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No. 69661-1-I

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

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

Respondents,

v.

STATE OF WASHINGTON and HEALTH CARE AUTHORITY,

Appellants.

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**REPLY BRIEF OF APPELLANTS**

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ROBERT W. FERGUSON  
Attorney General

Todd R. Bowers, WSBA #25274  
Senior Counsel  
800 Fifth Avenue, Suite 2000  
Seattle, WA 98104-3188  
(206) 464-7352

CALFO HARRIGAN LEYH &  
EAKES LLP

Timothy G. Leyh, WSBA #14853  
Randall Thomsen, WSBA #25310  
Katherine Kennedy, WSBA #15117  
Special Assistant Attorneys General  
999 Third Avenue, Suite 4400  
Seattle, WA 98104  
(206) 623-1700



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## I. INTRODUCTION

The question posed by this appeal is how to measure the damages, if any, suffered by part-time State employees who were denied employer-sponsored health insurance benefits. Because this is a Civil Rule 23(b)(3) class action only, the issue is the appropriate methodology to measure Plaintiffs' monetary losses caused by the denial of health insurance.

The generally-accepted measure of damage for the denial of health insurance, applied by the overwhelming majority of the courts in both individual cases and class actions, requires plaintiffs to prove actual monetary loss caused by the denial of the health insurance, such as out-of-pocket payments for health care costs or premiums paid for substitute insurance.<sup>1</sup>

Here, instead of requiring proof that each class member suffered actual monetary loss, the trial court adopted Plaintiffs' premiums-based proxy for actual damages.<sup>2</sup> This proxy is to multiply the total number of months that class members were denied health insurance, times the

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<sup>1</sup> See Brief of Appellants at 20-27 (discussing cases).

<sup>2</sup> See, e.g., CP 590-91; RP (10/26/12) 40, 42, 47 (rejecting individualized approach). Although it adopted the premiums approach, the court found disputed issues of fact as to the amount of the premiums that the court should use under that approach. RP (10/26/12) 44 (“what employer would have paid in premiums” involves unanswered factual questions).

average monthly premiums the State paid insurance carriers to insure a different group of employees (*i.e.*, full-time employees).<sup>3</sup>

The main problem with Plaintiffs' premiums proxy as a substitute for proof of actual damages is that it improperly assumes that each class member suffered monetary damage, and would provide each class member with the unpaid premiums for each month he or she was denied health insurance. This proxy and assumption of monetary loss is improper because it runs directly contrary to the parties' stipulation and the trial court's finding that some members of the class in fact incurred no health care costs during months they were without coverage – *i.e.*, they suffered no actual monetary damage.<sup>4</sup> Plaintiffs' damage methodology, adopted by the trial court, necessarily would overcompensate the class as a whole.<sup>5</sup>

The trial court's "premiums" measure of damage also violates due process because it would allow Plaintiffs to evade their burden to establish

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<sup>3</sup> Plaintiffs say they are proposing three different "methodologies," but these are simply different labels for the identical calculation, and they all involve the same fundamental flaws. The so-called "wage," "restitution," and "actuarial" approaches each use premiums that employers paid on behalf of a different group of public employees than the class.

<sup>4</sup> CP 47-50 (stipulation stating that some class members "incurred no health care costs [during the months they were eligible for employer-funded health benefits but not given the opportunity to enroll] because those class members did not receive any health care services.").

<sup>5</sup> This problem is particularly acute here because a significant portion of the class was without coverage for only a short period of time – one or two months. *See, e.g.*, CP 489. These employees, who took their jobs with no anticipation of coverage, likely incurred no health care costs at all during that short period, simply because they were healthy.

damage and causation for each class member, and deny the State its right to contest Plaintiffs' proof of those elements, contrary to *Sitton v. State Farm Mut. Auto. Ins. Co.*, 116 Wn. App. 245, 63 P.3d 198 (2003).

Plaintiffs label these concerns "rhetoric" and assert that the Supreme Court rejected *Sitton* in *Moeller v. Farmers Ins. Co. of Wash.*, 173 Wn.2d 264, 267 P.3d 998 (2011). But in *Moeller*, the Supreme Court distinguished *Sitton* and "specifically noted that class certification would not impede Farmers' ability to defend against individual claims, presumably encompassing a defense based on lack of damages." 173 Wn.2d at 280. This case is different from *Moeller* and like *Sitton* because here, as in *Sitton*, Plaintiffs would receive a damages award "without requiring individual claimants to establish causation and damages." 116 Wn. App. at 258 (emphasis added). In *Sitton*, this Court rejected that approach, and the Court should do so here.

While Plaintiffs now rely on the trial court's comments regarding the "impacts" of deferred health care, arguing that such impacts constitute damage in fact, Plaintiffs offered no evidence that the amount of monetary damage from deferred health care bears any relationship whatsoever to the health insurance premiums that are at the core of the damage methodology adopted by the trial court.

Another fundamental problem with Plaintiffs' methodology is that premiums paid on behalf of other employees (full-time State employees) bear no reasonable relationship to the actual monetary loss incurred by this class of part-time and seasonal employees. The evidence was that the class is demographically different (younger and healthier) than the full-time employees who were provided insurance, and as a result, the cost to insure class members would be lower.<sup>6</sup> In addition, the premiums paid to third-party insurers include insurer profits and administrative costs that are not part of the health care costs of the class.

Finally, the administrative burden Plaintiffs perceive in requiring them to prove actual monetary damage by each class member, purportedly through "thousands of mini-trials," is overblown. The type of claims process the State proposes commonly is used in class actions and can easily accommodate the administrative burdens Plaintiffs cite. Indeed, Plaintiffs propose a similar process to distribute any class damages award to individual class members.<sup>7</sup> This Court should follow the overwhelming weight of authority and reverse the trial court on the measure of damages.

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<sup>6</sup> CP 286-87.

<sup>7</sup> CP 181 ("Another possibility concerning distribution of the class-wide loss is an administratively-efficient non-adversarial claim process to allow those class members with especially large claims the opportunity to submit a claim for a damage award larger than the average . . .").

## II. REPLY TO PLAINTIFFS' "COUNTERSTATEMENT OF THE CASE"

In their "Counterstatement of the Case," Plaintiffs attack the State's good faith in promulgating its 2004 policy on not allowing averaging of hours of employees to determine their eligibility for health insurance benefits. Not only are these accusations false, but they are completely irrelevant to this appeal regarding the appropriate damages methodology.<sup>8</sup> The trial court long ago held that the State must average employees' hours for purposes of eligibility. The Legislature later codified that ruling into state law. This appeal simply does not involve liability issues at all.

Plaintiffs also misstate the record by repeatedly claiming that the "undisputed evidence" is that their damage methodology is superior to the State's proposed method, and that it is "undisputed" that the latter is "not a scientifically valid method." In fact, the State's experts pointed out numerous material defects in Plaintiffs' method and testified about the need for the individualized damage determinations sought by the State.<sup>9</sup>

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<sup>8</sup> Even if Policy 4-12 had any conceivable bearing here, the record demonstrates Plaintiffs' mischaracterizations. For example, a contemporaneous "Executive Summary" regarding Policy 4-12 states that the policy was drafted at the advice of counsel, who advised the Public Employees Benefit Board ("PEBB") that the Health Care Authority ("HCA"), in permitting averaging, had been operating outside WAC rules that did not mention averaging for purposes of PEBB eligibility. CP 626. And far from being "secret," the HCA posted Policy 4-12 on the PEBB Extranet. *Id.*

<sup>9</sup> *See, e.g.*, CP 303-04.

Likewise, Plaintiffs' assertion that the State's expert Stefan Boedecker "conceded" that an individual claims process was "not feasible" is incorrect. Mr. Boedecker merely pointed out mistaken assumptions in the declaration of Plaintiffs' expert.<sup>10</sup> Plaintiffs' assertions that the State admitted "inaccuracies" in its approach are false.

### III. ARGUMENT

#### A. The Standard of Review is *De Novo*, Not Abuse of Discretion.

The standard of review for summary judgment rulings such as those at issue here is *de novo*. *Sheikh v. Choe*, 156 Wn.2d 441, 447, 128 P.3d 574 (2006). The appropriate method to measure damages undisputedly is a question of law, also reviewed *de novo*. *Shoemake v. Ferrer*, 168 Wn.2d 193, 198, 225 P.3d 990 (2010); *Galindo v. Stoodly Co.*, 793 F.2d 1502, 1517 (9<sup>th</sup> Cir. 1986) ("whether the district court selected the correct legal standard" for damages is reviewed *de novo*). Plaintiffs argue that the standard is "abuse of discretion," but the case on which they rely, *In re Marriage of Farmer*, 172 Wn.2d 616, 259 P.3d 256 (2011), is inapposite.

*Farmer* was a dissolution case addressing damages for a spouse's fraudulent conversion of stock options.<sup>11</sup> The Court in *Farmer* ruled that

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<sup>10</sup> CP 1153-57.

<sup>11</sup> After the entry of a stipulated agreement dividing stock options equally between the

the trial court's award should be reviewed for abuse of discretion because "[s]itting in equity, a trial court enjoys broad discretion to grant relief to parties in a dissolution based on what it considers to be 'just and equitable,'" the standard found in the dissolution statute. *Id.* at 624. The Court agreed, however, that the trial court's decision on the "measure of damages is a question of law" and that such a question is subject to *de novo* review. *Id.* at 625. Combining both standards, the Court concluded that in a case brought in equity, "a trial court necessarily abuses its discretion if it awards damages based upon an improper method of measuring damages." *Id.*

The damage claim in this CR 23(b)(3) class action does not involve the Court's equitable jurisdiction or its discretion to rule on a "just and equitable" basis. This appeal challenges summary judgment rulings and the proper methodology to measure damage, both subject to *de novo* review.<sup>12</sup>

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husband and wife (with each given the choice of when to exercise his or her share of the options), the husband unilaterally exercised all of the options. *Id.* at 620-21. The issue was the measure of damages recoverable by the former wife for fraudulent conversion – the highest value at the time of conversion, or the reasonable value of the options a day before expiration of the options. The trial court adopted the latter approach, emphasizing its discretion as a "court of equity," and the need not to "reward Daniel's fraudulent conduct." *Id.* at 622-23.

<sup>12</sup> Even if *Farmer* somehow applied, the trial court here "necessarily abuse[d] its discretion" by adopting an improper damage methodology.

**B. The Trial Court's Damage Rulings Improperly Assume the Fact of Monetary Damage to Each Class Member.**

Plaintiffs bear the burden to demonstrate the fact of monetary damage for each class member. A class “must be able to prove the fact of injury . . . due to individual class members” to recover in a lawsuit. 1 JOSEPH M. McLAUGHLIN, *McLAUGHLIN ON CLASS ACTIONS: LAW & PRACTICE* § 4.19 at 731 (9<sup>th</sup> ed. 2012); *See also Collins v. Anthem Health Plans, Inc.*, 880 A.2d 106, 122 (Conn. 2005) (“[E]ach class member’s right to recover damages . . . is conditioned on the plaintiffs’ ability to prove, inter alia, that the class member suffered harm that was caused by the incentive program. Thus, the method advanced by the plaintiffs essentially amounts to an end run around the defendant’s right to have each class member prove the essential elements of liability.”)

Damages must be based on proof of injury to each class member under the same legal standards that would apply to individuals. 3 ALBA CONTE & HERBERT NEWBERG, *NEWBERG ON CLASS ACTIONS* § 10.5 at 478-79 (4<sup>th</sup> ed. 2002) (no special evidentiary standards used to support aggregate proof of the defendant’s monetary liability to the class). This class is certified under CR 23(b)(3), and the only remedy sought is monetary damages. *See Wal-Mart Stores, Inc. v. Dukes*, \_\_\_ U.S. \_\_\_,

131 S. Ct. 2541, 2558, 180 L. Ed. 2d 374 (2011) (“[W]e think it clear that individualized monetary claims belong in Rule 23(b)(3).”).

The only issue on this appeal is how to measure, in monetary damages under CR 23(b)(3), the harm caused by the failure to provide health insurance to State employees. Class members who did not suffer any actual monetary loss by paying for health care or substitute insurance are not entitled to monetary damages under CR 23(b)(3).

The “premiums” proxy adopted by the trial court assumes the fact of actual monetary damage for each class member, despite Plaintiffs’ stipulation to the contrary and the court’s finding based on that stipulation. Plaintiffs try to avoid this fundamental problem by arguing (1) that each class member suffered “monetary loss” in the form of the employer contribution to health insurance that was not paid, *i.e.*, the employer premiums; (2) that damage to every class member is established by the 1993 Washington statute finding that “the lack of basic health care coverage is detrimental to the health of individuals lacking coverage”; and (3) that the trial court “took notice” of the fact that individuals without health insurance have “deferred care” costs. None of these arguments comes close to meeting Plaintiffs’ burden to show that each class member suffered actual damage in dollars and cents, which is required in a CR 23(b)(3) class action.

**1. Employer-paid premiums for other employees are not an adequate substitute for proof of actual monetary damage to every class member.**

No Washington case has held that unpaid premiums are the appropriate measure of damage for denial of health insurance benefits. The remedy generally for failure to procure an insurance policy is the actual losses that would have been covered by the policy. *See Frank Coluccio Constr. Co. v. King County*, 136 Wn. App. 751, 766-67, 150 P.3d 1147 (2007).<sup>13</sup>

Plaintiffs strain to distinguish the many cases the State cited that expressly reject the “premiums” measure in favor of actual out-of-pocket losses, arguing that they involved plaintiffs with wrongful termination claims who were required to mitigate their damages.<sup>14</sup> That is a distinction without a difference. All plaintiffs are required to mitigate damages. Moreover, the handful of cases Plaintiffs cite for the “premiums” approach either were district court cases whose Courts of Appeals later rejected the “premiums” approach, or involve entirely different situations making them not persuasive authority.

If the State had properly applied the eligibility rules, it would have paid its share of appropriate premiums to insurance companies. The class

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<sup>13</sup> For additional Washington cases involving damages for failure to procure insurance, *see* Brief of Appellants at 28.

<sup>14</sup> Brief of Plaintiff Class/Respondents at 40 & n.39.

members never would have received those premiums; they would have received the opportunity to enroll for insurance benefits, which they may or may not have used.

Mere membership in this class does not mean that a class member actually suffered monetary damage. This case is unique in that the parties have agreed that the class contains some members who in fact suffered no actual monetary damages while they were without coverage. The parties do not know whether this portion of the class is small or large because there has been no discovery on class damages, but the State believes that a substantial portion of the class likely suffered no monetary damage because they were without health insurance for only a limited period of time.<sup>15</sup> That portion of the class would receive a monetary damages award under Plaintiffs' methodology. By adopting the Plaintiffs' premiums proxy, the trial court improperly relieved Plaintiffs of the burden of proving actual monetary damages for each class member.

While the trial court ruled that health insurance benefits are "wages" due to class members, applying that label (if correct) does not address how to measure Plaintiffs' actual losses in dollars and cents. The

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<sup>15</sup> See, e.g., CP 489 (approximately 51% of class only had apparent eligibility for two months or less).

same problem inheres in Plaintiffs' restitution theory. The *Cockle*<sup>16</sup> case on which Plaintiffs and the trial court relied does not answer the question of how to value the denial of health insurance, because the parties in *Cockle* stipulated that the unpaid premiums were the amount of the loss, which the State vigorously denies here. *Cockle*, 142 Wn.2d at 821 n.10. The monetary damage from not being provided health insurance simply was not at issue at *Cockle*.

*Cockle* involved the question of whether insurance benefits were recoverable under a worker's compensation statute including, in the definition of "time loss," "the reasonable value of board, housing, fuel, or other considerations of like nature received from the employer as part of the contract of hire." *Cockle*, 142 Wn.2d at 805. The Court's holding was based on the statutory language, the legislative history, and the canons of statutory construction, none of which apply here. *Id.* at 805, 811, 822.<sup>17</sup>

Plaintiffs also rely on the Thurgood Marshall dissent in *Morrison-Knudsen Constr. Co. v. Department of Labor*, 461 U.S. 624, 103 S. Ct. 2045, 76 L. Ed. 2d 194 (1983), but they omit the end of Justice Marshall's sentence stating that an employer's contribution to a trust fund has been accepted as the value of fringe benefits "when such benefits are expressly

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<sup>16</sup> *Cockle v. Department of Labor & Indus.*, 142 Wn.2d 801, 16 P.3d 583 (2001).

<sup>17</sup> The State addresses *Cockle* more fully in its opening brief. See Brief of Appellants at 32-33.

included in a statutory definition of wages,” as in the Davis-Bacon Act. There is no provision in Title 41 (the source of the duty to provide health insurance) that purportedly entitles Plaintiffs to health insurance benefits as “wages.” Indeed, “wage” is defined in Title 49 (governing labor relations) as compensation “payable in legal tender of the United States . . . .” RCW 49.46.010. It does not encompass non-monetary benefits.<sup>18</sup>

**2. Actual monetary damages cannot be assumed from the absence of insurance.**

Plaintiffs contend that uninsured employees were harmed even if they had no out-of-pocket expenses during the relevant period because the mere “absence of insurance is harmful.”<sup>19</sup> Plaintiffs argue for the first time in this case that the Court should presume “harm caused by lack of health coverage,” *i.e.*, damage in fact, because the Legislature found, in a 1993 statute, that “[the] lack of basic health care coverage is detrimental to the health of the individuals lacking coverage . . . .”<sup>20</sup> RCW 70.47.010(2). But that general principle does nothing to satisfy Plaintiffs’ burden in a CR 23(b)(3) class action of establishing some actual monetary damage to each class member.

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<sup>18</sup> The trial court also ruled that class members are entitled to restitution, but restitution is based on the amount the defendant received, not actual monetary loss to a plaintiff. *See* RESTATEMENT OF RESTITUTION § 150 (1937); *see also* Brief of Appellants at 33-35.

<sup>19</sup> Brief of Plaintiff Class/Respondents at 26.

<sup>20</sup> Brief of Plaintiff Class/Respondents at 27-28 & n.22.

Plaintiffs also rely on RCW 41.05.050(1),<sup>21</sup> but that statute merely requires State agencies to “provide contributions to insurance and health care plans” for eligible employees; the State does not pay insurance premiums to employees themselves. And even if the statute had any conceivable relevance here, it would be limited to the issue of liability which already has been decided and is not part of this appeal.

**3. Actual monetary damage in a CR 23(b)(3) class action cannot be assumed from hypothetical “deferred health care.”**

The trial court offered its views regarding the “impacts” of deferred health despite the lack of evidence that (1) any class member actually suffered any monetary damage from being denied the opportunity to acquire health insurance; or (2) that the amount of monetary damage from “deferred health care” has any relationship to health insurance premiums, which are the basis for each of Plaintiffs’ damage theories.<sup>22</sup>

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<sup>21</sup> Brief of Plaintiff Class/Respondents at 18.

<sup>22</sup> In Respondents’ Statement of Additional Authority (12/17/13), Plaintiffs offer the recent case of *Estate v. Dormaier*, \_\_\_ Wn. App. \_\_\_, 313 P.3d 431 (Nov. 14, 2013) in an apparent effort to support their argument that deferred health care may constitute damage in fact. *Dormaier* was a wrongful death action alleging medical negligence in failing to diagnose a patient with pulmonary embolus, and to treat her with anticoagulants before surgery. The issue was whether a jury instruction on “lost chance of survival” was appropriate. The case does not remotely address the circumstances here, where some class members admittedly had no damages caused by the State, and the trial court’s ruling violated defendant’s due process right to present evidence of that fact.

Plaintiffs argue misleadingly that the trial court relied on “many studies concerning the harms caused by lack of insurance,”<sup>23</sup> referring to studies collected in an *amicus* brief before the United States Supreme Court in a case challenging the Affordable Care Act.<sup>24</sup> But Plaintiff presented none of those studies to the trial court here, and they are not in the record. The trial court merely referred vaguely to “the studies that have come out” in connection with the Affordable Care Act.<sup>25</sup>

**C. Requiring Plaintiffs to Prove Their Actual Damages is Consistent with the Vast Majority of Other Jurisdictions that Have Considered this Issue.**

Plaintiffs’ “wage,” “restitution,” and “actuarial” approaches all involve the identical calculation and suffer from the same fatal defect: the fact that some class members had no actual monetary damage. The only way to avoid this fact-of-damage problem is to require Plaintiffs to prove which class members suffered an actual monetary loss as a result of the State’s denial of health insurance, such as uninsured medical expenses or the cost to purchase substitute insurance.

Plaintiffs fail to discredit the overwhelming majority rule on the proper “out-of-pocket” measure of damages for denial of health insurance.

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<sup>23</sup> Brief of Plaintiff Class/Respondents at 28-29 & n. 23.

<sup>24</sup> *Id.*

<sup>25</sup> RP (10/26/12) 40-41. In its written Order, the trial court stated that its “deferred care” conclusion was supported by “studies that are public knowledge,” without identifying any such studies. CP 590-91.

Aside from *United States v. City of New York*, 847 F. Supp. 2d 395 (E.D.N.Y. 2012), Plaintiffs do not address the specific cases at all, including cases decided by the Ninth Circuit and the Western District of Washington. Instead, they argue that the State's cases "all involve individuals who were not working for the defendant due to some wrongful conduct," who were required to mitigate their damages.<sup>26</sup> But the courts' rejection of a "premiums" proxy for damages does not depend on a "mitigation" rationale, but rather on the conclusion that a "premiums" measure of damage "would make a plaintiff more than whole." *See, e.g., Galindo v. Stoodly Co.*, 793 F.2d 1502, 1517 (9<sup>th</sup> Cir. 1986).

Contrary to Plaintiffs' argument, the outcomes of the cases cited by the State are not determined by whether plaintiffs were "not working" for the defendant. The main case on which Plaintiffs rely, *E.E.O.C. v. Dial Corp.*, 469 F.3d 735 (8<sup>th</sup> Cir. 2006), also involves plaintiffs who were "not working" for the defendant due to alleged discrimination, like some of the cases cited by the State.<sup>27</sup>

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<sup>26</sup> Brief of Plaintiff Class/Respondents at 40 & n. 38.

<sup>27</sup> The Eight Circuit's *E.E.O.C.* case is unpersuasive because it is based on *Fariss v. Lynchburg Foundry*, 769 F.2d 958, 965-66 (4<sup>th</sup> Cir. 1985), a case adopting a premiums-based measure of damage for denial of life insurance. Life insurance cases are factually distinguishable, as explained in *City of New York*, 847 F. Supp. 2d at 422 n.10 (because loss caused by lack of life insurance is felt by victim's beneficiary, "a premium or replacement measure of value lost may thus be more logical . . ."). Moreover, the Ninth Circuit's *Galindo* case disapproved of *Fariss*' "premiums" approach. *Galindo*, 793 F.2d at 1517 n.15.

Plaintiffs also assert that the cases cited by the State do not involve class actions, but that is incorrect. *See, City of New York*, 847 F. Supp. 2d 395.<sup>28</sup> Likewise, their assertion that the federal cases do not discuss due process is misplaced, since the State's due process right to defend on damages and causation is based on *Sitton*.

Plaintiffs make the misleading argument that “many federal cases” support their “premiums” approach, but they rely on older cases from district courts whose Circuit Courts subsequently adopted the opposite rule, or on distinguishable cases.<sup>29</sup> For example, they cite *Jones v. Kayser-Roth Hosiery, Inc.*, 748 F. Supp. 1276 (E.D. Tenn. 1990), and *Blackwell v. Sun Elec. Corp.*, 696 F.2d 1176, 1186 (6<sup>th</sup> Cir. 1983), but the Sixth Circuit later rejected the premiums standard and adopted the “out-of-pocket expenses” requirement based on “the more recent cases.” *Hance v. Norfolk S. Ry. Co.*, 571 F.3d 511, 522 (6<sup>th</sup> Cir. 2009). They cite *Jacobson v. Pittman-Moore, Inc.*, 582 F. Supp. 169 (D. Minn. 1984), but the Ninth Circuit expressly disapproved of its damage approach in *Galindo*, 793 F.2d at 1517 n.15.

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<sup>28</sup> *Aff'd in part & rev'd in part on other grounds*, 717 F.3d 72 (2<sup>nd</sup> Cir. 2013). The Second Circuit vacated summary judgment on the issue of disparate treatment and intentional discrimination, and narrowed the injunction. The Second Circuit left undisturbed the District Court's holding on the measure of damages for lost insurance benefits.

<sup>29</sup> *See* Brief of Plaintiff Class/Respondents at 18 n.15.

Plaintiffs cite the bankruptcy case of *In re Texas Wyo. Drilling, Inc.*, 486 B.R. 746 (Bankr. N.D. Tex. 2013), but the issue there was whether the cost of health insurance, in addition to vacation pay and expenses relating to the use of a truck, was recoverable under the Bankruptcy Code. This is a completely different issue than how to measure the loss of insurance benefits. In any event, the Fifth Circuit, in which the Texas bankruptcy court sits, repeatedly has adopted the out-of-pocket expense requirement and rejected the “premiums” approach. *Pearce v. Carrier Corp.*, 966 F.2d 958, 959 (5<sup>th</sup> Cir. 1992); *Lubke v. City of Arlington*, 455 F.3d 489, 499 (5<sup>th</sup> Cir. 2006).

Most fundamentally, none of the cases cited by Plaintiffs involve an aggregate award of damages to a CR 23(b)(3) class that admittedly includes members who had no monetary damage, as stipulated by the parties here.

**D. The Trial Court’s Rulings Deny the State its Due Process Right, Recognized in *Sitton*, to Require Plaintiffs to Prove Damage and Causation, and to Challenge Those Elements of their Claims as to Specific Class Members.**

The trial court did not address the State’s primary concern about Plaintiffs’ “premiums” approach, which is that it assumes that each class member suffered monetary damage despite a stipulation to the contrary, and violates the State’s due process right under *Sitton* to require Plaintiffs

to prove all of the elements of their claim, including actual monetary injury by each class member caused by the State's failure to provide health insurance.

Plaintiffs argue that the Supreme Court "rejected" *Sitton's* due process argument in *Moeller v. Farmers Ins. Co. of Wash.*, 173 Wn.2d 264, 267 P.3d 998 (2011). However, *Moeller* does not apply to the facts presented here.

In *Moeller*, the issue was the appropriateness of class certification rather than the measure of damages. The *Moeller* court rejected the argument that a class-wide award of damages "would allow damages to be awarded before individual class members prove they suffered damage" because the trial court expressly had permitted defendant to defend against individual claims on the basis of lack of damages. *Id.* at 279. Unlike *Moeller*, the trial court in this case specifically rejected any individualized claims process, stating: "I do reject the defendants' argument that this [the issue of damages] is an individualized inquiry . . . ." <sup>30</sup> In contrast, the trial judge in *Moeller* permitted defendant to "present evidence on individual claims supporting defenses unique to each claim and defend against the nature and extent of damages, if any, in this Court." *Id.* at 280 (quoting trial court's ruling).

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<sup>30</sup> RP (10/26/12) 47.

Furthermore, the *Moeller* Court specifically found that plaintiff had not made any “admission” regarding damage and causation. *Id.* In contrast, the parties here stipulated that some class members had no actual damage during months they were eligible for health insurance because they did not receive any medical care, or incurred health care costs that would not have been covered by the employer-sponsored insurance.<sup>31</sup> That stipulation makes this case unique. Plaintiffs’ premiums proxy is inappropriate because it precludes the State from determining which or even how many class members fall into the categories described by the stipulation.

In *Sitton*, this Court noted the “faulty syllogism” that a determination of liability meant that “the full amount of every claim made is valid.” *Sitton*, 116 Wn. App. at 259. Here, the “faulty syllogism” is that because the State failed to offer class members health insurance, all class members sustained some actual monetary damage. That syllogism is incorrect both as a matter of logic and as a matter of fact, given the parties’ stipulation.

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<sup>31</sup> CP 48.

**E. The Use of a Premiums Proxy Under Any of Plaintiffs' Damage Theories Would Overcompensate the Class.**

Even if they could establish the fact of damage for each class member, Plaintiffs' premiums proxy for measuring damages would yield an inaccurate and unfair result.<sup>32</sup> Plaintiffs argue that the court decided "to measure damages as lost wages" based on the State's insurance premiums "because the measure is based on a statute the state violated, RCW 41.05.050(1), and it constitutes the precise wages the employees did not receive."<sup>33</sup> Each of those propositions is incorrect.

Plaintiffs did not mention RCW 41.05.050(1) in their summary judgment papers and argument in the trial court, and the court did not rely on the statute in its rulings.<sup>34</sup> RCW 41.05.050(1) says only that State agencies "shall provide contributions to insurance and health plans for its [eligible] employees"; it may state a duty, but it does not define damages and it does not say how to measure damages for failing to insure.

Nor do insurance premiums paid to other employees constitute "the precise wages" class members were denied. Plaintiffs never would

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<sup>32</sup> CP 286-87.

<sup>33</sup> Brief of Plaintiff Class/Respondents at 14.

<sup>34</sup> See RP (10/26/12) 38-47; CP 588-93 ("Order RE Measure of Damages on Plaintiffs' Statutory Claim"); CP 125-48 ("Plaintiffs' Motion on Measure of Damages"); CP 455-61 ("Plaintiffs' Reply on Measure of Damages"); CP 511-34 ("Plaintiffs' [Corrected] Response to State's Motion for Individual Bill Submissions"). There was no such "motion for individual bill submissions."

have received payment of premiums as wages; the premiums are paid to third-party insurers.

Plaintiffs did not (and cannot) establish what premiums would have been paid on behalf of the class members, part-time and seasonal workers who as a group are substantially younger than other, full-time employees, and more likely to have waived insurance coverage. The premiums Plaintiffs propose to use as a proxy for actual damages are those that the State paid to insure full time State employees whom the parties agree are demographically different from the class, resulting in different costs to insure.<sup>35</sup> Plaintiffs have done nothing to establish that premiums paid on behalf of a distinctly different group bear any relationship to the actual monetary damages suffered by the class, such that they are a reasonable proxy for actual damages. In view of the demographic and other differences, even if the parties had not stipulated that some members of the class suffered no actual monetary damage, Plaintiffs failed to establish that their premium proxy reasonably approximates actual monetary loss by the class.<sup>36</sup>

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<sup>35</sup> Compare CP 286-87 (demographic differences exist between the two groups) with CP 154 & n.3 (Plaintiffs' expert conceding that he is assuming no material demographic differences, and that it is conceivable that such differences exist).

<sup>36</sup> CP 294.

These problems with the use of a premiums measure of damages apply equally to Plaintiffs' "wage," "restitution," and "actuarial" theories, which involve identical calculations based on the employers' contributions to health insurance premiums for a demographically-distinct group of employees.<sup>37</sup> Even Plaintiffs' expert admits that the class is not necessarily "comparable" to the group of insured employees.<sup>38</sup> The trial court agreed: "I don't agree with the plaintiffs that it's an appropriate proxy to say that the [class members] would have behaved like the people who did receive insurance coverage" with regard to opting for State offered insurance.<sup>39</sup>

Because, as the trial court acknowledged, class members may have made different health insurance choices than State employees who received State-funded coverage, it clearly is improper to measure class members' damages by the premiums paid to insure the other employees.

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<sup>37</sup> Regarding restitution, an additional salient fact is that the HCA did not "retain" the employer portion of the premiums that were not paid to insurers to cover that part of the class that did suffer a monetary loss. Because the class members were not designated by their employers as eligible for insurance, the Legislature never raised or appropriated the funding to cover the premiums for those class members, and the State has not retained any "windfall" from the non-payment of premiums on behalf of class members.

<sup>38</sup> See, CP 154.

<sup>39</sup> RP (10/26/12) at 39:14-25.

#### IV. CONCLUSION

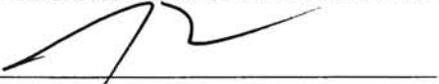
The trial court erred in adopting Plaintiffs' premiums proxy for damages because it assumes that all class members suffered a monetary loss. Such an assumption is directly contrary to the parties' stipulation and the trial court's finding that not all class members suffered such a loss. The court's erroneous measure of damages also violates the State's due process right to require Plaintiffs to prove the fact of damage for each class member, caused by the State's denial of health insurance.

For these and the other reasons stated herein, this Court should reverse the trial court and remand, directing the lower court to require proof of out-of-pocket expenses incurred by each class member as a result of the State's failure to offer health insurance to those members.

RESPECTFULLY SUBMITTED this 20<sup>th</sup> day of December, 2013.

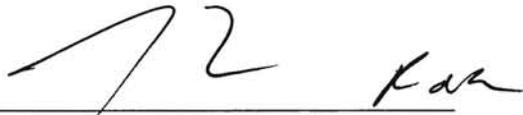
CALFO HARRIGAN LEYH & EAKES LLP

By

  
\_\_\_\_\_  
Timothy G. Leyh, WSBA #14853  
Randall Thomsen, WSBA #25310  
Katherine Kennedy, WSBA #15117

Special Assistant Attorneys General for  
Defendants Health Care Authority and the  
State of Washington

ROBERT FERGUSON  
Attorney General

By   
Todd R. Bowers, WSBA #25274

Senior Counsel for Defendants Health Care  
Authority and the State of Washington