

89774-3

No. 69661-1-I

**COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON**

STATE OF WASHINGTON and HEALTH CARE AUTHORITY,
Petitioners,

v.

DOUGLAS L. MOORE, MARY CAMP, GAYLORD CASE, and a class
of similarly situated individuals,
Respondents.

**STATE OF WASHINGTON'S REPLY IN SUPPORT OF
MOTION FOR DISCRETIONARY REVIEW**

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I. INTRODUCTION

Plaintiffs acknowledge that interlocutory review is available where the trial court's "error is reasonably certain and its impact on the trial is manifest." *Minehart v. Boys Ranch*, 156 Wn. App. 457, 462, 232 P.3d 591 (2010). This is such a case.

Even though this case involves a CR 23(b)(3) class seeking monetary damage, the trial court rejected the requirement that plaintiffs establish actual monetary damage (the cost of substitute insurance or out-of-pocket payments for medical care), reasoning that damage could be incurred from deferred health care.¹ But plaintiffs have never offered any evidence that any (much less each) class member deferred health care, and likewise have offered no trial plan to value the alleged damage caused by such hypothetical deferred health care.

The court accepted plaintiffs' trial plan that proposes to measure the value of omitted health benefits by use of a proxy – health insurance premiums paid by the State for another group of employees. But that proxy bears no relationship to the alleged value of any deferred medical care, or to any actual monetary damages. The court ignored the measure of damages most courts have adopted to value unpaid health insurance benefits. By doing so, the court has deprived the State of the opportunity

¹ Ex. 1 to Motion for Discretionary Review (Verbatim Report of Proceedings dated 10/26/12) at 40-41.

to defend based on at least the following: (1) some class members suffered no actual monetary damage (stipulated by plaintiffs); (2) some class members incurred neither out-of-pocket costs nor deferred health care during the period they were denied benefits; and (3) insurance premiums bear no relationship to the value of harm, if any, caused by deferred health care.

Plaintiffs' argument that their "proxy" damage approach would be more accurate than the State's proposed individualized claims process is flatly contradicted by the record.² This case is unique in that plaintiffs are seeking monetary damage under CR 23(b)(3), but the parties agree that some undetermined number of class members suffered no actual monetary damage.³ The State is entitled to determine at trial whether this number comprises a small part or most of the class.

Moreover, plaintiffs' specter of "20,000 mini-trials" is overblown hysteria; plaintiffs themselves concede that the current class is "materially overstated."⁴ Fifty-one percent of current class members had only two or less months of missing health insurance, and plaintiffs admit they probably are "wrongly included" in the class.⁵ There are outstanding issues regarding class members' eligibility for benefits, which will further

² See Exs. A, B, and C attached to this Reply, and discussion of those declarations, below.

³ See Stipulation attached as Ex. 2 to Motion for Discretionary Review.

⁴ See Plaintiffs' Motion to Require Corrective Notice (10-16-12) at 5:15.

⁵ Answer to Motion for Discretionary Review at 19.

reduce the class. And no “mini-trials” would be required to establish damage attributable to the State; class actions often involve simplified claims processes for damage determinations.⁶

Plaintiffs mistakenly argue that the State does not assign error to the trial court’s rulings based on plaintiffs’ “wages” and restitution theories. These are merely different labels for the same aggregate damage approach as plaintiffs’ “actuarial” method.⁷ All three involve the identical calculation of multiplying the total months that eligible employees were without coverage, times the average monthly premium the State pays insurers to provide coverage. All three approaches suffer from the same defect – they “skip over” the State’s right to defend on the basis that some (or many) class members in fact suffered no actual loss.

Finally, plaintiffs argue that interlocutory review is inappropriate because the trial in this case is scheduled for June 2013. This is a factor weighting in favor of review. A trial in which the State is denied its due process right to defend would be a useless waste of resources.

II. ARGUMENT

A. *Sitton* Requires Discretionary Review

⁶ The courts have developed multiple case management techniques to address variations in damages among class members. See Joseph M. McLaughlin, *McLaughlin on Class Actions*, § 4:19 at 665-66 (8th ed. 2011).

⁷ Moreover, the State clearly challenge the trial court’s erroneous “wage” rulings under *Cockle v. DLI*, 142 Wn.2d 801, 16 P.3d 583 (2001). See Motion for Discretionary Review at 7-8 and 15, n. 13.

Plaintiffs argue that *Sitton v. State Farm*, 156 Wn. App. 457, 232 P.3d 591 (2010), does not apply because the State’s statutory liability already has been determined, and “it is undisputed here that liability is a classwide issue of law and all class members were wrongly denied health benefits in specific months when they were eligible.” Not all class members were “wrongly denied health benefits,” however, because some class members (particularly employees eligible for benefits only for one or two months) would not have elected to receive health insurance and pay the employee’s share of the cost. Indeed, the parties stipulated that some class members suffered no monetary damage.⁸ The State is entitled to demonstrate how many at trial.

The trial court avoided *Sitton* by reasoning that liability was “skipped over” in that case, while here “we haven’t skipped over anything [because] we know that some of the members of the class in fact didn’t get their benefits.”⁹ But in the same ruling, the court also held that there were “huge factual issues” regarding whether all class members would have opted for coverage, or instead waived a right to PEBB health insurance. Individuals who would have waived coverage cannot establish any actual damage caused by the State. Both waiver and fact of damage were “skipped over” when the court rejected an individualized claims process.

⁸ See Ex. 2 to Motion for Discretionary Review.

⁹ Ex. 1 to Motion for Discretionary Review at 20:3 to 21:24 (emphasis added).

The trial court held, without any evidence or support in the law, that persons without health insurance may have suffered “impacts” in the form of deferred health care. Plaintiffs offered no evidence that any class member suffered monetary loss from deferred care (or any other actual damages), and the trial court foreclosed the State from defending on the basis that at least some portion of the class did not defer any medical care during the period they were eligible for benefits. Some unquestionably were healthy throughout the short time they were entitled to insurance. Unless they paid for health care or substitute insurance, they suffered no harm, and certainly no monetary harm compensable under (23)(b)(3). As in *Sitton*, defendant’s due process rights were violated by the trial court’s presumption that all class members suffered damage caused by defendant.

Plaintiffs assert that an individualized claims process would be “unmanageable”—the same argument made by plaintiffs in *Sitton*. The Court of Appeals rejected the argument there,¹⁰ and should reject it here.

¹⁰ *Sitton* stated:

It is true that management of any complex class action with significant individual issues is likely to be a challenge. [H]owever, the trial court has a variety of tools available to deal with these challenges. As illustrative examples, the court can make use of special masters to preside over individual causation and damages proceedings. . . . Or the court could certify subclasses . . . or even decertify the class altogether after the [liability] phase, and give notice to class members concerning how to proceed on individual damage claims.

Id. at 259-60.

B. The Trial Court Erred in Not Requiring Actual Monetary Damage by Each Class Member

The majority of courts that have addressed the proper measure of damage for wrongful denial of health insurance have required actual monetary damage in the form of an employee's out-of-pocket expenses, rejecting a "premium" measure of damage. *United States v. City of New York*, 847 F. Supp.2d 395, 409 (E.D.N.Y. 2012). This is the approach taken by the Ninth Circuit, *Galindo v. Stoodly Co.*, 793 F.2d 1502, 1517 (9th Cir. 1986) and the Western District of Washington, *E.E.O.C. v. Northwest Airlines*, 1989 WL 168009 at *16 (W.D. Wash. 1989). Plaintiffs cite to a few cases applying the minority rule, but none involved an aggregate award of damages to a CR 23(b)(3) class that includes members who undisputedly had no monetary damage.

Contrary to plaintiffs' argument, the Washington Supreme Court in *Cockle* has not "expressly held the employer premium represents the 'value' of the benefit to the employee." There, the Court decided the issue of "whether the value of employer-provided health coverage is included in the basis used to calculate workers' compensation payments under RCW

51.08.178.” 142 Wn.2d at 805. The parties stipulated that premiums fairly reflected the value of health insurance. *Id.* at 821, n. 10.¹¹ Labeling benefits as part of “wages” for purposes of workers’ compensation does not address the question of how to value lost benefits.

The other case relied on by plaintiffs for the premium measure of damages, *Bates v. City of Richland*, 112 Wn. App. 919, 51 P.3d 816 (2002), also did not decide the issue; that case was an action by retired police officers for pensions calculated under a particular pension system. Considering whether the successful plaintiffs were entitled to attorney fees under RCW 49.48.030, the Court held that they were, since pensions are “deferred compensation for work performed.” *Id.* at 940.¹²

The trial court here stated, without citing to any authority, that “[t]here’s plenty of federal cases indicating that it’s perfectly appropriate in this kind of class action to look at the plaintiffs in aggregate, not individually.”¹³ The issue, however, is not whether aggregate relief may be authorized in class actions, but whether such relief is proper here, where plaintiffs seek monetary damage in a CR 23(b)(3) class action, yet

¹¹ Thus, *Cockle’s* use of language from the dissent in *Morrison-Knudsen Constr. Co. v. Dir., Office of Workers’ Comp. Programs*, 461 U.S. 624, 642-43 (1983), decided under the federal Longshore and Harbor Workers’ Compensation Act, is dicta.

¹² Bates noted that court had interpreted “wages or salary owed” to include “back pay, front pay, commissions, and reimbursements for sick leave,” but did not mention health insurance. 112 Wn. App. at 940.

¹³ Ex. 1 to Motion at 40.

an indeterminate and potentially large number of plaintiffs undisputedly suffered no monetary damage. A recovery based on plaintiffs' damages methodologies clearly would include an undeserved windfall to the class.

C. The State Provided Ample Evidence that Plaintiffs' Damage Methodologies Are Inaccurate and Unreliable

Plaintiffs make the bogus assertion that the State "did not dispute" the testimony of plaintiffs' experts, David Wilson and Susan Long, regarding the alleged accuracy of plaintiffs' damage methodologies and the "highly error-prone" results of the individual claim process requested by the State.¹⁴ In fact, the record clearly demonstrates fact issues regarding the competing damages methodologies. The State's damage experts pointed out numerous material deficiencies in plaintiffs' analysis, and testified to the need for individualized damage determinations.¹⁵

Forensic accountant Steve Ross, a damages expert for the State, submitted several declarations in response to the Wilson declarations, demonstrating how the individualized review process proposed by the State would lead to a more accurate determination of the fact and amount

¹⁴ Answer to Motion for Discretionary Review at 7, 1, respectively.

¹⁵ For example, Mr. Ross testified: "To derive a reasonable estimate of actual economic damages for the *Moore* class, it is necessary to undertake individualized assessment of both the individual's actual eligibility for employer-provided health care benefits as well as any out-of-pocket expenditures incurred to secure replacement coverage and/or procure health care services in periods when it can be reliably established that State benefits were improperly denied." Declaration of Stephen C. Ross Re: Measure of Damages (9/28/12) at ¶ 22, Ex. A to this Reply.

of class members' damages than one of the aggregate damages approaches that plaintiffs propose.¹⁶ Mr. Ross stated, in part:

[The damages approach advocated by Plaintiffs will result in a significant overstatement of the economic loss suffered by the actual *Moore* class. . . . Plaintiffs' approach would make the State liable for significant damages without establishing that the damages were actually caused by actions of the State. . . . To derive a reasonable estimate of actual economic damages for the *Moore* class, it is necessary to undertake individualized assessment of both the individual's actual eligibility for employer-provided health care benefits as well as any out-of-pocket expenditures incurred to secure replacement coverage and/or procure health care services in periods when it can be reliably established that State benefits were improperly denied.¹⁷

Mr. Ross then described in detail the specific shortcomings in Mr.

Wilson's proposed damages methodologies that render them inaccurate.¹⁸

Furthermore, Dr. Roger Feldman, a nationally-prominent health care economist, testified for the State that the demographics of the class differ materially from the demographics of the employees who received State-funded health insurance, particularly with regard to younger class

¹⁶ Mr. Ross specifically references and rebuts the testimony of Mr. Wilson in his Declaration of Stephen C. Ross Re: Measure of Damages, dated Sept. 28, 2012, Ex. A to this Reply; his Second Declaration dated October 5, 2012, Ex. 4 to the State's Motion for Discretionary Review; and his most recent declaration dated January 18, 2013, Ex. B to this Reply.

¹⁷ Declaration of Stephen C. Ross (9/28/12) at ¶¶ 12-22, Ex. A to Motion for Discretionary Review.

¹⁸ For example, Mr. Ross pointed out that each approach multiplied the total number of months in which class members were allegedly denied insurance, by the premium paid for PEBB subscribers, but that each of these inputs was faulty: the number of class members and months was materially overstated, and premium approach ignored whether all class members suffered any damage during the relevant period (among other shortcomings). *Id.* at ¶¶ 23-34.

members who were much more likely to have waived coverage.¹⁹ Those who would have opted out of coverage can claim no damage attributable to the State. Dr. Feldman also testified that the use of employer premiums to calculate class members' damages would not be an accurate measure of actual loss, because premiums include insurance carriers' administrative costs and profits, which can be as much as 40% of the premium.²⁰

Plaintiffs fail to disclose that the Long Declaration was submitted in response to the State's Motion for Leave to Conduct Discovery in the form of a survey, and that the State ultimately agreed to forego the survey because plaintiffs stipulated to the fact that the survey would have established – that some class members incurred no damage as a result of the State's conduct.²¹ Mr. Boedecker's declaration did not concede that an individual claims process was “not feasible,” and pointed out mistaken assumptions underlying Dr. Long's declaration.²² Plaintiffs' assertions that the State conceded “inaccuracies” of its approach are unsupported.

III. CONCLUSION

For the reasons stated herein and in the State's opening brief, the State respectfully requests that discretionary review be accepted.

¹⁹ See Feldman Decl. (1/18/13) at ¶¶ 4-6, Ex. C to this Reply.

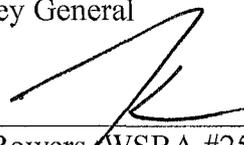
²⁰ *Id.* at ¶ 8.

²¹ Motion for Discretionary Review, Ex. 2.

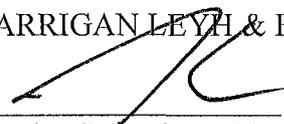
²² Declaration of Stefan Boedecker (8/24/11) at ¶¶ 2-7, Ex. D to this Reply.

DATED this 14th day of February, 2013.

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CERTIFICATE OF SERVICE

I, Linda Bledsoe, swear under penalty of perjury under the laws of the State of Washington to the following:

1. I am over the age of 21 and not a party to this action.
2. On the 14th day of February, 2013, I caused the preceding

document to be served on counsel of record in the following manner:

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LINDA BLEDSOE

EXHIBIT A

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The Honorable Catherine Shaffer
Friday, October 26, 2012
With Oral Argument at 10:00 a.m.

**STATE OF WASHINGTON
KING COUNTY SUPERIOR COURT**

DOUGLAS L. MOORE, MARY CAMP,
GAYLORD CASE, and a class of similarly
situated individuals,

Plaintiffs,

v.

HEALTH CARE AUTHORITY, STATE
OF WASHINGTON,

Defendants.

NO. 06-2-21115-4 SEA

DECLARATION OF STEPHEN C. ROSS
RE: MEASURE OF DAMAGES

I, STEPHEN C. ROSS, am over the age of 18, base this declaration on
personal knowledge, and am competent to make this declaration.

Introduction

1. I have been designated by the Defendants as a testifying expert in this litigation
("Moore"). I have personal knowledge of the facts set forth herein and have been asked by
the State of Washington to offer my opinions with respect to the matters discussed in this
declaration.

1 putative *Moore* class for the purpose of providing notice of this lawsuit (the “notice class
2 queries”). I understand the query specifications have been vetted with counsel for the
3 Plaintiffs.

4 9. As of the date of this declaration, the notice class queries have generated a
5 putative *Moore* class list in excess of 31,000 individuals comprising approximately 202,000
6 months of “apparent” eligibility for employer-provided PEBB health benefits which were not
7 received.

8 10. I have reviewed the output from these queries and have concluded that similar
9 to the liability phase class list, the notice class query results materially overstate the actual
10 *Moore* class and the potential months for which class members may have been eligible for,
11 but did not receive, the employer contribution for PEBB health benefits. Again, this is a
12 result of the limitations inherent in performing the analysis of eligibility solely based on
13 electronic payroll and benefits data.

14 11. The issues are discussed in further detail in paragraphs 35 to 65 below.
15

16 Issues Addressed in this Declaration

17 12. I have been asked to review Plaintiffs’ proposed approach to estimating class-
18 wide damages in this litigation and render opinions regarding whether the proposed approach
19 is likely to provide a reasonable basis for estimating the actual economic loss experienced by
20 *Moore* class members who were improperly “*denied health care benefits.*”³
21
22
23
24

25 ³ To have been improperly “*denied health care benefits*” (a prerequisite for inclusion in the *Moore* class by
26 virtue of the clarified class definition) requires that an employee was actually eligible for employer-provided health insurance.

1 Summary of Opinions

2 18. As discussed in the remainder of this declaration, while Plaintiffs' proposed
3 approach clearly is simplistic and can be implemented quickly, it produces a measurement of
4 damages that is arbitrary, speculative and divorced from the specific economic circumstances
5 of each member of the *Moore* class. Plaintiffs' formulaic "one size fits all" approach
6 bypasses proof of the *fact of damage* for each individual class member and fails to establish
7 the *amount of damage* for each individual class member with reasonable certainty.

8 19. Plaintiffs' approach unreasonably assumes that every class member suffered
9 harm, every claim is valid and that all class members have been damaged *in exactly the same*
10 *amount* for each respective month without employer-provided health coverage.

11 20. Moreover, the damages approach advocated by Plaintiffs will result in a
12 significant overstatement of the economic loss suffered by the actual *Moore* class. It would
13 result in damage awards inapposite to the value of individual class member's valid claims
14 and an aggregate award quantified without regard to the class' actual loss. Plaintiffs'
15 approach will not provide a reasonable basis for estimating the actual economic loss
16 experienced by those *Moore* class members who can establish that they were improperly
17 "*denied health care benefits.*"

18 21. Plaintiffs' approach would make the State liable for significant damages without
19 establishing that the damages were actually caused by the actions of the State. It would
20 result in an award of damages without regard for whether the injured parties were put in the
21 same economic position they would have been but for the breach (in this instance the failure
22 to provide the employer contribution for health benefits). As a consequence, it will not result
23 in a reasonable estimate of actual economic damages.

24 22. To derive a reasonable estimate of actual economic damages for the *Moore*
25 class, it is necessary to undertake individualized assessment of both the individual's actual
26

1 eligibility for employer-provided health care benefits as well as any out-of-pocket
2 expenditures incurred to secure replacement coverage and/or procure health care services in
3 periods when it can be reliably established that State benefits were improperly denied.
4

5 **Shortcomings in Plaintiffs' Proposed Approach**

6 23. Plaintiffs propose a simple damages model with just two inputs. For simplicity,
7 I refer to the inputs as "X" and "Y," whereby, for each calendar year:

- 8 (a) X represents the total number of class members and respective months
9 in which each was allegedly denied employer-provided health insurance
10 (currently represented by the notice class lists); and
11 (b) Y represents the State's monthly weighted average composite cost to
12 provide medical and dental benefits to covered PEBB subscribers for
13 that year in the class period.

14 24. Under Plaintiffs' proposed approach, for each year X is multiplied by Y to
15 derive "Z." The sum of Z for each year represents "aggregate class-wide damages."

16 25. There are two fundamental shortcomings in the scheme espoused by Plaintiffs.

17 26. First, the *Moore* class and total number of months in each calendar year in
18 which each individual was actually eligible for employer-provided health insurance as
19 represented by the current notice class lists (the X variable) is materially overstated. The
20 reasons why the notice class lists are overstated are discussed in paragraphs 35 to 65 below.

21 27. Accurate identification of those individuals who were actually "*denied health*
22 *care benefits*" and the specific months for which benefits were improperly denied (data
23 required to derive the true value of X) requires individualized assessment of electronic
24 payroll and health benefits data as well as extrinsic data and documentation for each putative
25 class member.
26

1 28. The first test necessary to establish the *fact of damage* requires that an employee
2 actually have been eligible for and improperly “*denied health care benefits.*” This cannot be
3 established reliably solely from electronic payroll and benefits data. It requires
4 individualized assessment.

5 29. Second, Plaintiffs’ reliance on the State’s monthly weighted average composite
6 cost to provide medical and dental benefits to covered PEBB subscribers (the Y variable) as a
7 proxy for actual damages disregards entirely the economic circumstances of each eligible
8 class member. For periods when it can be established that a class member actually was
9 eligible for and improperly denied employer-provided health insurance, Plaintiffs’ approach
10 ignores whether class members:

- 11 (a) Procured comparable replacement insurance, and if so at what cost;
- 12 (b) Were covered by another non-collateral State funded insurance;
- 13 (c) Were covered as a spouse or dependent under another (non-State)
14 employer’s policy;
- 15 (d) Incurred out-of-pocket expenses for health care and if so, in what
16 amount; and/or,
- 17 (e) Incurred expenditures that would have been a covered expense under the
18 relevant PEBB policy.

19 30. If the individual did procure replacement insurance or incur costs for health care
20 services, it would be necessary to deduct the costs that would have been incurred for health
21 care services (for example the subscriber contribution) had insurance been provided by the
22 State to derive a proper measure of damages.

23 31. These issues are foundational to the *amount of damages* that class members may
24 have sustained. To derive a reasonable basis to estimate actual economic damages requires
25 individualized assessment of the actual circumstances of each eligible class member.
26

1 32. Furthermore, the State's monthly weighted average composite cost is based on
2 the historical mix of premium expenditures paid by the State across all plans and tiers of
3 coverage. This includes the State's self-insured plan (the Uniform Medical Plan, "UMP")
4 and plans offered by various insurance carriers. Insurance premiums paid by the State are
5 priced in an attempt to predict the collective cost of medical care of the insured group, as
6 well as insurer costs, taxes, risk reserves, overhead and profit and other factors unrelated to
7 the predicted cost of medical care. The metric used by Plaintiffs as the measure of damages
8 is an "ex ante" estimate considering information known and available at the time the
9 forecasts were made (2003-2009). Moreover, the estimate includes elements unrelated to
10 expected health care costs of the insured group. It does not represent the composite amount
11 the insurers *paid* to cover health care claims of the covered pool. Given that damages are
12 being quantified in 2012, outcomes can be determined "ex post" based on what actually
13 occurred, including any mitigation efforts. To the extent eligible members of the class
14 obtained replacement insurance coverage or funded out-of-pocket health care expenditures,
15 these costs have been incurred. In my experience as a damages expert, the use of data and
16 information pertinent to what actually occurred generally results in the best estimate of
17 damages. This approach is favored by many practitioners and courts because it "*offers the*
18 *only means of putting plaintiffs in the same position they would have been in but for the*
19 *unlawful act.*"⁷ Using the information pertinent to what actually occurred will result in a
20 reasonable measurement of damages and militate against circumstances whereby class
21 members are grossly over or under compensated by use of the formulaic "one size fits all"
22 approach advocated by Plaintiffs.
23
24
25

26 ⁷ Litigation Services Handbook, The Role of the Financial Expert, Fourth Edition, 2007, ¶8.4 (a) (iii)

1 33. Even if it was appropriate to use a proxy for class members' actual damages, the
2 State's monthly weighted average composite cost advocated by Plaintiffs materially
3 overstates class-wide damages for the following reasons:

4 (a) It is based on all tiers of coverage (subscriber, subscriber/spouse,
5 subscriber/children, subscriber/spouse/children) rather than subscriber
6 only. I understand that damages in this lawsuit are limited to those
7 suffered by subscribers. The data reflect that health care expenditures
8 (and insurance premium costs) are considerably higher for
9 subscriber/dependant(s) than for subscriber only.

10 (b) It does not account for the demographic differences between the *Moore*
11 notice class and the covered PEBB subscribers. Based on preliminary
12 data I have analyzed, the *Moore* notice class is considerably younger
13 than the population of the PEBB enrolled group.

14 (c) This is relevant because younger individuals are generally healthier and
15 have lower health care expenses than older individuals.⁸ All else equal,
16 a younger insured population will incur less health care costs than an
17 older population. Based on input from Milliman, Inc. (the HCA's
18 actuarial consultant), the demographic differences between the *Moore*
19 notice class and the PEBB covered group are considered actuarially
20 "significant, to extreme" and would be expected to have a "substantial
21 and material impact" on the composite cost of health insurance versus
22 the PEBB covered group.⁹ Because the State's monthly weighted
23 average composite cost is based on the expected health care
24

25 ⁸ Plaintiffs' expert acknowledges this point. See Declaration of David Wilson, September 13, 2012, Pg 8,
footnote 4.

26 ⁹ Interview of Mr. Troy Pritchett, Consulting Actuary, Milliman, Inc.

1 expenditures of an older population, it is not a reasonable proxy to
2 estimate the health care costs of the *Moore* notice class. Dr. Feldman,
3 the State's health care expert, has reached similar conclusions on this
4 issue.¹⁰

5 (d) Although Mr. Wilson states that he "*could easily adjust the premium or*
6 *estimated health care costs to take into account any material differences*
7 *in demographics when calculating the aggregate loss to the class,"* he
8 has not articulated how this would occur. Based on my understanding of
9 the issues, any such adjustments would involve voluminous data and
10 complex calculations.¹¹ This point was confirmed both by Dr. Feldman
11 in his second declaration (at paragraph 9) and in my discussions with
12 Milliman, Inc.

13 (e) The health care premiums paid by the State are based on bids prepared
14 by each insurer that consider numerous factors and assumptions.
15 Certain of these factors relate to claims history and some do not. For
16 example, the premium includes ancillary components such as: existing
17 claims cost; amounts set aside for payment of subrogation claims;
18 estimated amounts to cover projected trends in medical and dental costs;

19 ¹⁰ Second Declaration of Roger Feldman, PhD. September 26, 2012, ¶¶6, 7.

20 ¹¹ Adjusting the State's historical composite cost for insurance for demographic differences in the *Moore* class
21 versus the enrolled PEBB subscribers would be a very data-intensive and complex undertaking and likely
22 subject to numerous unknowns. For example, it would first require that the *Moore* class and months of actual
23 eligibility be determined. As discussed elsewhere in this declaration, and in my previous declarations, this
24 requires individualized assessments of both payroll data and other extrinsic documentation for each member
25 of the *Moore* notice class. Once the class was reliably identified, the demographic characteristics of the class
26 would also need to be determined. Variables such as health status would need to be incorporated. If damages
were determined by the Court to extend beyond the subscriber (i.e., to include spouses and children),
presumably it would be necessary to compile demographic data for these individuals as well. It would also
be necessary to forecast the class coverage tier distribution (subscriber, subscriber/spouse,
subscriber/children, subscriber/spouse/children) as this would influence the composite cost of insurance.
Then this data would need to be incorporated into the State's existing actuarial models for each relevant year
of the class period (2003 to 2012) so that adjusted rates reflecting the demographic makeup of the class could
be quantified.

1 make-up factors (amounts to offset previous shortfalls or benefits
2 received but not rated); demographic changes; amounts for investment
3 in new technology and construction, when applicable; projected insurer
4 costs including administrative overhead, salaries, advertising, utilities,
5 etc.; assessments payable to the Washington High Risk Insurance Pool
6 and federal taxes charged for each insurance carrier premium; estimates
7 for the cost of government mandated plan changes; risk reserves for
8 incurred, but unpaid claims and in the event plan costs exceed
9 projections; and, recovery of insurer overhead and profit.¹² Premiums
10 for the State's self-insured program (UMP) include amounts to
11 compensate the Plan's third-party administrator.¹³ Furthermore, the
12 final contracted premium is negotiated with the insurer and thus reflects
13 various commercial considerations, market factors and related issues.
14 To determine the actual portion of the premium cost that relates to the
15 actuarial cost of health care (the proxy used by Plaintiffs for "uncovered
16 health care costs") requires that the elements not directly related to the
17 actuarial cost of health care be deducted. As Dr. Feldman opined, "*these*
18 *cost items will vary for each insurance company and potentially for each*
19 *type of coverage and policy contract. Profit margins, for instance can*
20 *vary greatly based on plan design, demographics, and many other*
21 *factors.*"¹⁴ Adjusting for these factors would be a significant and
22 complex undertaking as it would be necessary to perform an analysis for
23 each plan offered by each insurer for each tier of coverage for each year
24

25 ¹² Declaration of Kim Grindrod, September 28, 2012, ¶9-12.

26 ¹³ Declaration of Kim Grindrod, September 28, 2012, ¶7.

¹⁴ Second Declaration of Roger Feldman, PhD. September 26, 2012, ¶10

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in the class period. Failure to make this adjustment would result in an overstatement of damages. Again, Mr. Wilson does not articulate how such adjustments would be incorporated into his damages approach.

(f) Because it ignores the actual circumstances of each eligible class member, Plaintiffs' formulaic "one size fits all" method will necessarily result in a windfall for those with limited or no expenditures while under-compensating those with significant out-of-pocket costs.

34. Under Plaintiffs' proposed approach, the actual values of the X and Y variables are currently unknown. The current *Moore* notice class list materially overstates both the actual class members and the actual months of eligibility. The values proposed by Plaintiffs as a proxy for damages for each month of omitted coverage are materially overstated and unrelated to the actual damages each class member may have suffered. Therefore, the resulting class-wide damages estimation (Z) is unreasonable and speculative as a measure of damages.

The Need for Individualized Assessment of PEBB Eligibility

35. In my previous declarations, I described in considerable detail why a reliable identification of actual class members and the months of actual eligibility for the employer contribution for PEBB health benefits necessarily requires individualized assessment of employment documentation and information (extrinsic data), in addition to analysis of the electronic payroll and health benefits data.

36. To highlight some of the issues, I previously provided 31 examples (relating to the Court's liability phase class definition) that demonstrate how reliance solely on the

1 | electronic payroll and health benefits data leads to an incorrect presumption of class member
2 | eligibility for the employer contribution for PEBB health benefits, in whole or in part.¹⁵

3 | 37. In short, it is impossible to develop computer queries that will accommodate all
4 | the potential eligibility scenarios without generating a significantly overly-inclusive dataset.
5 | Moreover, by its nature, the electronic payroll and health benefits data is not a complete
6 | record of information that is critical to determining PEBB health benefits eligibility, and
7 | hence potential inclusion in the *Moore* class. It was never intended to serve that function.
8 | Finally, electronic payroll and health benefits data will not provide objective information
9 | regarding the employee's actual work circumstances. The data relied upon is limited to hours
10 | worked and whether PEBB health benefits were provided or waived (to the extent the
11 | information is recorded accurately in the data). As such, it is necessary to undertake
12 | individualized assessments to determine whether an employee has in fact met the eligibility
13 | criteria by examining other extrinsic data including employee personnel records, human
14 | resources records and, at times, input from payroll, human resources and/or managerial
15 | personnel at the employing agencies.

16 | 38. Although the class definition used to generate the *Moore* notice class has been
17 | clarified by agreement of the parties, these issues remain, and in certain respects have
18 | become even more acute.

19 | 39. To accommodate every possible eligibility scenario for the purposes of
20 | identifying the *Moore* notice class, it was necessary to specify very broad parameters for the
21 | "decision rules." Accordingly, the *Moore* notice class "net" has been widely cast.

22 | 40. As an example, the Agreed Order Clarifying Class Definition defines Career
23 | Seasonal/Instructional Year Employees as:
24 |
25 |

26 | ¹⁵ See Ross declaration dated November 10, 2011 and accompanying Exhibits 2-32.

1 *“Persons who worked: a) an average of at least half-time over a nine, ten or eleven*
2 *month working season with some hours worked in each month of the season; b)*
3 *followed by a three, two or one month off-season, respectively, in which the person did*
4 *not work; c) followed by a return to work in the same position as demonstrated by some*
5 *hours worked in the first month of the second season, and d) who were denied health*
6 *care benefits.”*

7 41. However, Doug Moore, Plaintiffs’ representative for the career seasonal
8 category of employees, at times worked at the Horse Racing Commission in the “off season”
9 in a different position from that in his “working season.” Therefore, “decision rules” which
10 require no work in the off season (consistent with the clarified class definition) would
11 exclude Doug Moore from the class. They would also exclude part-time faculty who elected
12 to work in the summer quarter/semester or other “off season” period. To accommodate these
13 circumstances, the “decision rules” for the *Moore* notice class allow employees to work year
14 round without any limitation on the number of hours worked during the “off season”. As
15 would be expected, this results in many individuals ostensibly “meeting” the overly broad
16 definition of “Career Seasonal/Instructional Year Employees” who in fact are not.

17 42. Furthermore, the clarified class definition requires that the employee continue
18 employment “in the same position” to qualify for benefits as a career seasonal/instructional
19 year employee. In my first declaration I discussed the many challenges involved in
20 determining whether in fact an employee continued to work “in the same position” based
21 solely on the electronic payroll data.¹⁶ These same challenges and limitations exist with the
22 *Moore* notice class. At present, the requirement that the employee continue employment “in
23 the same position” has not been imposed in the “decision rules” because it cannot be
24 objectively and reliably determined from the electronic payroll data. However, to establish
25

26 ¹⁶ See Ross declaration dated November 10, 2011, paragraphs 71-78.

1 actual eligibility for PEBB health benefits (and inclusion in the *Moore* class) it is necessary
2 to determine whether the employee continued employment “in the same position.” This
3 issue is also germane to determining eligibility for the non-permanent employee
4 classification. Again, this requires individualized assessment of extrinsic data.

5 43. The electronic payroll and health benefits data does not contain any field or
6 indicator to identify career seasonal employees consistent with the WACs or the clarified
7 class definition. Therefore, it is necessary to identify these personnel through individualized
8 assessment of extrinsic data. Eligibility cannot be determined reliably solely based on
9 computer queries of electronic payroll and health benefits data.

10 44. Another example involves individuals who, based upon computer queries of the
11 electronic payroll and benefits data, “appear” to meet the clarified class definition of both a
12 non-permanent employee as well as a career seasonal/instructional year employee. However,
13 an employee cannot be both a non-permanent employee as well as a career
14 seasonal/instructional year employee in accordance with clarified class definition at the same
15 time.

16 45. To illustrate, included within the notice class is an employee identified as
17 having 18 months of “apparent” eligibility (February 2005 – July 2006). As set out in the
18 table below, these 18 months are derived as the union of: 1) 11 months of “apparent”
19 eligibility resulting from the application of the non-permanent employee query specifications
20 (September 2005 – July 2006) and 2) 12 months of “apparent” eligibility resulting from the
21 application of the non-faculty career seasonal employee query specifications (February 2005
22 – January 2006).

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Month	Non-Permanent Employee	Non-Faculty Career Seasonal Employee	Class Notice Eligibility (Union)
February 2005	No	Yes	Yes
March 2005	No	Yes	Yes
April 2005	No	Yes	Yes
May 2005	No	Yes	Yes
June 2005	No	Yes	Yes
July 2005	No	Yes	Yes
August 2005	No	Yes	Yes
September 2005	Yes	Yes	Yes
October 2005	Yes	Yes	Yes
November 2005	Yes	Yes	Yes
December 2005	Yes	Yes	Yes
January 2006	Yes	Yes	Yes
February 2006	Yes	No	Yes
March 2006	Yes	No	Yes
April 2006	Yes	No	Yes
May 2006	Yes	No	Yes
June 2006	Yes	No	Yes
July 2006	Yes	No	Yes
Count	11 months	12 months	18 months

46. Months of “apparent” eligibility that are duplicated in the results of different queries (September 2005 – January 2006 in this example) are counted once. Hence, the union of the queries results in 18 months of “apparent” eligibility.

47. Queries of the electronic payroll and benefits data alone will not allow a reliable determination of whether the individual should be categorized as career seasonal/instructional year class members, non-permanent class members or neither. It is necessary to consider other extrinsic data through individualized assessment. The actual work circumstances of each such employee would need to be evaluated based on extrinsic documentation.

48. In this example, it does not appear that the “apparent” eligibility should be 18 months. It would be 11 months if the extrinsic data indicates the individual was a non-

1 permanent employee, or 12 months if the extrinsic data indicates the individual was a career
2 seasonal employee.^{17, 18}

3 49. Moreover, in reaching the agreements leading to the clarified class definition,
4 the parties agreed that “*there remain issues that may affect whether any person falls within*
5 *the clarified class definition and, if so, whether any particular class member is entitled to*
6 *relief. These include but are not limited to:*

7 a. *The definition of “half-time” as used in the relevant rule;*

8 b. *Whether an employee must establish and maintain eligibility through*
9 *hours worked in the same position at the same agency;*

10 c. *The proper definition of a termination that requires an employee to*
11 *reestablish eligibility for benefits if he or she later returns to work and the*
12 *nature and sufficiency of the evidence establishing the fact of such a*
13 *termination;*

14 d. *Whether the State is entitled to set-offs and off-sets for persons who meet*
15 *the clarified class definition, but who received health benefits through the Basic*
16 *Health Plan, Medicaid, or any other state-funded program; and*

17 e. *The fact of damages, method for calculating damages, amount of*
18 *damages, and whether the class members are entitled to double damages.”¹⁹*

19 50. The Moore notice class lists have been generated without regard to how these
20 issues might be decided. The outcome / resolution of these issues could materially impact
21
22

23 ¹⁷ Even if it could be demonstrated that the employee transitioned from a career seasonal position to a non-
24 permanent position beginning February 2006, as discussed elsewhere in this declaration, questions then
25 would arise as to whether the employee would be required to reestablish eligibility due to a change of
26 position or termination.

¹⁸ It still would be necessary to consider the extrinsic data to evaluate whether actual eligibility existed during
the 11 or 12 month period.

¹⁹ Agreed Order Clarifying Class Definition, March 29, 2012, ¶3 a. - e.

1 the application of eligibility rules, the determination of the *Moore* class and specific periods
2 of eligibility for PEBB benefits and attendant damages.

3 51. For example, all *Moore* notice class eligibility queries have been run using 80
4 hours per month as the half-time definition (480 hours over six months). However, prior to
5 2010, various agencies used a higher half-time definition, consistent with their internal
6 business practices (for example the State Board of Community and Technical Colleges used
7 87 hours per month, or 522 hours over six months).²⁰ As a consequence of using the 80
8 hours per month half-time definition, the *Moore* notice class queries identify numerous
9 individuals who meet the “apparent” eligibility requirement who would not do so if their
10 eligibility was evaluated based on the contemporaneous half-time definition used by their
11 employer. This issue is compounded by the 8-hour rule, whereby once employees become
12 eligible for benefits, they remain eligible as long as they remain in pay status 8 hours or more
13 each month.

14 52. Similarly, all *Moore* notice class eligibility queries allow “concurrent stacking”
15 and “consecutive stacking” of employment across multiple State employers or within a single
16 employer for the purposes of evaluating potential benefit eligibility. “Concurrent stacking”
17 is holding multiple working positions at the same time while “consecutive stacking” involves
18 moving from one position to another consecutively. Prior to the effective date of RCW
19 41.05.065 (January 1, 2010), the regulations specifically permitted stacking only for part-
20 time faculty. To be eligible for benefits, the regulations required that such faculty notify
21 each employer quarterly, in writing, of the faculty’s multiple employment.²¹ Failure to
22 comply with this requirement barred the employer-provided benefit. There is no requirement
23 for providing written notice in the *Moore* notice class query,²² nor is eligibility based on
24

25 ²⁰ RCW 41.05.065 standardized the half time definition for all State employers at 80 hours per month beginning
January 1, 2010.

26 ²¹ WAC 182-12-115 (5)(d).

²² Establishing whether or not written notice was provided would require review of extrinsic data.

1 stacking limited to part-time faculty prior to 2010. Furthermore, while the 2010 amendments
2 in RCW 41.05.065 allow “concurrent stacking” and “consecutive stacking” for non-
3 permanent and seasonal employees, this is limited to work within one State agency (not
4 multiple employers). There is also an affirmative requirement that the employee notify the
5 employer in writing if they believe they are eligible through stacking.

6 53. Once the issues reserved by the parties have been decided by the Court, or
7 otherwise resolved, it will be necessary to incorporate any resulting modifications to the class
8 definition so that revised analyses of potential class eligibility can be performed. Again, it
9 will be necessary to undertake individualized assessments to evaluate these questions. This
10 can only reduce the size of the *Moore* notice class and months of “apparent” eligibility.

11 54. Finally, while the parties agree that the class does not include “*employees who*
12 *waived health benefits*”,²³ as discussed in my first declaration, there is no single source of
13 electronic data that provides a complete record of waivers. Therefore, to ensure whether in
14 fact an employee might have waived health benefits, it is necessary to undertake
15 individualized assessments of extrinsic documentation for each putative class member.

16
17 **Issues Arising from Sole Reliance on Electronic Payroll and Health Benefits Data**

18 55. To assist in illustrating the continuing issues inherent in reliably indentifying
19 the *Moore* class and actual periods of health benefits eligibility based solely on computer
20 queries of the State’s electronic payroll and health benefits data, attached as exhibits 1
21 through 24 to this declaration are examples extracted from the *Moore* notice class list.²⁴

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25 ²³ Agreed Order Clarifying Class Definition, March 29, 2012, (page 3)

26 ²⁴ As noted earlier, I included 31 examples in my first declaration based on the *Moore* liability phase class definition.

1 56. These examples demonstrate how sole reliance on the electronic payroll and
2 health benefits data can lead to an incorrect presumption of putative class member eligibility
3 for the employer contribution for PEBB health benefits, in whole or in part.

4 57. Each exhibit begins with a brief narrative explaining the issue(s). Behind the
5 narrative is an excerpt from spreadsheets that were developed from query results of the
6 electronic payroll and health benefits data used to develop the *Moore* notice class lists.
7 These examples pertain to potential health benefits eligibility under the non-permanent and
8 career seasonal employee eligibility rules.

9 58. The exhibits are categorized as follows:

- 10 (a) Employees not eligible for health benefits;
11 (b) Issues with identification of career seasonal employees;
12 (c) Definition of half-time employment;
13 (d) Requirement to establish and maintain eligibility in the same job
14 position;
15 (e) Terminations;
16 (f) Unexplained changes in health benefits; and,
17 (g) Further findings based upon extrinsic data.

18 59. Employees not eligible for health benefits: Although work study employees are
19 to be excluded from the class,²⁵ the query specifications utilized for the purpose of class
20 notice do not exclude all such employees. This is because the electronic payroll data does
21 not contain a standard or consistent indicator that can be used to identify work study
22 employees. When the electronic payroll data includes the position / job function, that
23 information sometimes provides an indication.²⁶

24
25 ²⁵ Per Agreed Order Clarifying Class Definition dated March 28, 2012.

26 ²⁶ Examples where the electronic payroll data does not provide such an indication or indicates the position using different nomenclature were set out in my earlier declaration dated November 10, 2011, exhibits 19-24 in particular.

1 60. Issues with identification of career seasonal employees: As discussed at
2 paragraph 41 above, the current non-faculty, career seasonal query specifications utilized for
3 the purpose of class notice do not limit the number of hours that can be worked during the
4 “off season.” As such, the query identifies as career seasonal many more employees than
5 actually worked in career seasonal positions. For example, the query would identify as
6 career seasonal an administrative assistant who worked in a year-round position and
7 averaged more than half-time during a nine month “work season” and also worked more than
8 half-time during the corresponding three month “off season.”

9 61. Definition of half-time employment: This issue is described at paragraph 51
10 above.

11 62. Requirement to establish and maintain eligibility in the same job position: The
12 current query specifications utilized for the purpose of class notice do not require that an
13 employee work in the same job position in order to either establish or maintain eligibility for
14 PEBB health benefits.²⁷ For example, the query would identify as eligible for PEBB health
15 benefits an employee who worked in multiple jobs (at either the same or multiple agencies)
16 for six months or more, and during that time worked less than half-time at each job, but more
17 than half-time in total.

18 63. Terminations: The current query specifications utilized for the purpose of class
19 notice do not require that an employee reestablish eligibility (or restart the establishment of
20 eligibility) for PEBB health benefits when the electronic payroll data indicates a termination
21 occurred. For example, if an employee who was eligible for PEBB health benefits resigned
22 his/her position and the following month began work at a non-permanent position, the query
23 specifications do not require the employee to reestablish eligibility for PEBB health benefits.
24 Instead, the query would identify the employee as immediately eligible for PEBB health

25 _____
26 ²⁷ This is discussed at ¶42 above in respect of career seasonal/instructional year employees and at ¶52 above in
relation to “concurrent stacking” and “consecutive stacking”.

1 | benefits in the non-permanent position. Furthermore, the payroll data does not reflect a
2 | complete record of actual terminations (for certain employers, the payroll data contains no
3 | record of terminations). Therefore it is necessary to undertake individualized assessments to
4 | determine whether and when an employee may have terminated a position.

5 | 64. Unexplained changes in health benefits: The results of the notice class queries
6 | include a number of employees who received PEBB health benefits for a period of time
7 | where the electronic data indicates those benefits then ceased, even though the employee
8 | continued working and, based upon the electronic payroll data, the employee appeared to
9 | meet the requirements for continued benefits. There are a number of possible explanations
10 | for such instances (such as unrecorded waiver, or unrecorded termination and re-hire). To
11 | determine whether such employees improperly were denied health benefits, it would be
12 | necessary to review extrinsic data.

13 | 65. Further findings based on extrinsic data: In my prior declaration, I provided
14 | examples of the additional information and findings that can result from the review of the
15 | relevant agency's extrinsic data. I reviewed the notice class query results for a sample of
16 | those individuals and my view is unchanged that such further inquiry and investigation is
17 | needed to reliably identify the class members and the months for which each person is
18 | eligible for health benefits.

19 |
20 | **The Need for Individualized Assessment of Damages**

21 | 66. If, after individualized assessment with respect to potential eligibility, an
22 | individual is determined to have been improperly denied health benefits in certain months of
23 | employment, it is then necessary to assess whether and to what extent the individual suffered
24 | any loss as a consequence. As noted above, this includes determining whether such class
25 | members:
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- (a) Procured comparable replacement insurance, and if so at what cost;
- (b) Were covered by another non-collateral State funded insurance;
- (c) Were covered as a spouse or dependent under another (non-State) employer's policy;
- (d) Incurred out-of-pocket expenses for health care and if so, in what amount; and/or,
- (e) Incurred expenditures that would have been a covered expense under the relevant PEBB policy.

67. If the individual did procure replacement insurance or incur costs for health care services, it would be necessary to deduct the costs that would have been incurred for health care services (for example the subscriber contribution) had insurance been provided by the State to derive a proper measure of damages.

68. This can only be reliably accomplished based on individualized assessment of extrinsic data for each class member.

DATED this 28th day of September 2012 in Seattle, WA.



STEPHEN C. ROSS

EXHIBIT B

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The Honorable Catherine Shaffer

STATE OF WASHINGTON
KING COUNTY SUPERIOR COURT

DOUGLAS L. MOORE, MARY CAMP,
GAYLORD CASE, and a class of similarly
situated individuals,

Plaintiffs,

v.

HEALTH CARE AUTHORITY, STATE
OF WASHINGTON,

Defendants.

NO. 06-2-21115-4 SEA

DECLARATION OF STEPHEN C. ROSS
IN SUPPORT OF STATE'S RESPONSE
RE: CERTIFICATION OF CONTRACT
CLAIMS

I, STEPHEN C. ROSS, am over the age of 18, base this declaration on
personal knowledge, and am competent to make this declaration.

Introduction

1. I have been designated by the Defendants as a testifying expert in this litigation
("Moore"). I have personal knowledge of the facts set forth herein and have been asked by
the State of Washington to offer my opinions with respect to the matters discussed in this
declaration.

- 1 (c) Demographic (age and gender) data as available for personnel included
2 in the *Moore* notice class query for the period June 2000 through May
3 2003;
- 4 (d) Demographic (age and gender) and health care plan enrollment data for
5 the group of State employees who were enrolled in medical benefits
6 under PEBB for the period 2000 through 2003; and
- 7 (e) Data extracts from the *Moore* notice class query for the period June
8 2000 through May 2003.
- 9

10 Response to the Wilson Declaration

11 6. Inherent in the approach espoused by Mr. Wilson is the assumption that “*the*
12 *class for the contract claim here is large enough from a statistical standpoint that the overall*
13 *distribution of omitted employees to each plan and tier of coverage in each calendar year*
14 *would have been approximately the same for the class as it was for the State employees who*
15 *received health benefits*”. Wilson Dec., ¶10. Mr. Wilson states his understanding that
16 “*between June 2000 and May 2003 there were potentially 16,459 class members who did not*
17 *receive health benefits when they were eligible.*” Wilson Dec., ¶7.

18 7. The 16,459 potential “class members” cited by Mr. Wilson were identified
19 using the *Moore* notice class queries. As I explained in my earlier declarations, the *Moore*
20 notice class queries substantially overstate both the individuals and the months for which
21 they were actually eligible for, and wrongly denied, health benefits.²

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25 _____
26 ² The reasons the *Moore* Notice Class list is overbroad are discussed in detail in my declarations dated
September 28, October 5, and October 21, 2012.

1 individuals in the “*Moore* BoC class” to similar data for the group of State employees
2 enrolled to receive medical benefits under PEBB in the relevant period (“PEBB-enrolled
3 group”).⁴

4 13. Demographic (age and gender) data for both the “*Moore* BoC class” and the
5 PEBB-enrolled group of employees was provided by HCA. The ages of both populations
6 was benchmarked at January of each year.^{5,6}

7 14. Of the 16,459 individuals in the “*Moore* BoC class”, 12,608 had “apparent
8 eligibility” during some or all of the period June 2000 through May 2003 only. In other
9 words, assuming they are proven to be actual class members, these persons have a claim only
10 under Plaintiffs’ breach of contract theory. The remaining 3,851 also had “apparent
11 eligibility” in subsequent periods and thus have both a contract and statutory claim (again
12 assuming they are proven to be class members). For the purposes of this comparison, I was
13 asked to present the data under two scenarios. Scenario 1 includes all 16,459 individuals in
14 the “Entire *Moore* BoC class”. Scenario 2 includes the 12,608 individuals with “apparent
15 eligibility” during some or all of the period June 2000 through May 2003 only (“BoC only
16 class”).⁷

17 The data with respect to relative age for Scenario 1 is summarized in Charts A and B
18 below:

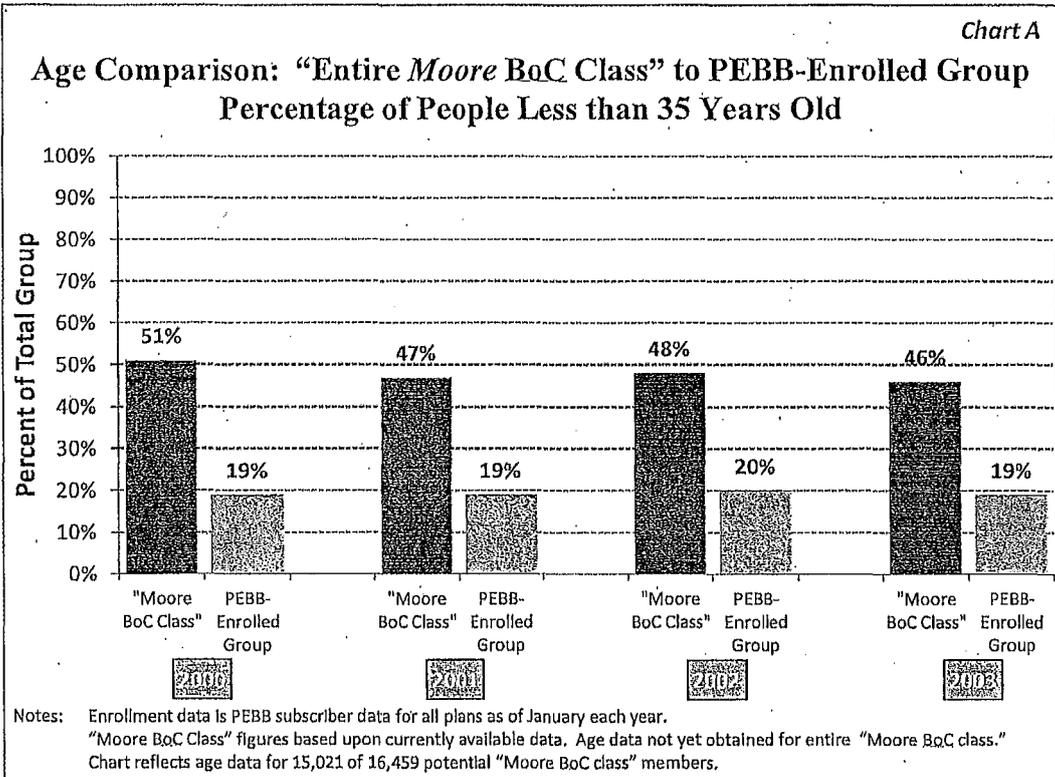
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23 ⁴ For ease of reference, I refer to the 16,459 individuals identified through the application of the *Moore* notice
class queries as the “*Moore* BoC class”. This is not intended to suggest that this group in any way represents
the individuals who were eligible for, and wrongly denied benefits (the actual *Moore* class).

24 ⁵ Age and gender information was available for 15,021 of the 16,459 (91%).

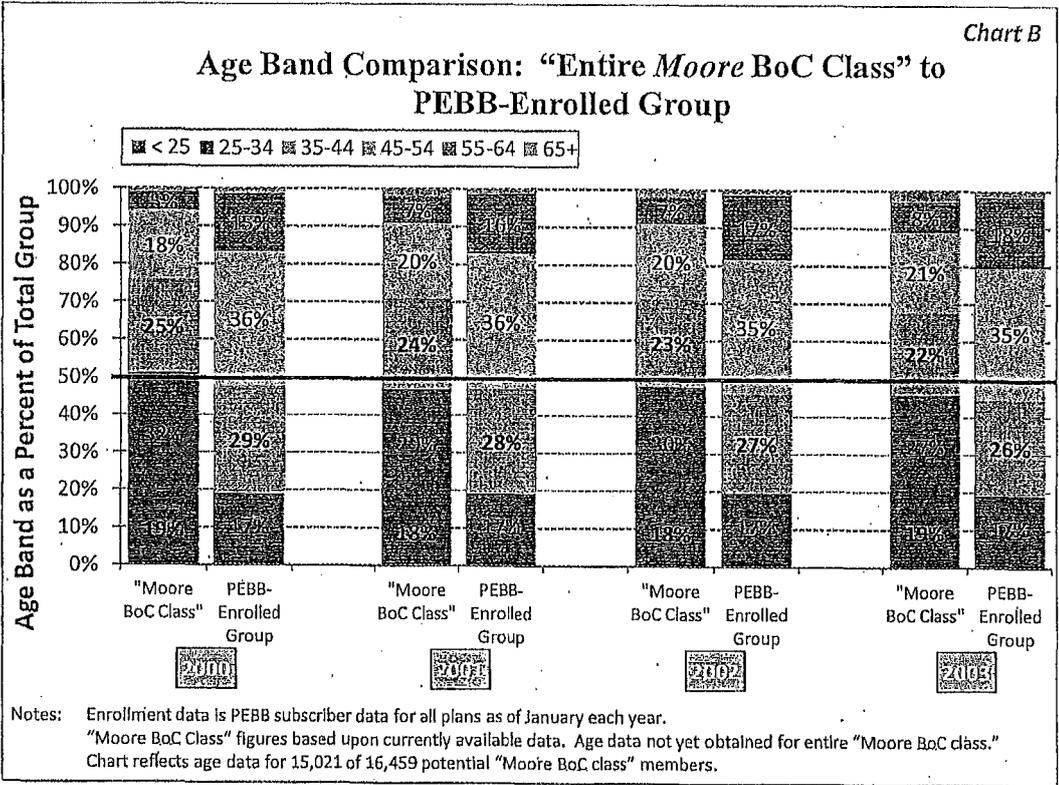
25 ⁶ The data for the employees in the “*Moore* BoC class” begins in June 2000 and ends in May 2003. The data
for the PEBB-enrolled group is based on enrollment in January of each year 2000 through 2003 and includes
only state and higher education employees.

26 ⁷ Age and gender information was available for 11,575 of the 12,608 (92%).

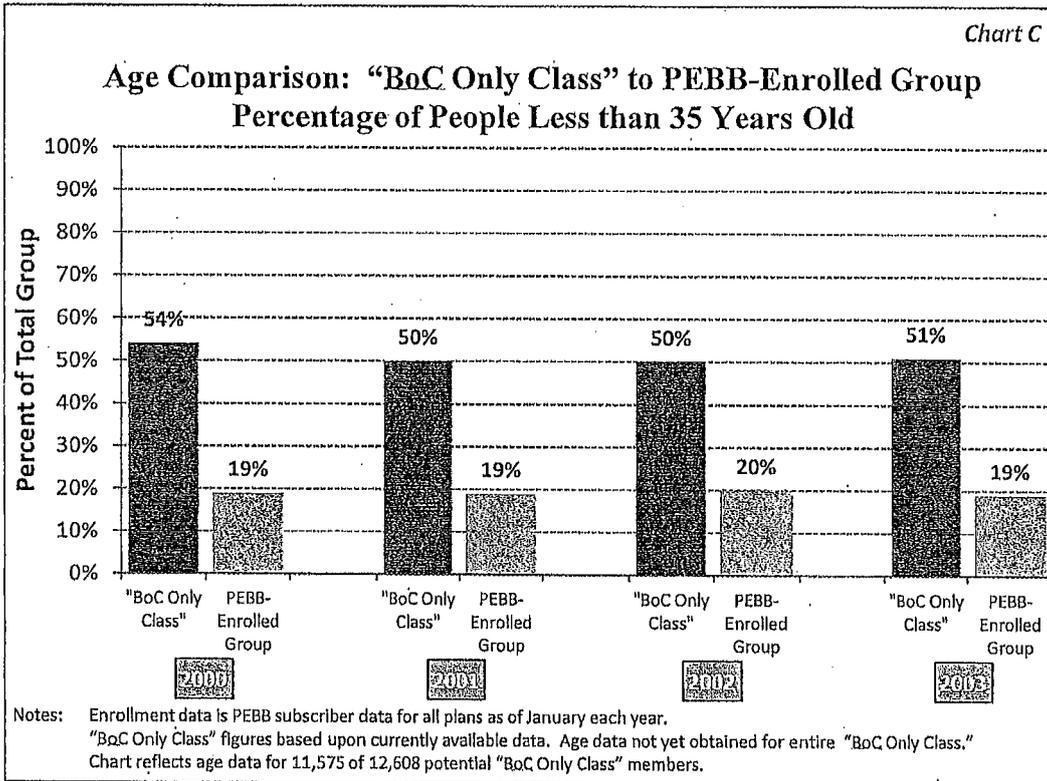
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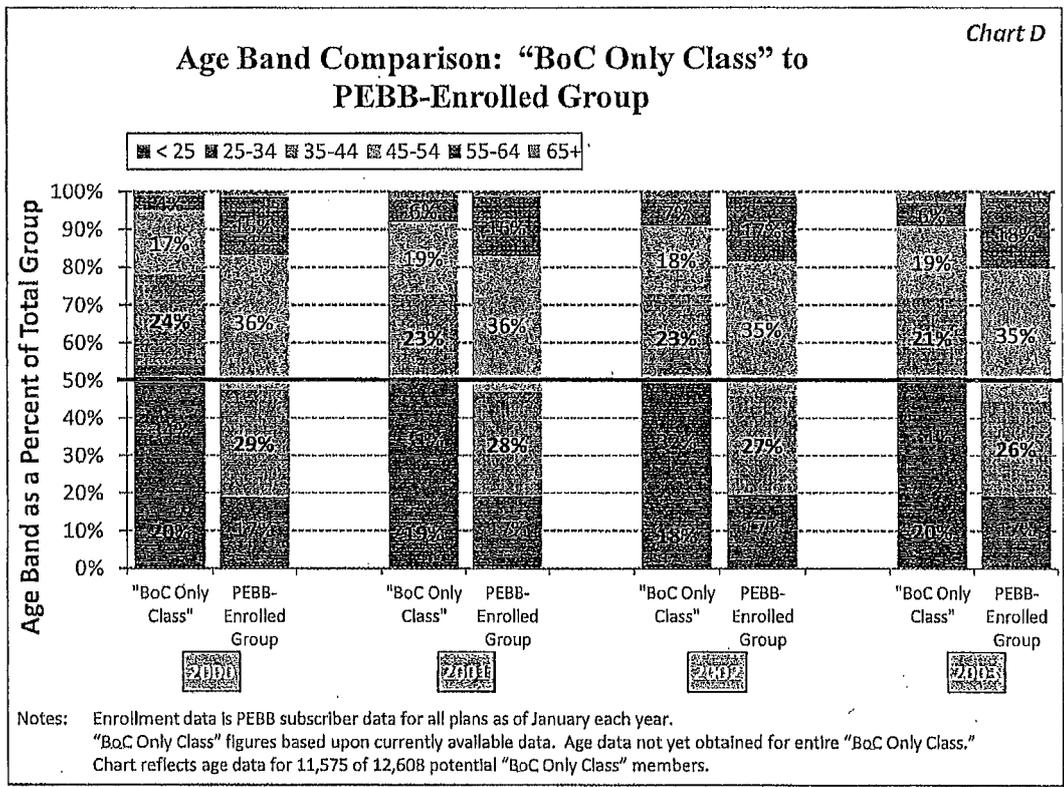
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1 15. The data with respect to age for Scenario 2 - focusing on those BoC class
 2 members who only have a contract claim ("BoC only class") - is summarized in Charts C and
 3 D below:
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16. As is evident from the charts under both Scenarios, the "Moore BoC class" is a considerably younger population than the PEBB-enrolled group. This is relevant because younger individuals are generally healthier and have lower health care expenses than older individuals.⁸ All else equal, a younger insured population will incur less health care costs than an older population. I understand that other important differences between the respective populations and the significance of these differences are addressed in the declarations of other State expert witnesses.

17. I have also reviewed data with respect to gender. Table 1A below summarizes data with respect to gender for the "Entire Moore BoC class" as compared to the PEBB-

⁸ Plaintiffs' expert acknowledges this point. See Declaration of David Wilson, September 13, 2012, Pg 8, footnote 4.

1 enrolled group. Table 1B reflects presents a similar comparison for just those BoC class
2 members who only have a contract claim ("BoC only class"):
3

4 **Table 1A**

Year & Gender	"Entire Moore BoC Class"	PEBB-Enrolled Group
2000 - Male	43%	46%
2000 - Female	57%	54%
2001 - Male	44%	46%
2001 - Female	56%	54%
2002 - Male	44%	46%
2002 - Female	56%	54%
2003 - Male	41%	46%
2003 -Female	59%	54%

12 **Table 1B**

Year & Gender	"BoC Only Class"	PEBB-Enrolled Group
2000 - Male	44%	46%
2000 - Female	56%	54%
2001 - Male	44%	46%
2001 - Female	56%	54%
2002 - Male	45%	46%
2002 - Female	55%	54%
2003 - Male	42%	46%
2003 - Female	58%	54%

1 Individuals with 2 Months or Less of "Apparent Eligibility"

2 18. I was asked to address the number of persons who had "apparent eligibility" for
3 only two months or less.⁹ This data is presented in Table 2 below:
4

5

Table 2			
	Total Number of Individuals	Individuals with Two Months or Less of "Apparent Eligibility"	Percent of Total
"BoC Only Class"	12,608	6,657	53%
"Entire Moore BoC Class"	16,459	7,681	47%

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11 19. Of the 16,459 individuals in the "Entire Moore BoC class", 7,681 persons
12 (47%) had two months or less of "apparent eligibility". For those with potential claims only
13 in the breach of contract period ("BoC only class"), 6,657 persons (53%) had two months or
14 less of "apparent eligibility".

15 20. Of the 16,459 individuals in the "Entire Moore BoC class", 4,551 persons
16 (28%) had only one month of "apparent eligibility". For those with potential claims only in
17 the breach of contract period, 3,946 persons (31%) had only one month of "apparent
18 eligibility".

19 21. The fact that nearly half of the "Entire Moore BoC class" (53% for those with
20 potential claims only in the breach of contract period) has "apparent eligibility" for two
21 months of benefits or less (further analysis of extrinsic data is required to establish actual
22 eligibility) strongly suggests that the lack of benefits was not a result of the State's failure to
23 properly apply averaging, or to otherwise intentionally deny benefits. It also raises issues
24

25 ⁹ I made a similar comparison for the Moore notice class in my declaration dated October 5, 2012. In that
26 declaration, I concluded that more than half of the Moore notice class (16,068 individuals) had "apparent
eligibility" for only two months or less. Of this group, 9,494 had "apparent eligibility" for only one month.

1 with respect to potential damages. It is reasonable to assume that individuals without health
2 insurance for one or at most two months would be less likely to procure alternative insurance
3 or incur health care expenses in that period compared to individuals who were without health
4 insurance for considerably more extended periods. In any event, individualized assessment
5 is necessary to determine whether and in what amount damages may have been incurred.

6
7 **Frequency of Work in Months with "Apparent Eligibility"**

8 22. For the 16,459 individuals in the "Entire *Moore* BoC class", I was asked to
9 quantify the relative frequency of work in months when they had "apparent eligibility" for,
10 but did not receive, employer-provided health insurance. I was asked to present this data in
11 the following categories:

12 (a) Those who worked 100 hours per month or less in all months of
13 "apparent eligibility";

14 (b) Those who 100 hours per month or less in some, but not all months of
15 "apparent eligibility"; and

16 (c) Those who worked more than 100 hours in all months of "apparent
17 eligibility".

18
19 This data is summarized in Table 3 below.

20

Table 3		
Frequency of Work	Number of Individuals	Percent of Total
Worked <100 hours in all months	7,430	45%
Worked <100 hours in some months but not all	5,732	35%
Worked >100 hours in all months	3,297	20%
Total "<i>Moore</i> BoC Class"	16,459	100%

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PROOF OF SERVICE

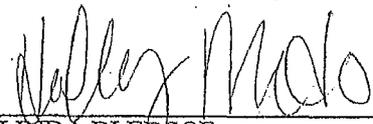
I hereby declare that on this 18th day of January 2013, I caused to be electronically filed the foregoing document with the Clerk of the Court using the King County E-filing system and/or E-Service which will send notification of such filing and that I also served a copy of this document on all parties or their counsel of record on the date below as follows:

Hand Delivery

Stephen K. Strong
Stephen K. Fester
Bendich, Stobaugh & Strong, P.C.
701 Fifth Avenue, Suite 6550
Seattle, WA 98104

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 18th day of January 2013, at Seattle, Washington.



LINDA BLEDSOE
Holly Morado

EXHIBIT C

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The Honorable Catherine Shaffer

STATE OF WASHINGTON
KING COUNTY SUPERIOR COURT

DOUGLAS L. MOORE, MARY CAMP,
GAYLORD CASE, and a class of similarly
situated individuals,

Plaintiffs,

v.

HEALTH CARE AUTHORITY, STATE
OF WASHINGTON,

Defendants.

NO. 06-2-21115-4 SEA

THIRD DECLARATION OF ROGER
FELDMAN, PH.D.

I, ROGER FELDMAN, PH.D., declare that I am over the age of 18, base this
declaration on personal knowledge, and am competent to make this declaration.

1. I am a health care economist and the Blue Cross Professor of Health Insurance
at the University of Minnesota School of Public Health, Division of Health Policy and
Management. I earned a Ph.D. in Economics from the University of Rochester in 1976. I also
hold a Masters of Science in Economics from the London School of Economics (1969), where
I was a Marshall Scholar, and a Bachelor of Science from the University of Wisconsin-
Madison (1967). Additional information regarding my qualification is contained in my prior
declarations filed in this matter and are incorporated herein by reference.

1 2. I have been retained by the State of Washington to serve as an expert in this
2 matter. In this declaration, I have been asked to respond to the opinions offered by David
3 Wilson, an expert witness retained by plaintiffs. I base the opinions expressed herein on my
4 education, experience and training, as well as my review of data regarding the putative class
5 identified for the period between June 2000 and May 2003, the larger group of state employees
6 enrolled for benefits during that time period, and the relevant and scientifically accepted
7 literature in the area.

8 3. I have reviewed the declaration submitted by David Wilson, entitled
9 Declaration of David Wilson re Contract Claim (January 2, 2013). In his declaration, Mr.
10 Wilson asserts that what he calls the "actuarial method" presents a reasonable, efficient, and
11 accurate way to determine class-wide damages for plaintiffs' contract claim. For a variety of
12 important reasons, Mr. Wilson's approach would not produce a reasonable estimate of the
13 actual loss of any putative class member, or of the contract claim class as a whole. To the
14 contrary, it would yield a result that would be misleading, inaccurate, and unrepresentative of
15 the actual damages suffered either by the putative class as a whole, or its individual members.
16 My reasons for these conclusions are summarized below.

17 4. First, Mr. Wilson bases his opinion on the assumption that "the class for the
18 contract claim here is large enough from a statistical standpoint that the overall distribution of
19 omitted employees to each plan and tier of coverage in each calendar year would have been
20 approximately the same for the class as it was for the State employees who received health
21 benefits." From a statistical standpoint, it is neither appropriate nor accurate to use the larger
22 group as a model of the choices the putative class would have made when the populations
23 being compared are different. Here, I understand that the populations being compared -- the
24 PEBB-enrolled employees vs. putative contract class members -- are different in several
25 material respects, including age and gender.
26

1 5. Where meaningful differences are shown in the putative class as compared to
2 the group of PEBB enrollees regarding such demographic factors as age and gender, the
3 contract class members' choices on whether to take up benefits (i.e., to enroll), as well as plan
4 choice and coverage tier choice, will be different from the larger group of state employees
5 who did enroll.

6 6. "Take-up" refers to whether a person enrolls for (i.e., "takes up") coverage. In
7 general, younger persons tend to take up coverage at a lower rate than older persons. In
8 addition, part time workers who work less than twenty-five hours per week are significantly
9 less likely to take up coverage than those who work more twenty-five hours per week. Mr.
10 Wilson has not accounted for the factor of hours-worked by the putative class.

11 7. In addition, there is a clear relationship between age and an employee's choice
12 of plans. For example, older workers are significantly more likely to choose plans that offer
13 greater facility and physician choice. Studies of women have produced more mixed results,
14 but these include studies showing that gender affects plan choice.

15 8. Mr. Wilson suggests in his declaration that the "average monthly cost of
16 employee medical benefits" can be used to address any differences between plan and tier
17 choice of the class, because it takes into account the different premiums paid to different
18 carriers based on each plan and tier of coverage. However, there are many problems with this.
19 The premiums paid to insurance carriers for coverage include not only costs related to
20 providing health care, but other costs such as administrative costs and profits. As I noted in
21 my second declaration, the non-health care related portion of the premiums can vary widely
22 among different carriers and can be as much as 40 percent annually. Plaintiffs, however, do
23 not provide any information about the various carriers' non-health-care-related costs from
24 2000-03. If the premium is to be used as a proxy for actual medical expenses incurred by
25 class members, these non-health-care related costs must be stripped out of the carriers'
26

1 premiums and, hence, the "average monthly cost of employee medical benefits." However,
2 Mr. Wilson provides no details on how this can be done where the amount of the non-health-
3 care-related costs for the carriers is not known.

4 9. In conclusion, Mr. Wilson's "actuarial method" approach does not produce a
5 reasonable estimate of the actual loss of any putative class member, or of the class as a whole,
6 and it does not account for the likelihood of material differences between class members and
7 larger group of all State employees who enrolled for health benefits.

8 I declare under penalty of perjury under the laws of the State of Washington that the
9 foregoing is true and correct.

10 DATED this 18th day of January 2013, in Minneapolis, MN.

11
12 Roger Feldman
13 ROGER FELDMAN, PH.D.
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PROOF OF SERVICE

I hereby declare that on this 18th day of January 2013, I caused to be electronically filed the foregoing document with the Clerk of the Court using the King County E-filing system and/or E-Service which will send notification of such filing and that I also served a copy of this document on all parties or their counsel of record on the date below as follows:

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Stephen K. Strong
Stephen K. Fester
Bendich, Stobaugh & Strong, P.C.
701 Fifth Avenue, Suite 6550
Seattle, WA 98104

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 18th day of January 2013, at Seattle, Washington.



HOLLY MORADO
Legal Assistant

EXHIBIT D

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The Honorable Catherine Shaffer
Thursday, August 25, 2011
Without Oral Argument

STATE OF WASHINGTON
KING COUNTY SUPERIOR COURT

DOUGLAS L. MOORE, MARY CAMP,
GAYLORD CASE, and a class of similarly
situated individuals,

Plaintiffs,

v.

HEALTH CARE AUTHORITY, STATE
OF WASHINGTON,

Defendants.

NO. 06-2-21115-4 SEA

DECLARATION OF STEFAN
BOEDEKER IN SUPPORT OF
DEFENDANTS' REPLY RE MOTION
FOR LEAVE TO CONDUCT
DISCOVERY ON SAMPLE OF
UNNAMED PUTATIVE CLASS
MEMBERS

I, Stefan Boedeker, declare that I am over the age of 18, base this declaration on my personal knowledge, and am competent to make this declaration.

1. I am a Director for Berkeley Research Group, LLC. I have been retained by the Defendants in this matter, Washington Health Care Authority (HCA) and the State of Washington.

2. I have previously issued a declaration in this case about the selection of a discovery sample with a sample size of 60 that would yield a margin of error of approximately +/- 10% at a 90% confidence level. In the declaration I used the terminology of "using the sample to estimate the occurrence of attributes." In the context of statistical sampling the term "attribute" refers to a characteristic that an element of the population has or does not have.

3. Attribute sampling tests binary questions (e.g., yes/no, correct/incorrect,

1 present/not present). In attribute sampling, an estimate is made of the proportion of the pop-
2 ulation that contains one of the characteristics of the binary variable of interest, e.g., whether
3 an employee mitigated damages by purchasing substitute insurance.

4 4. In attribute sampling no consideration is given to the magnitude of the
5 characteristic. For example, if the variable of interest is the proportion of correctly classified
6 health care expenses, attribute sampling will tell us the proportion of correctly classified
7 expenses (within a margin of error), but it will not tell us the amount of those expenses. The
8 type of sampling that can produce estimates of the magnitude of a characteristic is often called
9 "amount" or "variable" sampling. In these applications of statistical sampling dollar amounts,
10 medical expenses, etc. will be estimated.

11 5. I have reviewed Dr. Long's declaration submitted by Plaintiffs in this case.
12 Practically all of her declaration presumes – incorrectly – that the type of sampling the State
13 intends to do (with my services) is amount sampling. For example, in Paragraph 16 of her
14 declaration Professor Moore calls the examples of relevant attributes identified by the State
15 "vague." However, she then goes on to jump to the conclusion that I must be referring to
16 "dollar amounts of health expenses in each month". She further assumes that "the 60
17 individual survey is intended to show that the health insurance expenses incurred by the class
18 members for the months that they did not receive health insurance are less on average...". In
19 both instances Professor Long incorrectly presumes that the discovery or attribute sample of 60
20 is intended to estimate dollar amounts rather than the proportion of a binary characteristic such
21 as whether substitute insurance was procured. The State intends to do the latter, not the
22 former. It is not the scope of the discovery sample to estimate medical expenses.

23 In Paragraph 17 Professor Long states again that my "proposed sample size of 60
24 people is certainly too small to provide accurate information with respect to the 'relevant
25 attributes' he identifies, particularly the medical expenses incurred..." Again, her point
26

1 becomes mute when binary attributes are the object of measurement as they are in my
2 proposed attribute sampling method.

3 The State intends to do discovery or attribute sampling to ascertain the relative
4 frequency of relevant characteristics or factors in the larger class (e.g., whether an employee
5 purchased substitute insurance during the month or months he or she did not have state-funded
6 health care). Dr. Long incorrectly presumes the State intends to do amount sampling.

7 6. As a result, I do not disagree with much of Dr. Long's technical conclusions.
8 They are relatively accurate with regard to her opinions on amount sampling. However, they
9 simply do not apply here because the State does not intend to engage in amount sampling, but
10 rather attribute sampling.

11 7. Dr. Long does discuss attribute sampling in one paragraph of her declaration –
12 paragraph 19. Her statement there that the size of an attribute sample must be over 250
13 persons in order to achieve a 90% confidence interval with a margin of error of +/- 10% is
14 simply incorrect. This is illustrated by application of the formula described in paragraph 8,
15 below. The formula there is the formula for a simple random sample and plugging in the
16 values suggested by Professor Long yields a +/- 5.2% precision level.

17 8. The estimator for the proportion in attribute sampling is based on the binomial
18 distribution. The formula for the sample size for the proportion estimator is given by the
19 equation:

$$n = Z_{\alpha}^2 * p * (1-p) / ME^2$$

21 In the above equation:

- 22 • n is the sample size,
- 23 • Z_{α} is the confidence coefficient for confidence level α ,
- 24 • p is the proportion of the attribute to be estimated – a number between 0 and 1,
- 25
- 26

- 1 • (1-p) is the proportion of the other attribute of the binary variable, and
2 • ME is the desired margin of error.
3
4 a. The above formula has the advantage that a sample size can be calculated
5 without knowing what the variation of the underlying variable is. The term $p*(1-p)$
6 takes it largest value for $p=0.5$.
7
8 b. Plugging in 1.645 for Z_{90} , 0.5 for p , and 60 for n , rearranging the terms and
9 solving for the margin of error yields a value of $ME=10.6\%$, a value of $p=.8$ for
10 example would yield a value of $ME=8.5\%$.
11
12 c. Therefore, the statement in my previous declaration that a sample size of 60
13 would yield a margin of error of approximately $\pm 10\%$ for a confidence level of 90%
14 is correct. Dr. Long is simply incorrect in her assertion made in paragraph 3.

15 9. The following comments on various paragraphs from Dr. Long's declaration
16 again demonstrate her erroneous presumption that the sample I have constructed is designed
17 for amount sampling when, as I have described in some detail above, I have designed an
18 attribute sample, focusing on identifying the relative frequency of relevant binary-type factors
19 relating to damages. As I stated above, then, Dr. Long's criticisms -- applicable as they are
20 only to amount sampling - are simply inapplicable to attribute sampling.
21

22 a. In Paragraph 20 Professor Long states that "a small sample, such as 60, may be
23 appropriate when the variable that one is trying to measure does not have much
24 variability within the population from which the sample is drawn. Binary attributes
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don't have a large degree of variation because by definition they can only take two distinct values.

b. In Paragraphs 21 and 22 all the points Professor Long makes against the sample size of 60 for binary attributes refer to medical expenses. No claim was ever made that a sample of size 60 would enable the estimation of dollar amounts at 90% confidence with a precision of +/- 10%.

c. In Paragraphs 24 and 25 Professor Long goes into great detail how stratification could be used to reduce the sample size for the estimation of medical expenses and how a much larger sample size was needed if one wanted to "accurately measure the medical expenses for individual strata." The stratification proposed in my previous declaration was intended to ensure a proportional allocation across agencies which would not be guaranteed by a simple random sampling approach. The proposed minimum sample size of three for any stratum was not intended to obtain precise stratum specific estimates but much rather was intended to ensure that the different agencies in the universe were represented adequately.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

DATED this 24th day of August 2011, in Los Angeles, California.


STEFAN BOEDEKER