insurance, without requiring all car insurance companies be joined as parties).

The trial court agreed that not every health insurer must be joined by a party, but held that at least one must be joined. CP 618; *see also* RP 23. This was error. Courts plainly may resolve disputes between consumers and the Insurance Commissioner regarding Washington’s insurance laws, even if no insurer is a party to the case. For example, in *Horan v. Marquardt*, 29 Wn. App. 801, 630 P.2d 947 (1981), consumers and auto repair companies brought a declaratory-judgment action against the Insurance Commissioner regarding the validity of regulations relating to automobile insurance. Even though the decision would affect all insurers issuing such policies, no insurer was joined as a party. The trial court nevertheless considered the plaintiffs’ challenges to the regulations on the merits and awarded summary judgment to the Insurance Commissioner; the Court of Appeals affirmed. *See Horan*, 29 Wn. App. at 807.

Petitioners' declaratory-judgment claim is a controversy between Petitioners and the Insurance Commissioner regarding the correct interpretation of RCW 48.43.093, which the Insurance Commissioner is required to enforce. Petitioners seek relief only against the Insurance Commissioner. No additional parties are necessary for the Court to resolve this controversy.

B. Petitioners Are Entitled to Summary Judgment on Their Declaratory-Judgment Claim.

The trial court should have awarded summary judgment to Petitioners on their declaratory-judgment claim, and erred by not doing so. This Court now should correct that error and determine that Petitioners are entitled to summary judgment on this claim.

“Statutory construction is a question of law[.]” *Cockle v. Dep't of Labor and Indus.*, 142 Wn.2d 801, 805, 16 P.3d 583 (2001). “In any question of statutory construction,” the Court “look[s] to ascertain the intention of the legislature by first examining a statute’s *plain meaning*. Statutes must be interpreted and construed so that *all the language used is given effect, with no portion rendered meaningless or superfluous*. If the statute’s meaning is plain on its face, then the court must give effect to that plain meaning as an expression of legislative intent. Plain meaning is discerned from the ordinary meaning of the language at issue, the context

of the statute in which that provision is found, related provisions, and the statutory scheme as a whole.” *State v. Hirschfelder*, 170 Wn.2d 536, 543, 242 P.3d 876 (2010) (citations and internal quotation marks omitted; emphasis added).

RCW 48.43.093 is plain on its face. In subpart (1)(a), the statute provides that “[w]ith respect to care obtained from a nonparticipating hospital emergency department, a health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson would have reasonably believed that use of a participating hospital emergency department would result in a delay that would worsen the emergency” or certain other circumstances are present. In subpart (1)(c), the statute provides that the insurer may shift only \$50 of the differential cost associated with a nonparticipating provider to the covered person.

The Insurance Commissioner’s interpretation of RCW 48.43.093 does not “give effect” to the language contained in subpart (1)(c), and renders that language “meaningless or superfluous.” *Hirschfelder*, 170 Wn.2d at 543. If the Insurance Commissioner is correct that RCW 48.43.093 only requires insurers to pay out-of-network providers the same rates paid to in-network providers, there would be no “differential” in the cost of the two types of providers, and this language would be

meaningless. Moreover, if insurers are required to pay out-of-network providers only the rates paid to in-network providers, it would be superfluous to cap at \$50 the portion of the differential cost that the insurer may shift to the policyholder. The Court should decline to interpret RCW 48.43.093 in a way that renders this language meaningless and superfluous. *See Veit ex rel. Nelson v. Burlington N. Santa Fe Corp.*, 171 Wn.2d 88, 113, 249 P.3d 607 (2011) (rejecting proposed interpretation “that would render superfluous a provision of the statute”).

In addition, the Insurance Commissioner’s interpretation of the statute contradicts what OIC concedes was the purpose of the statute. OIC states that RCW 48.43.093 was intended to relieve policyholders of the risk of having to pay for emergency services. CP 495 (“The various protections provided in RCW 48.43.093 allow policy holders to seek emergency health care services *without fearing their emergency claims will be disputed* if the condition is not life threatening.”) (emphasis added). Yet the Insurance Commissioner simultaneously argues that RCW 48.43.093 should be interpreted such that policyholders are liable for the difference between what out-of-network providers charge them for such services (i.e., the “billed charges”) and the percentage of those charges which their insurers are willing to pay (i.e., the “allowable charges”). CP 477 (nonparticipating providers “have the option of seeking

payment directly from the patient, or 'balance billing,' for the difference between what the health carrier will pay, and what the physician charges"). How the Insurance Commissioner says the statute should be interpreted cannot be reconciled with what he says the statute was intended to do.

Notably, the Insurance Commissioner has never, to Petitioners' knowledge, explained what level of coverage an insurer must provide when it has negotiated different rates with various participating providers. Must it provide coverage equivalent to the highest rate it pays to any of its participating providers? Must it only provide coverage equivalent to the lowest rate it pays to any of its participating providers? This ambiguity in the Insurance Commissioner's interpretation also suggests that the Insurance Commissioner's interpretation is wrong.

Petitioners' interpretation of RCW 48.43.093, on the other hand, is based on the plain language of the statute and gives effect to all language in the statute. It also is consistent with what the statute was intended to do. The Court should determine, as a matter of law, that Petitioners' interpretation of RCW 48.43.093 is the correct one, and issue a declaration so interpreting the statute. Emergency physicians and their patients, and health plans and their policyholders, will then be able to proceed

accordingly, and the Insurance Commissioner will be able to carry out his duty to enforce the statute consistently with what it actually requires.

C. Petitioners' Mandamus Claim Is Not Contingent Upon Their Declaratory Judgment Claim.

As discussed above, the trial court dismissed petitioners' declaratory-judgment claim on a technical ground set forth in the UDJA, namely the RCW 7.24.110 requirement regarding joinder of parties. Even if the trial court was correct to do so, it was error for the trial court to dismiss petitioners' mandamus claim on the basis that it was contingent upon the UDJA claim. The trial court instead should have treated Petitioners' mandamus claim as a stand-alone claim.

Washington courts have issued numerous writs of mandamus against state officers without also issuing declaratory judgments. There simply is no requirement that a party must assert, and prevail on, a UDJA claim as a prerequisite to bring a mandamus claim.

For example, in *Land Title of Walla Walla, Inc. v. Martin*, 117 Wn. App. 286, 70 P.3d 978 (2003), the Court of Appeals determined that a county auditor's interpretation of a statute was incorrect and ordered the issuance of a writ of mandamus for the auditor to enforce the statute consistently with the correct interpretation. The only claim considered by

the court in that case was the petition for a writ of mandamus; no declaratory judgment was sought or granted.

D. Petitioners Are Entitled to Summary Judgment on Their Mandamus Claim.

The trial court should have awarded summary judgment to Petitioners on their mandamus claim, and erred by not doing so. This Court now should correct that error and determine that Petitioners are entitled to summary judgment on this claim.

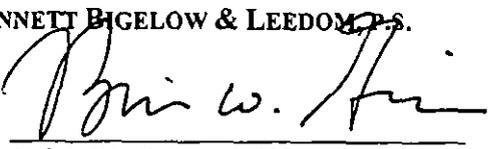
The Insurance Commissioner is required to enforce RCW 48.43.093. See RCW 48.02.060(2). Although the Insurance Commissioner has discretion regarding what specific types of enforcement actions to take or not take, he does not have discretion regarding what the statute means. That is a question of law. See *Cockle*, 142 Wn.2d at 807. When an agency is “enforcing” a statute based on an incorrect interpretation of the statute, a writ of mandamus should be issued, ordering the agency to enforce the statute based on the correct interpretation. See *Land Title of Walla Walla, Inc.*, 117 Wn. App. at 291. Therefore, if the Court agrees with Petitioners regarding the correct interpretation of RCW 48.43.093, it should issue a writ of mandamus ordering the Insurance Commissioner to enforce the statute consistently with this interpretation.

## VII. CONCLUSION

The Insurance Commissioner's new interpretation of RCW 48.43.093 cannot be reconciled with the actual language of the statute and is indefensible under the applicable rules of statutory interpretation. Petitioners respectfully request that the Court issue a declaratory judgment interpreting the statute consistently with its plain meaning, described above, and issue a writ of mandamus requiring the Insurance Commissioner to enforce the statute consistently with the correct interpretation.

Respectfully submitted this 6th day of January, 2012.

**BENNETT BIGELOW & LEEDOM, P.S.**

By: 

Brian W. Grimm, WSBA #29619

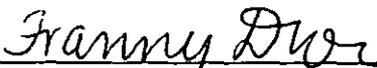
Attorneys for Petitioners,  
Washington State Medical Association and  
Washington Chapter of the American  
College of Emergency Physicians

**CERTIFICATE OF SERVICE**

I, Franny Drobny, certify under penalty of perjury under the laws of the State of Washington that today I caused to be served the foregoing *Petitioners' Opening Brief* on the following persons by e-mail, pursuant to the parties' agreement regarding service by e-mail:

Jean Wilkinson, Senior Counsel  
JeanW@atg.wa.gov  
Marta DeLeon, Assistant Attorney General  
MartaD@atg.wa.gov  
Meghan Lehnhoff, Legal Assistant  
MeghanL@atg.wa.gov  
Office of the Attorney General  
Government Compliance & Enforcement Division  
P.O. Box 40100  
1125 Washington St. SE  
Olympia, WA 98504-0100  
Attorneys for Respondent

DATED this 6th day of January, 2012, at Seattle, Washington.

  
Franny Drobny, Legal Assistant

# APPENDIX

RCW 48.43.093

Health carrier coverage of emergency medical services — Requirements — Conditions.

(1) When conducting a review of the necessity and appropriateness of emergency services or making a benefit determination for emergency services:

(a) A health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a health carrier shall not require prior authorization of such services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a nonparticipating hospital emergency department, a health carrier shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson would have reasonably believed that use of a participating hospital emergency department would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider or facility. In addition, a health carrier shall not require prior authorization of such services provided prior to the point of stabilization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of a participating hospital emergency department would result in a delay that would worsen the emergency.

(b) If an authorized representative of a health carrier authorizes coverage of emergency services, the health carrier shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services.

(c) Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles, and a health carrier may impose reasonable differential cost-sharing arrangements for emergency services rendered by nonparticipating providers, if such differential between cost-sharing amounts applied to emergency services rendered by participating provider versus nonparticipating provider does not exceed fifty dollars.

Differential cost sharing for emergency services may not be applied when a covered person presents to a nonparticipating hospital emergency department rather than a participating hospital emergency department when the health carrier requires preauthorization for postevaluation or poststabilization emergency services if:

(i) Due to circumstances beyond the covered person's control, the covered person was unable to go to a participating hospital emergency department in a timely fashion without serious impairment to the covered person's health; or

(ii) A prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that he or she would be unable to go to a participating hospital emergency department in a timely fashion without serious impairment to the covered person's health.

(d) If a health carrier requires preauthorization for postevaluation or poststabilization services, the health carrier shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review. In order for postevaluation or poststabilization services to be covered by the health carrier, the provider or facility must make a documented good faith effort to contact the covered person's health carrier within thirty minutes of stabilization, if the covered person needs to be stabilized. The health carrier's authorized representative is required to respond to a telephone request for preauthorization from a provider or facility within thirty minutes. Failure of the health carrier to respond within thirty minutes constitutes authorization for the provision of immediately required medically necessary postevaluation and poststabilization services, unless the health carrier documents that it made a good faith effort but was unable to reach the provider or facility within thirty minutes after receiving the request.

(e) A health carrier shall immediately arrange for an alternative plan of treatment for the covered person if a nonparticipating emergency provider and health plan cannot reach an agreement on which services are necessary beyond those immediately necessary to stabilize the covered person consistent with state and federal laws.

(2) Nothing in this section is to be construed as prohibiting the health

carrier from requiring notification within the time frame specified in the contract for inpatient admission or as soon thereafter as medically possible but no less than twenty-four hours. Nothing in this section is to be construed as preventing the health carrier from reserving the right to require transfer of a hospitalized covered person upon stabilization. Follow-up care that is a direct result of the emergency must be obtained in accordance with the health plan's usual terms and conditions of coverage. All other terms and conditions of coverage may be applied to emergency services.

[1997 c 231 § 301.]

Notes:

**Short title -- Part headings and captions not law -- Severability --  
Effective dates -- 1997 c 231: See notes following RCW 48.43.005.**

**OFFICE RECEPTIONIST, CLERK**

---

**To:** Franny J. Drobny  
**Cc:** Brian W. Grimm  
**Subject:** RE: Email filing: WA State Medical Assn. v. Kreidler, Supreme Court No. 86647-3

Received 1/6/12

Please note that any pleading filed as an attachment to e-mail will be treated as the original. Therefore, if a filing is by e-mail attachment, it is not necessary to mail to the court the original of the document.

---

**From:** Franny J. Drobny [<mailto:FDrobny@bblaw.com>]  
**Sent:** Friday, January 06, 2012 1:33 PM  
**To:** OFFICE RECEPTIONIST, CLERK  
**Cc:** Brian W. Grimm  
**Subject:** Email filing: WA State Medical Assn. v. Kreidler, Supreme Court No. 86647-3

**Attached for filing is the following pleading:**  
Petitioners' Opening Brief

**Case name:**  
*Washington State Medical Association, et al. v. Mike Kreidler*

**Case No.:**  
Supreme Court No. 86647-3

**Contact information of person filing documents:**

BRIAN D. GRIMM  
WSBA NO. 29619  
Bennett Bigelow & Leedom, P.S.  
1700 Seventh Avenue, Suite 1900  
Seattle, WA 98101  
Telephone: (206) 622-5511  
Fax: (206) 622-8986  
[bgrimm@bblaw.com](mailto:bgrimm@bblaw.com)

Attorneys for Petitioners

Thank you for your assistance in filing this pleading. We look forward to your reply acknowledging receipt.

Copy of pleading served by separate email with attachments to Jean Wilkinson, Marta DeLeon, and Meghan Lehnhoff

Franny Drobny  
Legal Assistant to Brian W. Grimm  
Bennett Bigelow & Leedom, P.S.  
1700 Seventh Ave. Suite 1900  
Seattle, WA 98101  
T: 206-622-5511  
F: 206-622-8986  
[www.bblaw.com](http://www.bblaw.com)

CONFIDENTIALITY NOTICE

The contents of this message may be protected by the attorney-client privilege, work product doctrine or other applicable protection. If you are not the intended recipient, any dissemination, distribution or copying is strictly prohibited. If you think that you have received this email message in error, please notify the sender via email or telephone at (206) 622-5511.

2