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STATE OF WASHINGTON

No. 90533-9

SUPREME COURT OF THE STATE OF WASHINGTON

No. 69848-6-I

COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION 1

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

Respondents

v.

PREMERA, a Washington corporation; PREMERA BLUE CROSS, a
Washington corporation; LIFEWISE HEALTH PLAN OF
WASHINGTON, a Washington corporation; and WASHINGTON
ALLIANCE FOR HEALTHCARE INSURANCE TRUST and its Trustee,
F. BENTLEY LOVEJOY,

Petitioners.

SUPPLEMENTAL/AMICI CURIAE BRIEF SUBMITTED BY
NATIONAL ASSOCIATION OF MUTUAL INSURANCE
COMPANIES AND PROPERTY CASUALTY INSURANCE
ASSOCIATION OF AMERICA

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TABLE OF CONTENTS

	Page
I. SUMMARY	1
II. INTERESTS OF <i>AMICI</i>	3
III. THE FILED RATE DOCTRINE	4
IV. RATE REGULATION: A FRAMEWORK.....	7
V. THIS IS A RATE CASE.....	10
VI. THE FILED RATE DOCTRINE APPLIES TO THIS RATE CASE.....	11
VII. THE “FALSE ADVERTISING” LABEL IS NOT CONTROLLING.....	13
VIII. COURTS DO NOT REGULATE “SURPLUS”	14
A. “Surplus” is the Insurer’s Capital, and Constitutes the Protection Making Insurance Really Insurance.	15
B. The Legislature Has Chosen Not To Regulate Surplus At The Maximum. That Decision Is One Of Economic Policy, And Cannot Be Overruled By The Judicial Branch.....	17
IX. CONCLUSION	19

TABLE OF AUTHORITIES

	Page(s)
CASES	
<i>Am. Bankers' Ins. Co. of Fla. v. Wells</i> , 819 So. 2d 1196 (Miss. 2001).....	5
<i>Armstrong v. Safeco Ins. Co.</i> , 111 Wash. 2d 784, 765 P.2d 276 (1988).....	11, 18
<i>Ciamaichelo v. Independence Blue Cross</i> , 589 Pa. 415 (2006).....	18
<i>City of New York v. Aetna Cas. & Sur. Co.</i> , 693 N.Y.S.2d 139 (N.Y. App. Div. 1999).....	6
<i>Commonwealth v. Anthem Ins. Cos., Inc.</i> , 8 S.W.3d 48 (Ky. App. 1999).....	5
<i>Hill v. State Farm Mut. Auto. Ins. Co.</i> , 166 Cal. App. 4th 1438 (2008).....	15
<i>MacKay v. Superior Court</i> , 188 Cal. App. 4th 1427 (2010).....	5
<i>Minihane v. Weissman</i> , 640 N.Y.S.2d 102 (N.Y. App. Div. 1996).....	5
<i>Richardson v. Standard Guar. Ins. Co.</i> , 853 A.2d 955 (N.J. Super. Ct. App. Div. 2004).....	5
<i>Rios v. State Farm Fire and Cas. Co.</i> , 469 F. Supp. 2d 727 (S.D. Iowa 2007).....	7
<i>Schermer v. State Farm Fire and Cas. Co.</i> , 721 N.W.2d 307 (Minn. 2006).....	5
<i>Sher v. Allstate Ins. Co.</i> , 947 F. Supp. 2d 370 (S.D.N.Y. 2013).....	6
<i>Spielholz v. Superior Court</i> , 86 Cal. App. 4th 1366 (2001).....	13
<i>State Farm Mut. Auto. Ins. Co. v. Superior Court</i> , 114 Cal. App. 4th 434 (2003).....	15, 16, 17
<i>State v. Jackson</i> , 137 Wash. 2d 712 (1999).....	18

<i>State v. Sears</i> , 4 Wash. 2d 200, 103 P.2d 337 (1940).....	11
<i>Stutts v. Travelers Indem. Co.</i> , 682 S.E.2d 769 (N.C. Ct. App. 2009).....	7
<i>Tenore v. AT&T Wireless Servs.</i> , 136 Wash. 2d 322 (1998).....	7, 14
<i>Woodhams v. Allstate Fire and Cas. Co.</i> , 748 F. Supp. 2d 211 (S.D.N.Y. 2010), <i>aff'd</i> 453 Fed. Appx. 108 (2d Cir. 2012).....	6

STATUTES

RCW 48.01.050	8
RCW 48.18.100	8
RCW 48.18.110	8
RCW 48.18.110(2).....	9
RCW 48.19.020	9
RCW 48.19.030(3).....	8, 9
RCW 48.19.040	8
RCW 48.19.040(2)(c)	9
RCW 48.19.040(2).....	8
RCW 48.19.060	8
RCW 48.19.100	8
RCW 48.44.020	8
RCW 48.44.020(3).....	9
WAC 284-24-065.....	8
WAC 284-43-920(1).....	10
WAC 284-43-945.....	9

OTHER AUTHORITIES

Washington State SERFF Health and Disability Rate General
Filing Instructions, version 04-07-2014,
[http://www.insurance.wa.gov/for-insurers/filing-
instructions/file-health-care-disability/rate-filing-instructions/](http://www.insurance.wa.gov/for-insurers/filing-instructions/file-health-care-disability/rate-filing-instructions/) 9

Washington State SERFF Property and Casualty Rate Filing
General Instructions and The State of Washington-P/C Rate
Filing Checklist, [http://www.insurance.wa.gov/for-
insurers/filing-instructions/property-casualty](http://www.insurance.wa.gov/for-insurers/filing-instructions/property-casualty) 9

Washington State Office of the Insurance Commissioner,
[http://www.insurance.wa.gov/your-insurance/health-
insurance/health-rates/how-we-review-rates/](http://www.insurance.wa.gov/your-insurance/health-insurance/health-rates/how-we-review-rates/) 10

I. SUMMARY

In the case before this Court plaintiffs/respondents seek to create a system for judicial oversight of highly technical and critical questions of economic policy concerning insurance *rates* and the *amount of capital* necessary to support the insurance business written by a specific insurer. The Complaint repeatedly and unequivocally asserts that respondents' claims are "for excessive, unnecessary, unfair and deceptive overcharges . . ." Complaint ¶ 22. But these charges – i.e., the rates and premiums – are filed with and subject to oversight by a state agency with technical expertise: the Office of the Insurance Commissioner ("OIC"). Because these insurance rates and premiums are regulated, the *filed rate doctrine* forecloses any action challenging the rates and premiums as unjustified by the ratemaking data submitted to the regulator, such as data concerning the costs of providing the insurance, and the determination of a reasonable profit.

This preclusion extends to claims labeled as "false advertising". Respondents argue that they are not challenging the rate; rather, they argue, they challenge false statements that rate increases were required by increases in costs. But the inquiry thus implicated – whether the rates were justified by cost increases – is foreclosed by the filed rate doctrine. The rates were filed and presumptively justified by the data included in the filing. Respondents cannot second-guess that determination through a civil action, which would place a court in the position of deciding a technical question assigned by law to a different branch of government.

Before this Court, respondents appear to concede that cost data supports the *rate level* Premera¹ was permitted by the OIC, but that petitioners should have funded that rate level by liquidating assets rather than charging premiums sufficient to meet rate needs. Respondents argue that Premera has excessive capital – called “surplus” in insurance accounting – and that rates were excessive because petitioners did not support rate need by reducing surplus to pay the costs of the insurance rather than charging facially adequate rates. According to respondents, the fact that the Legislature has withheld from the OIC the authority to regulate surplus means that the courts should perform this task. That is, respondents appeal to the courts to order Premera to conduct its insurance business on a leaner capital margin, and to retroactively reduce rates by liquidating capital.

Respondents’ notion that it would be better for insurers to operate the insurance business at minimum capitalization runs utterly counter to post-recession perspectives concerning consumer protection. Further, and more importantly for this Court, courts do not substitute their judgment for that of company management on the question of appropriate capitalization. The determination of appropriate surplus levels is a nuanced one that varies by company, and is consigned to the business judgment of company

¹ The petitioners here are Premera, Premera Blue Cross, Lifewise Health Plan of Washington, Washington Alliance for Healthcare Insurance Trust and its Trustee F. Bentley Lovejoy. Premera, Premera Blue Cross and Lifewise Health Plan of Washington are separately represented from Washington Alliance for Healthcare Insurance Trust and F. Bentley Lovejoy. For convenience only, *amici* refer to petitioners collectively as “Premera”.

management. That is where it must remain, unless and until the Legislature makes a different choice.

The boundaries drawn by the filed rate doctrine and business judgment rule apportion responsibility and oversight for insurance rates and capitalization to the insurance regulator and company management, not the courts. This division protects consumers by ensuring that critical questions of economic policy and corporate financial stability are decided by the bodies with the technical expertise to resolve them. Courts across the country have, accordingly, applied the filed rate doctrine based on the substance of the claim presented rather than the label. *Amici* urge this Court to align this State with that authority, and avoid the threat to the Washington insurance market presented by the respondents' case and the Court of Appeals' opinion.

II. INTERESTS OF *AMICI*

National Association of Mutual Insurance Companies (“NAMIC”) and Property Casualty Insurers Association of America (“PCI”) join Premera, as *amici curiae*, in seeking to protect the Washington insurance market from the impacts of judicial regulation of insurance rates and insurer capitalization, which would be permitted by the Court of Appeals' opinion.

NAMIC is a nationwide association of mutual insurers. A mutual insurance corporation is a specific organizational form without stockholders, and is managed for the benefit of policyholders. For almost 120 years,

NAMIC has been serving the best interests of mutual insurance companies – large and small – across the country. NAMIC has approximately 1,400 property/casualty company members serving more than 135 million auto, home, and business policyholders. NAMIC members hold 50% of the auto/homeowners insurance market in the United States. Many of NAMIC’s members write insurance in Washington, and are likely to be subject to regulation through civil actions as a result of the Court of Appeals’ decision.

PCI is a diverse nationwide trade association of property-casualty insurers. PCI has more than 1000 members, consisting of large and small companies in all 50 states. PCI’s members represent every form of ownership: stock; mutual; risk retention group; and reciprocal. PCI’s members write \$210 billion in annual premiums and represent 47% of the United States auto market, 33% of the homeowner’s market, 36% of the commercial property and liability market, and 39% of the private workers compensation market.² Many of PCI’s members write insurance in Washington, and are likely to be subject to regulation through civil actions as a result of the Court of Appeals’ decision.

III. THE FILED RATE DOCTRINE

Virtually all businesses throughout the country are free to set price for their products and services unrestricted by government control. That is not the case with insurance. Every jurisdiction subjects rates proposed for some or all insurance products to a varying degree of scrutiny by a dedicated

² Memberships can overlap as between NAMIC and PCI.

regulator. The regulator considers historical data, actuarial modeling of loss development and trends, and what constitutes a reasonable profit, in allowing the filing insurer to charge a rate that will cover projected costs and allow for a reasonable profit. The filing insurer must charge the filed rate.

In light of the regulation of insurance rates by a separate branch of government, the various states throughout the country have concluded that the *filed rate doctrine* applies to resolve potentially overlapping powers of the regulator and the courts, when a plaintiff files a civil action that implicates rates. At its core, the doctrine precludes civil actions challenging price where industry members must file rates with a government agency charged with regulating that industry. While this common law doctrine “originated in federal courts, ‘it “has been held to apply equally to state agencies by every court to have considered the question.””³

³ *MacKay v. Superior Court*, 188 Cal. App. 4th 1427, 1448-49 (2010) *citing and quoting* *Commonwealth v. Anthem Ins. Cos., Inc.*, 8 S.W.3d 48, 52 (Ky. App. 1999); *see also* *Schermer v. State Farm Fire and Cas. Co.*, 721 N.W.2d 307, 312-13 (Minn. 2006) (adopting filed rate doctrine and recognizing multiple rationales, including separation of powers, comity, legislative nature of ratemaking, technical expertise of regulator, and unforeseen consequences of potential court orders; noting that “most states have adopted the filed rate doctrine, and many apply it to insurance regulation.”); *Am. Bankers’ Ins. Co. of Fla. v. Wells*, 819 So. 2d 1196, 1205 (Miss. 2001) (noting that “the acceptance of the [filed rate] doctrine’s basic applicability is near-universal” and applying the doctrine to bar aspects of claim challenging insurance rates and terms); *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 963 (N.J. Super. Ct. App. Div. 2004) (“we also reject plaintiff’s mistaken contention that the filed rate doctrine does not apply to the insurance industry not only because courts are not institutionally suited to regulate insurance premiums and benefit rates, but also because of the extensive regulation of this industry. We, thus, align our decision with the considerable weight of authority from other jurisdictions that have applied the filed rate doctrine to ratemaking in the insurance industry.”); *Minihane v. Weissman*, 640 N.Y.S.2d 102, 103 (N.Y. App. Div. 1996) (holding that claim

Throughout the country, courts applying the filed rate doctrine in the insurance context look through form to substance to determine whether the doctrine applies. If the case pleaded by plaintiffs cannot be decided without re-examining the rate, it is barred by the filed rate doctrine. For example:

In *Woodhams v. Allstate Fire and Cas. Co.*, 748 F. Supp. 2d 211 (S.D.N.Y. 2010), *aff'd* 453 Fed. Appx. 108 (2d Cir. 2012), the court held that the filed rate doctrine barred a claim that portions of approved fire policies were worthless and illegal, requiring a refund of a pro-rated portion of premiums charged for the policies. The court explained that: “Because these policies and the premiums associated with them were approved by NYSID, Count I is a direct challenge to the reasonableness of the filed rates, and is therefore barred by the retroactive rate-setting strand of the filed rate doctrine.” 748 F. Supp. 2d at 220. *Accord Sher v. Allstate Ins. Co.*, 947 F. Supp. 2d 370 (S.D.N.Y. 2013) (following *Woodhams* to hold that filed rate doctrine barred claim for premium refunds premised on alleged illusory coverage where premiums were approved by regulator).

In *City of New York v. Aetna Cas. & Sur. Co.*, 693 N.Y.S.2d 139, 139 (N.Y. App. Div. 1999), the court held that the filed rate doctrine barred a cause of action asserted by the City and a putative class challenging auto rates as excessive because they did not drop when auto theft rates dropped.

challenging filed rate as fraudulently obtained was barred by the filed rate doctrine; doctrine exists “to ensure that rates charged are stable and non-discriminatory, bearing in mind that the regulatory agencies presumably are most familiar with the workings of the regulated industry and are in the best position, due to experience and investigative capacity, to establish the proper rates.”).

In *Rios v. State Farm Fire and Cas. Co.*, 469 F. Supp. 2d 727, 735, 739 (S.D. Iowa 2007), the court held that the filed rate doctrine barred a claim which would involve the court in determining the amount of the premium attributable to the alleged illusory endorsement and require the court to “second guess” what rate the regulator would have allowed absent the alleged illusory endorsement.

In *Stutts v. Travelers Indem. Co.*, 682 S.E.2d 769, 772-73 (N.C. Ct. App. 2009), the court held that a claim for breach of contract was barred by the filed rate doctrine where plaintiff could not prove breach of contract without the rates set by the regulator being questioned.

As can be discerned from this sampling, the touchstone is not the legal theory under which the claim is asserted. The determining factor is whether the action challenges the approved rates, and whether it is possible to entertain the action without re-examining the approved rates. *Cf. Tenore v. AT & T Wireless Servs.*, 136 Wash. 2d 322, 344-345 (1998) (discussing filed rate doctrine in the utility (wireless services) context, and recognizing that application of filed rate doctrine depends upon whether a proposed action requires re-examination of the filed rates). More fundamentally, the question is whether the case would require the courts to decide questions of economic public policy, which are essentially legislative in character. *See* cases cited in footnote 3.

IV. RATE REGULATION: A FRAMEWORK

Premera has described Washington’s rate regulation scheme applicable to healthcare coverage rates in the individual and small group market, and in

the large group market. *See* Brief of Respondent filed in Division 1 of the Court of Appeals of Washington, Case No. 69848-6-1, pp. 4-7 (individual and small group), pp. 8-10 (large group). *Amici* here provides the Court with a simplified description of rate regulation, generally, to illustrate to the Court the inextricable connection between the filed rates and respondents' civil action.

Washington actively regulates health care coverage rates as well as property casualty insurance rates. *See* RCW 48.44.020, RCW 48.18.100 and RCW 48.18.110 (rates and policy forms for Health Care Service Plans and disability insurers reviewed and approved as a package); RCW 48.19.040 (all "insurers" must file rates prior to use, stating a proposed effective date)⁴, RCW 48.19.060 (governing review and approval of filings, including deeming filed rates to meet requirements unless disapproved by the Commissioner), RCW 48.19.100 (governing disapproval of filings). While each system is tailored to the regulated line, in all cases the regulator – the Washington OIC – reviews the same types of data and actuarial calculations, and allows the applicant to charge the proposed rates – or not – based on the same concept. The applicant insurer must justify the rates based upon actual cost experience, actuarially sound methods for projecting future experience based on actual experience data, and a component for a reasonable profit. *See* RCW 48.19.030(3), RCW 48.19.040(2), WAC 284-24-065 (elaborating

⁴ RCW 48.01.050 defines "insurer" to include "every person engaged in the business of making contracts of insurance, other than a fraternal benefit society".

on the requirements for demonstrating that rates are not “excessive, inadequate, or unfairly discriminatory” standard of RCW 48.19.020); and WAC 284-43-945 (Summary for individual and small group contract filings). *See also* “Washington State SERFF Health and Disability Rate General Filing Instructions”, version 04-07-2014, available at <http://www.insurance.wa.gov/for-insurers/filing-instructions/file-health-care-disability/rate-filing-instructions/>, and the Washington State SERFF Property and Casualty Rate Filing General Instructions and The State of Washington-P/C Rate Filing Checklist, available at <http://www.insurance.wa.gov/for-insurers/filing-instructions/property-casualty>. The OIC takes the applicant’s investment income into account, as a source in addition to premium from which the applicant can meet its total financial needs. *See* RCW 48.19.040(2)(c), RCW 48.19.030(3), the Washington P/C Rate Filing Checklist (item 9), WAC 284-43-945, and the Washington State SERFF Health and Disability Rate General Filing Instructions. The standard for rate approval for healthcare coverage rates is that the rates must be reasonable in relation to the benefits provided in the policy. *See* RCW 48.18.110(2), RCW 48.44.020(3).

The OIC provides its own “primer” for consumers explaining rate review for individual and small group health plans. After listing “[f]actors that affect rates”, the OIC goes on to describe “[w]hat we do”. In that section, the OIC emphasizes that it scrutinizes the data for accuracy, examines the actuarial assumptions used to project future experience, and expressly considers “the company’s current level of surplus” in assessing

whether “[h]ow much profit the company expects to make” is reasonable. See <http://www.insurance.wa.gov/your-insurance/health-insurance/health-rates/how-we-review-rates/>.

Once the rates are approved by the OIC, the applicant is required by law to charge that rate, and cannot change the rate without making a new rate filing. See WAC 284-43-920(1) (specifying that rate schedules must be filed with the commissioner before use, and every eighteen months).

That is to say, the OIC does not approve rates in a vacuum. Rates must be justified by a submission establishing the costs of providing insureds with the benefits under the policy. The validity of the rate structure necessarily falls within the jurisdiction conferred by the Legislature on the OIC as part of the OIC’s authority over insurance rates.

V. THIS IS A RATE CASE

The case at issue here is a rate case, because that what the complaint pleads. In paragraphs 9 – 15, the plaintiffs specifically air their grievances regarding their premium rates. Paragraph 22 details at length the gravamen of the claim, which is all about rates:

The claims by the class representatives and on behalf of the class members are for excessive, unnecessary, unfair and deceptive overcharges for health insurance and as a result of such overcharges, over the 4-year period prior to the filing of this complaint, having and retaining at the present time as non-profit corporations, excessive surplus levels. During that period, [defendants have] . . . made profits by overcharging the plaintiffs and class members amounts for insurance that were far in excess of the cost . . . of providing the coverage

Plaintiffs clearly allege that they are challenging the approved rates as excessive. And it goes on. See Complaint ¶¶ 20, 28, 30, 65, and Prayer ¶

2.

VI. THE FILED RATE DOCTRINE APPLIES TO THIS RATE CASE

In this case, the Court of Appeals correctly observed that healthcare coverage rates are strictly regulated, and correctly held that the filed rate doctrine applies. That much of the Court of Appeals' holding should be affirmed, as it has its roots in the fundamental rule that courts do not interfere in questions of economic public policy – a rule long-settled in Washington. *See Armstrong v. Safeco Ins. Co.*, 111 Wash. 2d 784, 792, 765 P.2d 276, 280 (1988) (cautioning against “judicial legislation” requested by plaintiffs in action seeking to limit insurers’ underwriting authority); *cf. State v. Sears*, 4 Wash. 2d 200, 207, 103 P.2d 337, 341 (1940) (in the different context of a due process challenge to legislation, the Court declared: “It is primarily a legislative, and not a judicial, function to determine economic policy.”); *see also* cases cited in footnote 3 regarding derivation of filed rate doctrine.

In further ruling, however, that the filed rate doctrine did not apply because respondents’ action was labeled as one for false advertising, the Court of Appeals failed to perceive that the action framed by the Complaint necessarily compels a court to overstep the judicial purview and intrude into matters foreclosed by the doctrine.

If the theory of the Complaint is correct, the court will be required to determine whether the approved rates charged by Premera were really “far in excess of the cost . . . of providing the coverage” Complaint ¶ 22. That

question lies at the heart of the allegations that Premera engaged in “false advertising” by stating, in essence, that its rate levels were necessitated by costs. But, in approving the filed rates, the regulator *has already determined that Premera’s projected costs justified the approved rates*, based upon a presumptively complete and expert review of Premera’s projected losses and expenses, projected investment income on reserves as well as surplus, and the allowed profit component (if any).⁵

That is, the only way to prove or disprove the case presented by the Complaint is for the court to embroil itself in the legislative function of ratemaking, and to second guess the determination already made by the regulator that the filer’s costs do justify the rates. The only way for the court to award the relief requested is to retroactively reduce the regulator’s previously approved rates for the entirety of the putative class period.

Adjudicating this case requires the court to make economic determinations requiring both the technical expertise of the regulator, and the legislative power to determine the state’s economic public policy. It is in these circumstances that the filed rate doctrine applies to bar an ordinary civil action.

Here, the Complaint directly challenges the approved rates. The alleged fraud concerns the rates. It is not possible to either decide the issues or grant relief without re-examining the rates and “second guessing”

⁵ Premera’s Brief of Respondent filed in the Court of Appeals indicates that the OIC has found a reasonable profit component of zero, for some Premera filings. See Brief of Respondent at p. 7.

what the rate should have been without the alleged fraud. If Washington accepts that the filed rate doctrine applies to insurance rates – as the Court of Appeals held – then the doctrine applies here to bar this case.

VII. THE “FALSE ADVERTISING” LABEL IS NOT CONTROLLING

Respondents argue that there is a bright line preventing application of the filed rate doctrine to consumer protection act causes of action for false advertising. Respondents rely primarily upon a California decision that considered and did not apply the filed rate doctrine based on the gravamen of the action: *Spielholz v. Superior Court*, 86 Cal. App. 4th 1366 (2001).

Respondents misunderstand the *Spielholz* decision. This case finds no analog there. In *Spielholz*, the alleged wrong was that defendant allegedly had advertised a “seamless calling area” for its cellular service when, in fact, the calling area included dead zones. The action was not about the rates: the alleged misrepresentations were not about the rates. That an award of damages might theoretically and indirectly upset rate assumptions by introducing such an award is too remote an impact to implicate the policy concerns protected by the filed rate doctrine. The case was not *about* the rate, it was only that an award of damages might *affect* the rate.

The analog to *Spielholz* in the insurance context would be an action challenging as false advertising statements by an insurer allegedly promising certain coverage, which the insurer then denied. In the

language of *Spielholz*, the defendant (in the hypothetical) allegedly misrepresented the existence of “dead zones” in the coverage. A potential award of damages to a plaintiff – or plaintiff class – may upset the assumptions on which the rate was based: If a court determines there is coverage not intended by the insurer or previously provided, the cost experience and projections will not be sufficient to include that additional coverage, and rates may be inadequate. But, the impact is indirect. The case does not require the court to second guess the underpinnings of an approved rate, and therefore does not trigger the filed rate doctrine.

This case is different. The allegations of “false advertising” here specifically concern *the rate*. Did Premera really need that increase due to increased costs? That is a direct allegation concerning justification for the rate, which was presumptively considered by the OIC. Questions regarding rate justification were concluded by the rate order. A court cannot address the allegation that the statement was false, without second-guessing the rate determination. In contrast to *Tenore*, a court cannot decide whether Premera’s rates were justified by costs – and, hence, whether Premera’s representations were true or false – without “substitut[ing] its judgment for the agency’s” on questions concluded by the rate order. *Tenore*, 136 Wash. 2d at 345.

VIII. COURTS DO NOT REGULATE “SURPLUS”

Respondents underscore that Premera has retained an amount of “surplus” they insist is “excessive.” The complaint makes much of the Legislature’s decision to withhold from the OIC the power to order

disgorgement of surplus, or the power to reduce surplus by compelling rates subsidized by surplus. *See* Complaint ¶¶ 32-35 and n.4. Indeed, it appears to be respondents' position that by challenging surplus – particularly because the OIC lacks authority to regulate surplus – respondents have brought this action within the purview of the courts. That is not correct. Courts do not regulate surplus.

A. “Surplus” is the Insurer’s Capital, and Constitutes the Protection Making Insurance Really Insurance.

The Complaint appears to misunderstand the nature and purpose of “surplus”. Despite a potentially unfortunate label, “surplus” is not extra money. *See State Farm Mut. Auto. Ins. Co. v. Superior Court*, 114 Cal. App. 4th 434, 441 (2003). The term “surplus” is used to refer to the company’s assets that are excess of liabilities – a description of “equity” recognized by any homeowner. *Id.* (“An insurer’s ‘surplus’ is the excess of assets over liabilities.”). “The term ‘surplus’ means an insurance company’s assets less liabilities. Put another way, ‘surplus’ is the capital available to back up an insurer’s obligations under its policies.” *Hill v. State Farm Mutual Automobile Ins. Co.*, 166 Cal. App. 4th 1438, 1449 (2008).

Surplus is critical to the risk-shifting function served by insurance. As one court explained:

“[S]urplus provides a safety cushion to absorb adverse results and protects the policyholder and the company by helping maintain the company’s solvency during periods of unfavorable operating results.” (Troxel et al., *Property-Liability Insurance Accounting and Finance* (4th ed. 1995) p. 129.) As the amount of surplus increases, the risk of insolvency decreases. (See United States Congress, Congressional

Budget Office, *The Economic Impact of a Solvency Crisis in the Insurance Industry* (April 1994) pp. 44-45.) An insurer must have an adequate surplus at all times, especially in light of potential catastrophes that may result in substantial damage to numerous policyholders. (See United States Congress, Congressional Budget Office, *The Economic Impact of a Solvency Crisis in the Insurance Industry*, *supra*, at pp.13-15.)

State Farm v. Superior Court, 114 Cal. App. 4th at 441. Such “unfavorable operating results” may occur when underwriting losses increase beyond the levels typical of prior experience, when investment income on the invested assets decreases such as occurs in a recession, in the event of a catastrophe, or any other unforeseen event against which the company cannot reserve. *See id.*⁶

In the context of health care coverage, for example, results under new plans mandated by the Affordable Care Act are difficult to predict, and the experience could be worse than the assumptions made in rating those plans, depending upon the population electing coverage. As another example, an outbreak of the Ebola virus – or any epidemic – would constitute a catastrophe that must be fought using insurance dollars maintained in surplus. That is, surplus, far from being extra money, is what makes the insurance really insurance.

⁶ In answering NAMIC and PCI’s Amicus Curiae Memorandum, respondents confuse reserves with surplus. Reserves are set to fund known loss experience. Surplus protects against events against which an insurer cannot reserve, such as catastrophes, unexpected poor underwriting experience not predictable based on historical data or actuarial models, or adverse investment experience in volatile financial markets.

B. The Legislature Has Chosen Not To Regulate Surplus At The Maximum. That Decision Is One Of Economic Policy, And Cannot Be Overruled By The Judicial Branch.

A state legislature – the holder of the police power – could decide to regulate maximum surplus. Generally states choose not to regulate surplus because insurance is safer when decisions about surplus are left to the business judgment of the company’s management. As the court observed in *State Farm*, 114 Cal. App. 4th at 441:

The financial soundness of an insurance company “depends upon numerous factors that are difficult to quantify, and the insurance market is characterized by substantial diversity across insurers in types of business written, characteristics of customers, and methods of operation. It is impossible to specify the ‘right’ amount of [surplus] for most insurers through a formula.” [citation omitted] Each insurance company has its own method for determining the amount of surplus it considers to be adequate.

Any decision by government to regulate surplus – rather than leaving surplus level to the business judgment of management, where it resides absent exercise of the state’s police power – rests with the Legislature.⁷ Courts are not in the business of deciding either that the state should regulate surplus, or what the “right” amount of surplus should be. *Cf. State Farm, id.* at 445, 449-451, 453 (business judgment rule applies to insulate determinations regarding surplus level from judicial scrutiny).

Here, respondents insist that the gravamen of this case is the concept

⁷ Moreover, the power to regulate surplus level is not part of the power to regulate rates. The power to regulate rates is held by the state where the rates are to be charged. Management of surplus is considered an aspect of a company’s “internal affairs.” *See State Farm, id.* at 442. Consequently, the state with authority to regulate surplus level – should it make that legislative decision – is the state where the insurer is domiciled.

that Premera should have supported its rates with its surplus – its capital – rather than charge premiums as indicated to meet the supported rate level. The proposition that, in today’s economy, insurers should be compelled to waste capital to support current prices regardless of future risk is certainly novel. It is also, undeniably, a question of public policy and the prerogative of the Legislature rather than the courts. *See Armstrong*, 111 Wash. 2d at 792 (Court refused to adopt underwriting restrictions not adopted by the Legislature). As plaintiffs underscore, currently, the Washington Legislature has resisted the suggestion that it should intrude into management decisions concerning adequate capitalization, and has prudently retained the default: that company management is best equipped to evaluate all of the factors that must be balanced in assessing adequate capitalization – a decision left to management’s business judgment. When the Legislature has chosen not to adopt a proposed rule, a plaintiff supporting the rule cannot petition the Court to remedy the omission. *See State v. Jackson*, 137 Wash. 2d 712, 722-23 (1999) (Legislature’s choice to limit accomplice liability statute more restrictively than Model Act upon which Washington statute was fashioned demonstrated Legislature’s “considered decision”, which could not be altered by the courts.)⁸

⁸ The case *Ciamaichelo v. Independence Blue Cross*, 589 Pa. 415 (2006) – cited by respondents in their Answer to amici’s Amicus Curiae Memorandum – is distinguishable on this point. In that case, the plaintiffs challenged the amount of surplus held by defendant and the uses to which surplus was put *on the basis that it was inconsistent with statute*. 589 Pa. at 419-421 and footnotes 2 and 3. The case went to the Pennsylvania Supreme Court on a motion to dismiss, and the Court held only that plaintiffs could make the challenge under the applicable statute. Moreover, unlike the case before this Court, plaintiffs did not challenge *the rates* as allegedly

In every layer, respondents' action seeks to present to the courts questions that are to be resolved, if at all, by the legislative branch of government. But courts do not regulate. The Washington Legislature did not decline to intrude into decisions about capitalization so as to punt that question of economic policy to the courts. The Legislature determined *not* to extend the OIC's regulatory oversight to allow the OIC to police surplus as potentially excessive. Respondents argue for the oversight denied by the Legislature, but their recourse is with the authorized governing body – the Legislature. Respondents cannot seek to overturn legislative policy through a court action.

IX. CONCLUSION

This action, while labeled an action for “false advertising”, calls upon the courts to examine the underpinnings of Premera's approved rates, to answer the question of whether Premera's alleged statements to the effect that rate levels were justified by costs were true or false. That is exactly the exercise precluded by the filed rate doctrine. The OIC's approval of the rates concludes the question: the rates were approved; therefore they were justified.

Nor can respondents present a justiciable issue based on their theory that Premera held excessive surplus, and could and should have supported justified rate levels by liquidating assets rather than charging

excessive.. Plaintiffs directly challenged the level and use of surplus. That was the basis for the Court's holding that the filed rate doctrine did not apply.

premiums at the rate levels justified to the OIC. Courts do not regulate surplus, particularly where the State Legislature has chosen not to allow the insurance regulator to have that control. Respondents' articulated positions state economic policy concerns, not justiciable questions.

Consistent with nationwide jurisprudence, and in the interests of the stability and security of the insurance industry in this State, this action is barred by the filed rate doctrine.

Respectfully submitted on this 5th day of January, 2015.

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CERTIFICATE OF SERVICE

The undersigned declares under penalty of perjury under the laws of the United States and the State of California that, on the below date, I served a copy of the foregoing document on all counsel of record as indicated below:

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