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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,  
Plaintiffs/Respondents.

v.

HEALTH CARE AUTHORITY and STATE OF WASHINGTON,  
Defendants/Petitioners,

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**BRIEF OF PLAINTIFF CLASS/RESPONDENTS**

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## INTRODUCTION

This case addresses the damages due to part-time State employees who were deliberately denied health care benefits received by other State employees. The Health Care Authority (“HCA”) and the State of Washington unlawfully failed to provide these employer-paid health benefits to the plaintiff class of part-time State employees.<sup>1</sup> The primary issue is whether the trial court abused its discretion in choosing its measure of damages for the employees.

The trial court decided that damages could be measured by two alternative methods: lost wages and restitution. HCA barely discusses the trial court’s decision on wages because it has no authority holding it is unlawful to calculate employees’ lost wages, as the trial court did. The State’s employer contribution for health care premiums constituted lost wages under Washington law and, given the trial court’s wide discretion in determining damages, was a reasonable way to measure damages here. Restitution is also a reasonable alternative method.

HCA instead argues that the *only* way to measure damages is by calculating out-of-pocket costs on an individual-by-individual basis with documents and “oral or written testimony.” But not only is HCA’s

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<sup>1</sup> Defendants are generally referred to collectively as “HCA” because HCA is the lead defendant and primarily responsible for violating the law here. The *Moore* plaintiff class is generally referred to as the “employees.”

approach impractical, designed to throw up roadblocks to the part-time employees who were misused by the State, it is also scientifically invalid.

The trial court's decision on the measure of damages was correct and this Court should affirm it.

### **OBJECTION TO ASSIGNMENTS OF ERROR**

HCA's opening brief misstates the trial court's decision, the facts, the employees' arguments, and the pertinent law. Consequently, the issues must be restated.

### **ISSUES**

1. Did the trial court abuse its discretion when it decided to measure damages here as lost wages based on the State's contribution for health benefits that the employees did not receive as part of their employment compensation?

2. Did the trial court abuse its discretion in deciding an alternative remedy of restitution is appropriate here based on the monetary benefit the State obtained by wrongly not paying for the employees' health benefits?

3. Did the trial court err in ruling that it was not constitutionally required to adopt HCA's out-of-pocket measure?

### **COUNTER-STATEMENT OF THE CASE**

This *Moore* class action is a follow-up to *Mader v. Health Care Authority*, 149 Wn.2d 458, 70 P.3d 931 (2003). In *Mader*, our Supreme Court held that the HCA wrongly denied health benefits to part-time

college instructors who worked at least half-time in the instructional year under HCA's career seasonal rule. *Id.* at 470-76. As part of the post-remand *Mader* settlement in 2004, the parties agreed to provide settlement funds to part-time instructors who *averaged* half-time over the nine-month instructional year, but who did not work at least half-time each quarter. CP 607-08. Because this averaging issue was discovered after the Supreme Court's *Mader* remand, the parties agreed in the *Mader* settlement that HCA would undertake a "good faith review" of future health insurance eligibility for instructors who average at least half-time on an instructional-year basis, but who do not work half-time every quarter. *Id.*; CP 615-16.

HCA did not disclose what it was doing in the good faith review, so class counsel requested public records concerning HCA's practices relating to health insurance eligibility for employees who average half-time or more. CP 609. Those public records, and discovery in this class action, show that for the 15 years prior to the 2004 *Mader* settlement "HCA instructed state agency payroll offices . . . that they could apply averaging to intermittent, seasonal and nonpermanent state employees." CP 609-10, 632-33, 765.

But rather than provide health benefits to the *Mader* college instructors who *averaged* at least half-time, as the regulations had always provided, HCA decided to cover up the existence of the averaging rule and

end its use for all State employees, not just college instructors. CP 609-10, 628. Within days of signing the *Mader* settlement, HCA scrubbed its longstanding regulatory guidance on using averaging to calculate half-time from its informational website for state agencies. It also secretly adopted a staff policy statement, policy 4-12, which, HCA later said, ended averaging for all State employees. CP 609-10, 626, 628, 791, 812.

After class counsel complained to the Public Employees Benefits Board (“PEBB”) that the scrubbing of HCA’s long-standing regulatory interpretation and the staff’s new interpretation were the opposite of a good faith review, CP 707-23, HCA staff admitted that the agency had used the averaging method for calculating half-time since 1988, *i.e.*, since the time the Legislature established the HCA. CP 765-66. Despite a 1993 statute that prohibited the agency from enacting more restrictive eligibility criteria than those in effect in 1993 (RCW 41.05.065(2)(g) (pre-2010)), the PEBB nevertheless expressly eliminated averaging by requiring half-time work every month. CP 612, 673-75, 679-80, 716-23; WAC 182-12-115(3) (2006).

Due to HCA’s cover-up of its original statutory interpretation, followed by its purported elimination of averaging, many State employees (in addition to the part-time instructors in *Mader*) were excluded from employer-paid health insurance. CP 106. For example, representative plaintiff Doug Moore worked almost full-time on a nine-month seasonal

basis at the Washington State Horse Racing Commission. CP 655-56. But Moore did not work half-time every month; he averaged half-time work over the nine months needed to establish year-round eligibility for career seasonal employees (WAC 182-12-115(4) [pre-2006]). CP 655-56. HCA refused to recognize Moore's eligibility for state-paid health insurance during the three-month off-season. CP 648-52, 655-56.

Plaintiffs then filed this *Moore* class action on behalf of State employees who worked on average at least half-time for either (1) the six months required under the "nonpermanent" rule or (2) the nine months required under the "career seasonal" rule, but who were denied health insurance under HCA's 2004 reinterpretation of the health care statutes that the agency formally adopted in its 2006 rule. CP 1-5. The trial court certified a class of State employees with non-standard work schedules who worked on average at least half-time, but were denied health benefits. CP 14-18. The trial court found that "many class members' claims are relatively small and it would be cost-prohibitive to pursue individual lawsuits." CP 15.

The trial court then heard a series of partial summary judgment motions, and it ruled that HCA and the employing agencies violated several statutes by failing to provide health benefits to the employees. CP

735-38, 783-88, 864-65, 1958-69.<sup>2</sup> The trial court specifically ruled that the 2006 HCA regulations aimed at eliminating averaging violated three statutes, including the 1993 statute that prohibited HCA from enacting more restrictive eligibility criteria. *Id.*; RCW 41.05.065(2)(g) (pre-2010). HCA did not seek appellate review; it acquiesced in the trial court's ruling and started to implement the ruling in 2008.<sup>3</sup> Then, in 2009, the Legislature enacted amendments to RCW 41.05 that largely codified the trial court rulings. Under the statute employees who average at least half-time for six months or longer are eligible for health benefits. RCW 41.05.065(4)(a) (2010).<sup>4</sup>

The principal issue that remained below was damages for the class. The employees filed a motion to continue class certification for monetary relief in 2011, which HCA opposed primarily due to the need to review paper records to obtain an accurate class list. CP 53, 2056-357. The trial court certified the class for damages in December 2011, saying that “the court’s major concern here is to the extent I have a legitimate class, and

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<sup>2</sup> HCA states that the employees were denied “the opportunity to obtain employer-sponsored health care coverage” (HCA Br. 1, 5, 6, 7, 8, 9, 12, 29), implying that health benefits are optional, but the benefits are actually mandatory and cannot be waived by an employee unless the employee both chooses to waive and has comparable insurance, typically from a spouse. WAC 182-12-128.

<sup>3</sup> In 2008, HCA started to advise agencies that they “must begin averaging nonpermanent and career seasonal/instructional year employee work hours when determining their eligibility for [health] benefits[.]” CP 816-36.

<sup>4</sup> Laws of 2009, Ch. 537, § 7, amending RCW 41.05.065. Despite HCA’s acquiescence and this statute, major agencies continued to disregard the averaging rule and an injunction will likely be necessary. CP 461, 968-69, 1120-21, 1816.

indeed it is clear I do, I have a very large legitimate class here, it is important that the people in that class are able to obtain the relief to which they are entitled in the most efficient and fairest method possible.” CP 106, 53-54. The trial court again found that because most class members have relatively small claims, “joinder of all members is impracticable.” CP 15, 113. HCA did not seek review of that decision.

In October 2012, the trial court heard the parties’ motions on the measure of damages. The employees proposed three alternative measures of damages under CR 23(d)(1): (1) calculating wages lost, valued by the amount the State was required to pay for each employee for health insurance, (2) restitution of the financial benefit the State received when it violated the law by failing to make required payments for each employee for health insurance, and (3) calculating health care costs for the class as a whole, using the scientifically accurate actuarial method. CP 127. The employees supported their third alternative measure of damages — *i.e.* if actual health costs were the measure, they should be determined on a class-wide basis as opposed to HCA’s individual-by-individual approach — with expert testimony by healthcare actuary David Wilson and professor of statistics Susan Long.<sup>5</sup>

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<sup>5</sup> Wilson is a health care actuary with over 30 years of experience in determining health insurance costs. He previously served as both the lead actuary consultant to the State Health Benefits Plan in New Jersey, a plan with over one million members, and as the  
[continued]

On the other side, HCA proposed that out-of-pocket costs be proven by each individual class member, an approach that plainly would result in thousands of trials, if the class members were not deterred from seeking relief by that cumbersome process. CP 140-41, 478; *see also* HCA Br. 36, MDR<sup>6</sup> at 6, 11, MDR Reply at 2, 4, Comm. Ruling at 3 (jury trial). HCA submitted declarations by Stephen Ross, who mainly testified about HCA's programming errors in generating the class list and how it included individuals who were not class members and were not denied health benefits. CP 297-435, 484-91. HCA also submitted testimony by health care economist Dr. Roger Feldman who questioned only details about using the actuarial method here, but not the method itself, since he is not an actuary. CP 285-88. Actuary David Wilson explained how Feldman misunderstood the method. CP 439-54.

The trial court first denied the parties' motions because the facts were in dispute: "There are a number of factual issues remaining in this case that prevent the Court from ruling entirely in the plaintiffs' or the defendants' favor on the issues presented here."<sup>7</sup> CP 578. The trial court

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Supervising Actuary for CalPERS (health care benefits) in California. CP 150-51. Long is a statistician and professor of statistics at Syracuse University. CP 1124.

<sup>6</sup> "MDR" refers to HCA's Motion for Discretionary Review.

<sup>7</sup> The trial court's order on damages indicates that it "considered the pleadings filed in this case, including, but not limited to" 21 declarations filed by the parties. CP 587-89. These declarations and exhibits constitute more than 400 pages of materials. CP 81-124, 149-60, 214-41, 242-80, 281-84, 285-92, 293-96, 297-435, 436-38, 439-54, 462-76, 484-

[continued]

further rejected HCA's motion because it was "wrong as a matter of fact and law." CP 591. The trial court agreed with the employees that damages could be measured by lost wages and restitution, but it denied the employees' motion because additional actuarial evidence is needed to determine the amount that the employer contribution would have been.<sup>8</sup> CP 584-87. HCA sought discretionary review of the trial court's decision.

HCA argued to the Commissioner that due process requires individual-by-individual trials on out-of-pocket health expenses, while at the same time it conceded there are "fact issues regarding the [parties'] competing damage methodologies." MDR Reply at 8. The Commissioner's ruling granting review did not address the merits of the trial court's decision that damages can be measured by lost wages or restitution. Ruling at 1-3. The Commissioner also did not address the actuarial method for proving class-wide health care costs, other than noting "Plaintiffs and the State proffered conflicting expert opinions

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92, 1081-96, 1971-90, 1153-58, 1124-50, 1200-05, 1206-28, 1971-90, 2032-55, 2364-84, 2468-79.

<sup>8</sup> The trial court thought that the class might be demographically different from the covered employees, and therefore employer contributions might have been lower for the class than the amount paid by the State for covered employees. CP 584-87. The class list that the Court ordered the State to produce in discovery was substantially overbroad so the parties could not yet compare the class members to the covered employees to see if there really were actuarial differences that would make the amount owed for each employee lower. CP 579, 586, 603. After the State completes its agency reviews to ensure all non-class-member employees are correctly removed from the class list, and the parties resolve the remaining liability questions through agreement or motion practice, the remaining factual issues regarding damages can be addressed.

regarding the measurement of damages.” *Id.* at 2. The Commissioner misquoted the trial court’s ruling, saying it rejected HCA’s motion as “a matter of law” (*id.* at 3), when the trial court denied HCA’s motion for partial summary judgment because it was “wrong as a matter of fact and law.” CP 591. The Commissioner said the trial court’s decision violates due process and the State’s right to a jury trial based on *Sitton v. State Farm*, 116 Wn.App. 245, 267 P.3d 198 (2003). Ruling at 3.

### **SUMMARY OF ARGUMENT**

The trial court has wide discretion in measuring damages. And the trial court only abused that discretion here if the two alternative methods it chose to measure damages were both unlawful.

The trial court did not abuse its discretion in determining lost wages is an appropriate measure of damages. Under Washington law employer contributions for employee health benefits constitute wages. And the wages are valued by the employer contribution, not the out-of-pocket expenses the employees and their dependents incur for health care.

The trial court also did not abuse its discretion in deciding restitution is an appropriate remedy here. The State financially benefited when it violated the statutes on employee health benefits by not paying for the employees’ health insurance.

The trial court was not constitutionally required to adopt HCA’s method of calculating damages as a matter of due process. Individualized

proceedings are only necessary when liability cannot be determined on a class-wide basis. But here liability is being determined on a class-wide basis, and based on employment records liability will also be determined individually for each class member and each specific month before any damages are awarded.

HCA's proposed method also suffers from major deficiencies. It is not a scientifically valid method and it would result in an inaccurate calculation. The measure would also under-compensate the class because individuals without insurance are harmed irrespective of whether they have out-of-pocket expenses.

HCA's calculation method is proposed, not to provide fair and equitable relief for injured class members, but to deter them from obtaining relief by demanding an overly burdensome and costly process. HCA's argument is contrary to the public policy behind the class-action device, *i.e.*, to give individuals with claims too small to pursue individually a procedure for vindicating those claims and obtaining relief.

Finally, if out-of-pocket health care expenses were the only way to calculate damages, those expenses can be determined with the class-wide actuarial method rather than by individual-by-individual trials. The actuarial method is scientifically valid and would be much more efficient and accurate than individualized proceedings.

## ARGUMENT

### **THE TRIAL COURT DID NOT ABUSE ITS DISCRETION IN DENYING HCA'S MOTION FOR THOUSANDS OF TRIALS.**

#### **A. The Trial Court's Order is Reviewed for Abuse of Discretion.**

A measure of damages is appropriate if it “provides a reasonable basis for estimating the loss and does not amount to mere speculation or conjecture.” *Pellino v. Brink's, Inc.*, 164 Wn.App. 668, 698, 267 P.3d 383 (2011) (wage class action); *Seattle Western Indus. v. Mowat*, 110 Wn.2d 1, 6, 750 P.2d 245 (1988). HCA's brief assumes, however, that the choice of remedies here is an abstract issue of law, divorced from the underlying facts and nature of the action. HCA is wrong because a trial court has “wide discretion in determining the measure of damage” and the “inherent authority to . . . fashion judgments[.]” *Allen v. American Land Title Research*, 95 Wn.2d 841, 852, 631 P.2d 930 (1981) (affirming restitution remedy in class action). A trial court's power to fashion remedies is “inherently flexible and fact-specific.” *Proctor v. Huntington*, 169 Wn.2d 491, 503, 238 P.3d 1117 (2010).

Accordingly, a trial court “neither exceed[s] its authority or abuse[s] its discretion” when it “fashion[s] broad remedies to do substantial justice to the parties and put an end to the litigation.” *Esmieu v. Hsieh*, 92 Wn.2d 530, 535, 598 P.2d 1369 (1979). And a trial court does not abuse its discretion by choosing one of several lawful measures of damages. *Marriage of Farmer*, 172 Wn.2d 616, 631-32, 259 P.3d 256

(2011). “A trial court abuses its discretion when its decision or order [on damages] is manifestly unreasonable, exercised on untenable grounds, or exercised for untenable reasons[,]” *i.e.*, it chooses an unlawful measure. *Id.* at 625-27; *United Fin. Cas. Co. v. Coleman*, 173 Wn.App. 463, 477-78, 295 P.3d 763 (2012).<sup>9</sup>

In addition, when selecting an efficient measure of damages the trial court furthers the “state policy favoring aggregation of small claims for purposes of efficiency, deterrence, and access to justice.” *Scott v. Cingular Wireless*, 160 Wn.2d 843, 851-52, 161 P.3d 1000 (2007),<sup>10</sup> *citing Darling v. Champion Home Builders Co.*, 96 Wn.2d 701, 706, 638 P.2d 1249 (1982). Indeed, a “primary function of the class suit is to provide a procedure for vindicating claims which, taken individually, are too small to justify individual legal action but which are of significant size and importance if taken as a group.” *Brown v. Brown*, 6 Wn.App. 249, 253,

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<sup>9</sup> HCA asserts the standard of review is *de novo*, HCA Br. 14, n. 27, citing *Shoemaker v. Ferrer*, 168 Wn.2d 193, 199, 225 P.3d 990 (2010). *Shoemaker* states that is “generally” true. But *Marriage of Farmer*, which explains *Shoemaker*, says that “the trial court’s ultimate remedy” is reviewed under the abuse of discretion standard. 172 Wn.2d at 624. *Farmer* explains that while “the measure of damage is a question of law[,]” *i.e.*, it is the duty of the court to instruct [a jury] as to the measure of damages, *e.g.*, WPI 30.01 (tort), 503.01 (contract) and 330.81 (employment discrimination), a trial court only abuses its discretion when its measure is based on an error of law. “An error of law constitutes an untenable reason” and therefore an abuse of discretion. *Id.* at 625. But an error of law does not occur unless the trial court chooses an *unlawful* measure of damages. *Id.* at 626-28, 631. And whether a measure is unlawful and improper depends on the facts and circumstances. *Id.* at 631. Thus, *Farmer* held that “[b]ecause there are several possible methods for valuing converted stock options, we cannot conclude that the trial court erred as a matter of law by employing a tort measure of damages.” *Id.*

<sup>10</sup> *Scott* was later overruled on another ground -- federal preemption. *AT&T Mobility v. Concepcion*, \_\_\_ U.S. \_\_\_, 131 S.Ct. 1740, 179 L.Ed.2d 742 (2011).

492 P.2d 581 (1971); *Smith v. Behr Process Corp.*, 113 Wn.App. 306, 318-19, 54 P.3d 665 (2002).<sup>11</sup>

Accordingly, the trial court's order on class remedies is reviewed under the abuse of discretion standard. And here, after six years of litigation that established HCA's liability, and after the trial court received extensive evidence on several methods of calculating damages, the trial court exercised its discretion to choose two methods of measuring damages — wage loss and restitution. As either choice is not “untenable,” nor “manifestly unreasonable,” this Court should affirm the trial court's choice of remedy.

**B. The Trial Court Did Not Abuse Its Discretion in Deciding to Measure Damages as Lost Wages Valued by the Employer Contribution 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.**

The trial court decided to measure damages from the perspective of lost wages, which are determined individual-by-individual based on the precise months each class member was wrongly denied health benefits.

CP 127. HCA acknowledges that after it completes its agency reviews of

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<sup>11</sup> The trial court's choice of a method for calculating damages is also a discretionary part of managing a class action under CR 23(d)(1). “In class actions, courts have equitable power to manage the litigation in order to promote judicial economy and fairness to litigants.” *De Asencio v. Tyson Foods, Inc.*, 342 F.3d 301, 313 (3d Cir. 2003). “Rule 23(d) confirms the [trial] court's broad discretion to manage a complex class action.” *Amer. Timber & Trading Co. v. First Nat'l Bk. Of Oregon*, 690 F.2d 781, 786-87 (9<sup>th</sup> Cir. 1982). Where the trial court exercises “a case-management decision in a complex class action,” the trial court's “discretion is at its greatest.” *In re Vitamins Antitrust Class Actions*, 327 F.3d 1207, 1210 (D.C. Cir. 2003).

the class list “each agency will have independently determined the eligibility of all the employees identified as potential class members,” CP 1366, and it will have a “final, accurate class list[.]” CP 1890.

HCA largely overlooks this primary basis for the trial court’s decision by devoting only brief attention to it (Br. 32-33), and the Commissioner’s ruling did not discuss the merits of the trial court decision that health benefits are part of an employee’s compensation. CP 583-87. The value of these lost wages is not the money the employees spent on health care, but rather the monthly contribution the employer State failed to pay for the health benefits under RCW 41.05.050(1). The trial court explained (CP 583):

[I]t is very clear to me that in Washington, if not in other places, that we view the right to healthcare benefits as a form of wages. I agree that *Cockle* is a workers compensation case, but I do not agree that *Cockle* is limited to wages in the workers compensation context. The *Cockle* Court looked very broadly at what wages are under Washington law, and the Court expressly rejected any method that required a hypothetical calculation of market value. The Court in *Cockle* indicated that premiums actually paid by the employer to secure the benefit are going to be the best measurement for wages lost.

Our Supreme Court has held that health benefits are wages, stating the “employer’s contribution . . . has long been accepted as a reasonable measure of the value of fringe [health] benefits.” *Cockle v. Dep’t of Labor & Indus.*, 142 Wn.2d 801, 820 n. 10, 16 P.3d 583 (2001). HCA claims that *Cockle* has no relevance because the industrial insurance statute

requires a liberal construction of wages. HCA Br. 32 and n. 38. But what constitutes wages is also liberally construed in wage statutes (*Schilling v. Radio Holdings Inc.*, 136 Wn.2d 152, 159, 961 P.2d 371 (1998)):

[The statute's purpose is] to protect the *wages* . . . and to see that the employee shall realize the full amount of the wages which by statute, ordinance, or contract he is entitled to receive from his employer and which the employee is obligated to pay, and, further, to see that the employee is not deprived of such right, nor the employer permitted to evade his obligation, by a withholding of a part of the wages. (Emphasis by Court; internal quotations omitted.)

The wage collection statutes are “liberally construed to advance the Legislature’s intent to protect employee wages and assure payment.” *Id.*; *Bates v. City of Richland*, 112 Wn.App. 919, 939, 51 P.3d 816 (2002).<sup>12</sup>

Under this liberal construction, wages are “*any type of compensation due by reason of employment.*” *Bates*, 112 Wn.App. at 940 (emphasis added). And the ordinary meaning of wages includes “*amounts paid by the employer for insurance . . . and other benefits.*” *Webster’s Third New International Dictionary*, p. 2568 (1969), quoted in *Cockle*, 96 Wn.App. 69, 86-87, 977 P.2d 668 (1999) (emphasis by Court), *aff’d*, 142 Wn.2d 801. In *Cockle*, the plaintiff’s “health care coverage was worth ‘approximately 20 percent of her monetary compensation[.]’” 142 Wn.2d

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<sup>12</sup> HCA argued below to consider the narrow definition of wages in the Minimum Wage Act. CP 208. The minimum wage is an exception for policy reasons to the usual broad definition of wages. *Byrne v. Courtesy Ford, Inc.*, 108 Wn.App. 683, 688, 32 P.3d 307 (2001), *rev. denied*, 146 Wn.2d 1019 (2002). It would defeat the purpose of a minimum wage to include non-cash wages because one can only pay rent or buy groceries with cash.

at 818. Accordingly, *Cockle* held that an employer’s contribution to health benefits constitutes wages. *Id.* at 807-21. And the employer contributions for health insurance here constitute wages because these contributions are part of the compensation due by reason of employment. *Cockle*, 142 Wn.2d at 807-10; *Bates*, 112 Wn.App. at 939-40; RCW 41.05.050(1).<sup>13</sup>

HCA says that *Cockle* “did not address . . . how to value unprovided health insurance.” HCA Br. 32. But *Cockle* did address how to value health insurance as part of lost wages, and the Supreme Court expressly rejected the Court of Appeals’ decision on the precise issue of how to determine the reasonable value of lost health benefits. 142 Wn.2d at 820-21.<sup>14</sup>

The Supreme Court also stated in *Cockle*, quoting Justice Thurgood Marshall, that “[w]hile *an employer’s contribution may*

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<sup>13</sup> Federal tax law also states that “wages” “means all remuneration . . . for services performed by an employee for his employer, including the cash value of all remuneration (including benefits) paid in any medium other than cash[.]” 26 U.S.C. § 3401(a). Certain employee benefits such as health insurance are wages excluded from gross income for income tax purposes. 26 U.S.C. § 106. They are nontaxable wages, not something other than wages.

<sup>14</sup> HCA contends that *Cockle’s* holding on how to value lost health benefits is not a precedential holding because the Department of Labor & Industries (DLI) stipulated to the fact that “the employer paid health care premiums fairly reflected the benefits’ value.” HCA Br. p. 32. But the fact the Supreme Court’s holding is based on stipulated facts is immaterial. *See, e.g., Dolan v. King County*, 172 Wn.2d 299, 308, 310-11, 258 P.3d 20 (2011) (Court’s entire opinion and all of its holdings based on stipulated facts). Indeed, the fact that DLI agreed that the employer contribution “fairly reflected the benefits’ value” as lost wages *undercuts* rather than supports HCA’s argument. *See Schneider v. Snyder’s Foods, Inc.*, 116 Wn.App. 706, 716, 66 P.3d 640 (2003) (deference is given to DLI because it has “specialized knowledge and expertise” in wages).

*understate the true value of the benefits received . . .*, it nonetheless provides a readily identifiable and therefore reasonable surrogate for the ‘advantage’ received . . . [and] *has long been accepted as a reasonable measure of the value of fringe [health] benefits.*” *Cockle*, 142 Wn.2d at 820 n. 10 (citation omitted; emphasis added).

Moreover, the State is expressly required to pay the employer contribution for all eligible employees: “Every . . . Department, division, or separate agency of state government . . . *shall provide contributions to insurance and health care plans for its [eligible] employees and their dependent[s].*” RCW 41.05.050(1) (emphasis added). And the employees here obtained partial summary judgment on liability because the State “violate[d]” RCW 41.05.050(1) by failing to make the employer contributions. CP 738, 788, 1917, 1925, 1932, 1957, 1968-69. Using the omitted employer contributions for health insurance therefore reasonably measures each class member’s loss because this amount (the employer contribution) comes from the statute the State violated and it is the precise compensation the employees did not receive. *Id.*<sup>15</sup>

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<sup>15</sup> Consistent with *Cockle* and the trial court’s ruling, several class action cases found the employer contribution is a reasonable measure of the value of lost health benefits. *E.E.O.C. Corp. v. Dial*, 469 F.3d 735, 744 (8<sup>th</sup> Cir. 2006); *Jones v. Kayser-Roth Hosiery, Inc.*, 748 F.Supp. 1292, 1295 (E.D. Tenn. 1990); *Mister v. Illinois Central Gulf Railroad Co.*, 790 F.Supp. 1411, 1418-19 (S.D. Ill. 1992). There are also individual actions where the federal courts used the employer contribution as the reasonable value of lost health benefits. *Blackwell v. Sun Elec. Corp.*, 696 F.2d 1176, 1186 (6th Cir. 1983); *Jacobson v. Pitman-Moore, Inc.*, 582 F.Supp. 169, 179 (D. Minn. 1984); *In Re Texas Wyoming Drilling, Inc.*, 486 B.R. 746, 757-58 (N.D. Texas 2013).

In addition, HCA itself agreed in the predecessor *Mader* class action involving the same defendants, the same health benefits, and some of the same class (see *supra*, pp. 2-4), that “the State’s contribution for health benefits, i.e., the composite employer cost, is a reasonable measure of the value of benefits lost by the instructors [class members].” CP 617. HCA further agreed that “[t]he premium cost is a reasonable method to ascertain the value of the lost health benefits because it represents the State’s *actual* cost to secure the benefits.” *Id.* (italics in original).

Accordingly, the trial court did not abuse its discretion in using the State’s unpaid employer contribution for health benefits as the measure of the employees’ damages.

**C. The Trial Court Did Not Abuse Its Discretion in Deciding to Use the Alternative Remedy of Restitution When Calculating Damages.**

The trial court ruled that “plaintiffs’ restitution theory makes sense.” CP 585. “[T]he State received a windfall here as a whole, that it shouldn’t have received, by not paying for the folks that are in the class.” CP 586. HCA devotes scant attention to the trial court’s decision that the remedy of restitution is appropriate here. Br. 33-35.<sup>16</sup>

Restitution is available to prevent unjust enrichment when the amount of plaintiffs’ damages is difficult to establish under other methods.

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<sup>16</sup> The Commissioner’s ruling did not discuss the merits of the trial court’s decision on restitution.

1 Dobbs, *Law of Remedies*, §4.1(2), p. 559 (2<sup>nd</sup> ed. 1993); *Restatement of Contracts, Second*, §373, Comment, p. 209 (ALI 1981). Restitution remedies focus on disgorgement of the unjust enrichment of the defendant in contrast to losses suffered by individual class members, and restitution is often used in class actions because “restitution lends itself to easier calculation of class-wide monetary relief.” 3 *Newberg on Class Actions*, §10.3, p. 481 (4th ed. 2002). Our Supreme Court has approved the use of restitution as a remedy in class actions. *Allen*, 95 Wn.2d at 852; *Nelson v. Appleway Chevrolet, Inc.*, 160 Wn.2d 173, 187-88, 157 P.3d 847 (2007).

Here, undisputed facts in the record show that not only would determining damages through individual-by-individual trials be very difficult and impractical for both the employees and the court system, but it is also “not a scientifically valid method” to determine the loss to the class and would render an “inaccurate calculation.” CP 158-60, 442; see also pp. 46-49 (discussing impracticability of method). In contrast, the amount of restitution owed is simple to calculate — it is the monetary benefit the employer State received when it violated the law by not paying for the employees’ health insurance. CP 48, 50.

HCA argues that the employees are not entitled to restitution because they “did not plead any restitution or unjust enrichment claim.” HCA Br. 34. But the employees are not making an independent *claim* of

unjust enrichment.<sup>17</sup> Rather, the trial court agreed with the employees that the *remedy of restitution* is proper as an appropriate alternative measure of damages here. CP 585, 586. The trial court's decision was neither untenable nor unlawful. *Allen*, 95 Wn.2d at 852 (trial court has inherent authority to fashion remedies, including using remedy of restitution in class action); *Nelson*, 160 Wn.2d at 187-88 (class action remedy).

HCA's main argument against restitution is that the total dollar amount calculated by the restitution remedy would be approximately the same as the total dollar amount calculated as lost wages and the total dollar amount calculated as class-wide health care costs with the actuarial method. MDR Reply at 3; HCA Resp. to Motion to Modify at 16-17 and n. 25; Comm. Ruling at 2. The fact that these three alternative methods reach approximately the same dollar amount is no defense; indeed, it is normal. And it does not make all three measures the same. 1 Dobbs, *Law of Remedies* §3.1 p. 280 (2d ed. 1993) ("Damages and restitution may happen to provide the same dollar recovery, but they are often triggered by different situations and always measured by a different yardstick."). The measures here are not the same approaches: lost wages is based on the compensation the employees lost, restitution is based on the monetary benefit the employer State received when it failed to pay for the

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<sup>17</sup> See, e.g., *Bailie Communications v. Trend*, 61 Wn.App. 151, 159-60, 810 P.2d 12 (1991) (discussing elements of a claim of unjust enrichment).

employees' health insurance, and the actuarial method is based on the total health care costs of the class. The fact that these three calculations add up to approximately the same amount shows the accuracy, rather than inaccuracy, of the three methods.<sup>18</sup> The only exception here is HCA's unscientific, impractical, and inaccurate method.

In a burst of rhetoric, HCA argues that a "measure of damages [that] focuses on what the employing agency would have spent," rather than the expenses of class members, is "the antithesis of due process." HCA Br. 31. This is really an argument against restitution *per se*, contrary to Washington law. *Allen*, 95 Wn.2d at 852; *Nelson*, 160 Wn.2d at 187-88; See also 3 *Newberg on Class Actions*, §10.3, p. 481 and n 4. HCA has no authority for its rhetoric; instead, it just cites a district court in Georgia that preferred an out-of-pocket measure based on the facts of that specific case. HCA Br. 31.

HCA also argues that the restitution remedy does not apply because the employees supposedly "stipulated and the trial court expressly found that some portion of the class suffered no such loss." HCA Br. 34. But not only is this assertion baseless (see *infra*, pp. 34-36), but restitution is measured by the amount of the defendant's benefit *not* the plaintiffs'

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<sup>18</sup> When an appraiser uses three independent methods to value a commercial property — *e.g.*, the recent sales prices of comparable properties, the current cost to build the property, and the projected rental income from the property — the fact all three methods arrive at approximately the same amount supports the appraiser's valuation and does not undermine it.

loss (damages).

The remedy of restitution furthers two important principles underlying damages. First, difficulty in damage calculation should never reward the wrongdoer. *Wenzler & Ward Plumbing & Heating Co. v. Sellen*, 53 Wn.2d 96, 98-99, 330 P.2d 1668 (1958), citing *Bigelow v. RKO Radio Pictures, Inc.*, 327 U.S. 251, 265, 66 S. Ct. 574, 90 L.Ed 652 (1945). Second, a wrongdoer should not profit by its wrongdoing. *Id.* These principles are particularly significant here because HCA, which is the employer State's agency responsible for employee health benefits, *intentionally* denied eligible employees health benefits. (See *supra* pp. 3-5.) The trial court did not err in finding restitution an appropriate remedy.<sup>19</sup>

**D. The Trial Court Did Not Abuse Its Discretion in Rejecting HCA's Argument That It Was Required to Adopt an Inaccurate, Unscientific, and Impractical Measure of Damages.**

***1. The Undisputed Evidence is That HCA's Proposed Method is "Not a Scientifically Valid Method" and It Would Result in an "Inaccurate Calculation."***

If the Court finds that the trial court did not abuse its discretion in

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<sup>19</sup> HCA contends that the remedy of restitution does not apply because no benefit was received by the employer State due to the employing agencies not asking for appropriations. HCA Br. 35. But the State received the benefit of the employees' labor without fully compensating them for that labor. Assuming *arguendo* that the State did not retain the funds it should have used for the employer contributions and it spent the funds on something else, this does not mean restitution is unavailable. One is not excused from restitution merely because one re-directed funds that were supposed to benefit or belong to a particular person. If that were true, restitution could be easily avoided in every case by the wrongdoer spending the money on something else.

deciding to measure damages as either lost wages or restitution, then the Court does not need to address HCA's arguments concerning whether health care costs for the class should be measured through thousands of trials or through a class-wide actuarial method. But even if those first two methods are disregarded, the trial court did not err in rejecting HCA's individual-by-individual trials.

HCA's summary judgment motion could only be granted if HCA established that there are no issues of material fact and HCA is entitled to judgment as a matter of law. *Hisle v. Todd Pac. Shipyards Corp.*, 151 Wn.2d 853, 861, 93 P.3d 108 (2004). Facts in the record must be viewed in the light most favorable to the employees as the non-moving parties. *Id.* at 860-61. Here, the State concedes "the record clearly demonstrates fact issues regarding the competing damages methodologies" for determining the health care costs for the class. MDR Reply at 8; Comm. Ruling at 2. The trial court therefore did not error in denying HCA's motion.<sup>20</sup> *Hisle*, 151 Wn.2d at 860-61.

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<sup>20</sup> HCA does not describe or cite the record evidence that was considered by the trial court. CP 588-90 (order). And HCA did not designate in its Clerk's Papers all the declarations identified in the trial court's order as items considered. *Id.* The employees supplemented the Clerks Papers with this evidence. See *infra*, p. 8 n. 7. Hundreds of pages of evidence — submitted by both sides — are completely ignored by HCA. HCA's disregard of the facts is not inadvertent; the record contains an enormous amount of evidence that required denying HCA's motion. HCA's failure to discuss the large record illuminates its complete inability to show that the trial court erred in denying its motion.

Moreover, these fact issues include expert actuary David Wilson's testimony that HCA's method would be "highly error-prone" for numerous reasons and the "*method is not a scientifically valid method to determine the financial loss to the class and it would result in an inaccurate calculation.*" CP 442 (emphasis added). Wilson further testified to how time-consuming and impracticable HCA's method would be to implement. CP 158-60, 452-53 (Wilson's testimony on this point is discussed in further detail *infra* pp. 43-49). Statistics professor Susan Long agreed with Wilson that HCA's proposed method would render an inaccurate result, while the actuarial method for determining the class-wide loss is a valid scientific method that would result in an accurate calculation. CP 1131, 1209, 1222-24. And HCA also agrees that damages may be calculated on a class-wide basis. HCA Resp. to Mot. to Modify, at 8 n. 18.

HCA does not have any authority that holds the trial court was required to adopt, as a factual matter, an unscientific, inaccurate, and impracticable method for measuring damages, particularly when more reasonable methods are available.

**2. *Undisputed Evidence in the Record Shows That the Factual Presumption Underlying HCA's Measure of Damages —Employees Who Had No Expenses Are Not Harmed — Is Wrong.***

HCA's proposed measure is not only an unscientific, inaccurate,

and impractical method of calculating damages, but the trial court also found that the factual assumption underlying it is wrong, *i.e.*, HCA's measure wrongly assumes uninsured employees are not harmed if they have no out-of-pocket expenses. CP 590-91.<sup>21</sup> The trial court found as a factual matter that HCA's measure would under-compensate class members because "[a] lack of health insurance impacts an individual's healthcare choices by causing them to defer necessary healthcare and to not get routine care and checkups." CP 590. A measure based solely on out-of-pocket costs for the class therefore understates the actual damages suffered. CP 590-91.

HCA claims the trial court just presumed such damages out of nowhere. HCA Br. 4, 12, 29, 30. HCA is wrong because there is undisputed evidence showing the absence of insurance is harmful, with or without out-of-pocket expenditures in a given period. The evidence began with HCA citing a study of the medical expenses of insured and uninsured populations. That study expressly recognizes that even assuming there are lower *present* expenses for the uninsured compared to the expenses of the insured, these "lower present expenses are directly correlated to deferred costs and lost health and longevity for the uninsured because the lower

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<sup>21</sup> Some federal cases HCA cites are based on this same factual assumption. See, *e.g.*, *U.S. v. City of New York*, 847 F.Supp.2d 395, 421 (E.D.N.Y. 2012) ("an unemployed person would suffer an economic loss from not having health insurance only if he or she incurred medical expenses during his or her period of unemployment").

present expenses are due to the inability to access preventive services, timely care, and medical treatment.” CP 156.

In addition to leading to increased deferred health expenses because deferred medical care is often more expensive and less effective, the study also concluded that “the economic value [in 2003 dollars] of the healthier and longer life that an uninsured child or adult forgoes because he or she lacks health insurance ranges between \$1,645 and \$3,280 for each additional year spent without coverage.” Institute of Medicine, Hidden Costs, Value Lost: Uninsurance in America (National Academies Press 2003), p. 3; CP 156-57. This Hidden Costs report was cited by HCA’s health policy expert witness, Dr. Roger Feldman, as “the best available evidence on the costs of being uninsured in the United States.” CP 2397-98.

Consistent with HCA’s evidence, the Washington Legislature made specific legislative findings on the harm caused by lack of health coverage in its Health Care Reform Act. Ch. 492, Laws of 1993. This Act, which is a major source of the employees’ rights violated by HCA, contains these findings:<sup>22</sup>

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<sup>22</sup> These legislative findings are in §208, part II, of the Health Care Reform Act of 1993, which expanded the basic health plan and added insurance protection for State employees. Part II, §218, Ch. 492, Laws of 1993, enacted minimum standards for state employee health benefit eligibility. (See historical note to RCWA 41.05.065 (2013), pocket part pp. 56-57, Laws of 2009, Ch. 537.) This 1993 statute formed a major reason for the trial court’s liability decisions in this case. CP 735-38, 783-88, 864-65, 1958-69.

[continued]

- (1) The legislature finds that:
  - (a) A significant percentage of the population of this state does not have reasonably available insurance or other coverage of the costs of necessary basic health care services;
  - (b) *This lack of basic health care coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state. (Emphasis added.)*

Courts give great deference to the factual findings of the Legislature when applying the statute containing the findings. *State v. McQuisten*, 174 Wn.2d 369, 391-92, 275 P.3d 1092 (2012) (legislative findings are “deemed conclusive as to the circumstances asserted and must be given effect” unless obviously false).

HCA also questions the trial court’s reference to the federal Affordable Care Act for facts concerning the uninsured. HCA Br. 12, 20; MDR at 5. But the trial court was not relying on the Act itself, but instead referred to the many studies concerning the harms caused by lack of insurance that formed the basis for the federal act. CP 580-81.<sup>23</sup> Taking

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The provisions of Ch. 492, Laws of 1993, were codified in various places and the findings in §208 (quoted in the text above) are codified at RCW 70.47.010(2). See also the similar findings in Ch. 492, Laws of 1993, §101, Findings, found in the note to RCWA 43.20.050, p. 26 (2009).

<sup>23</sup> See, e.g., Shen *et al*, *Disparities in outcomes among patients with stroke associated with insurance status*, 38 STROKE 1010, 1013 (2007) (“Compared with privately insured patients, uninsured patients had a higher level of neurologic impairment, a longer average length of hospital stay, and higher mortality risk. For patients with intracerebral hemorrhage and acute ischemic stroke, mortality risk of uninsured patients was approximately 24% and 56% higher, respectively, than that of their privately insured peers”) (last retrieved from <http://stroke.ahajournals.org/content/38/3/1010.full.pdf> on 10-17-13); Fox, *et al.*, *Vital Signs: Health Insurance Coverage and Health Care*

[continued]

notice of such studies is well within the court's discretion under ER 201 (adjudicative facts), as well as proper for policy purposes in fashioning a remedy (legislative facts). *Cameron v. Murray*, 151 Wn.App. 646, 658-59, 214 P.3d 150 (2009) (trial court erred in excluding studies on teenage drinking when deciding summary judgment motion).

Finally, HCA's argument that there was no economic loss from being uninsured (other than out-of-pocket costs) heavily relies on its false assertion that "more than half of the class was without insurance for 60 days or less[.]" HCA Br. 10, *citing* CP 489-90; HCA Br. 3 n. 1, 9, 10, 14-

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*Utilization—United States, 2006-2009 and January-March 2010*, 59 MORBIDITY AND MORTALITY WKLY. REP. 1448, (2010) at p. 3 ("persons aged 18-64 years with no health insurance during the preceding year were seven times as likely (27.6% versus 4.0%) to forgo needed health care because of cost, compared with those continuously insured. Persons aged 18-64 years with no health insurance during the preceding year were approximately six times as likely to forgo needed care if they had hypertension (42.7% versus 6.7%) or diabetes mellitus (47.5% versus 7.7%) and five times as likely (40.8% versus 8.0%) to forgo needed care if they had asthma, compared with those with continuous coverage who had the same chronic condition") (last retrieved from <http://www.cdc.gov/mmwr/pdf/wk/mm59e1109.pdf> on 10-17-13); Ward, *et al.*, *Association of Insurance with Cancer Care Utilization and Outcomes*, 58 CANCER J. FOR CLINICIANS 9 (2008) at pp. 23, 25 ("In analyses of cancer survival for all cancer sites combined [including lung, colorectal, prostate and breast], patients who were uninsured and those who were Medicaid-insured at the time of diagnosis were 1.6 times as likely to die in 5 years as those with private insurance.) (last retrieved from <http://onlinelibrary.wiley.com/doi/10.3322/CA.2007.0011/pdf> on 10-17-13); Zhang, *et al.*, *The Missed Patient with Diabetes: How Access to Health Care Affects the Detection of Diabetes*, 31 DIABETES CARE 1748, 1749 (2008) at pp. 1748, 1751, 1752 ("Uninsured adults, compared with the insured, are much less likely to receive routine checkups or preventive services, tend to be more severely ill when diagnosed, and receive less therapeutic care. Having undetected diabetes puts one's health at substantial risk... Subjects uninsured for 1 year were essentially twice as likely as insured subjects without a break in insurance over the past year to have undetected diabetes") (last retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2518339/pdf/1748.pdf> on 10-17-13). These and other studies were collected in an *amici* brief before the U.S. Supreme Court in the Affordable Care Act case. *N.F.I.B. v. Sebelius*, \_\_\_ U.S. \_\_\_, 132 S. Ct. 2566, 183 L. Ed. 450 (2012) (Brief of American Cancer Society, American Diabetes Association, *et al.*, 2012 WL 105550).

15; MDR at 6, 11. HCA cites only the October 5, 2012 declaration of its accountant Stephen Ross for its factual assertion, HCA Br. 10, but Ross acknowledged in that very same declaration that “it has not yet been possible to accurately identify the Moore class members and the number of months during which they were wrongly denied benefits.” CP 486.

Ross further acknowledged in the declaration cited by HCA that the employees on the notice class list with just one or two months of eligibility appeared to be fully benefitted regular employees who were never denied health benefits and therefore were not actual class members. CP 490-91. They were included on the class list due to programming errors made while searching through electronic payroll records.<sup>24</sup> *Id.*; CP 1301-44. When the wrongly included individuals and months are excluded, class counsel’s estimate was that “90 percent of the [omitted] months” remain and the average length of time for the employees denied health benefits is an “average of ten months or twelve months, or something like that.” VRP [10/26/12] p. 37.<sup>25</sup> See also *infra* p. 38 (trial

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<sup>24</sup> The employees offered as a matter of efficiency in determining class membership with electronic records to stipulate that *none* of the individuals with apparent 1-2 months of eligibility are class members. CP 1890. HCA refused, apparently to keep pretending they are a majority of the class. *Id.*

<sup>25</sup> HCA also wrongly used its grossly exaggerated notice class list to assert that the employees are seeking \$100 million. VRP [10-26-12] 33; MDR 1; Resp. Mot. to Modify, p. 3. Recently it told the trial court that because the agency reviews are producing an accurate class list, its estimated figure would be much lower, as much as 85% lower. CP 1376. In any event, cases are decided on the law and facts, not on the alleged financial impact on the parties or others. *Phillips v. Thomas*, 70 Wash. 533, 534, 127 P.

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court ordered HCA to remove individuals wrongly included on the class list and HCA will soon have a final accurate list).

Accordingly, the trial court found that HCA's proposed method, along with the federal cases it cites for using out-of-pocket expenses (see pp. 39-41 *infra*), are based on the erroneous factual assumption that uninsured employees and their spouses and children with no out-of-pocket expenses suffer no harm. CP 580-81, 590-91. The trial court did not err in making this factual finding based on the undisputed evidence in the record, and also supported by legislative findings and the studies forming the basis for the Affordable Care Act.

3. ***HCA's Sitton "Due Process" Fact-of-Damage Argument is the Same Argument the Supreme Court Rejected in Moeller.***

Not only are there major factual deficiencies in HCA's measure (pp. 23-30), but there is also no support for HCA's underlying argument that the trial court is constitutionally required to adopt an unscientific, inaccurate, and impractical method. HCA's argument (Br. 2-4, 10-12, 15-20) that due process, *Sitton*, and a discovery stipulation require that damages be measured here in individual trials is directly contrary to the

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97 (1912) (defendant's wealth is inadmissible); *King v. Starr*, 43 Wn.2d 115, 121-22, 260 P.2d 351 (1953) ("inadmissible plea of poverty"). The rule is not different because the wrongdoer is the government. *Carlstrom v. State*, 103 Wn.2d 391, 396, 694 P.2d 1 (1985).

Supreme Court's *Moeller* decision. *Moeller v. Farmers Ins.*, 173 Wn.2d 264, 279-80, 267 P.3d 998 (2011), discussing *Sitton*, 116 Wn.App. 245.

In *Moeller*, a class action involving whether the plaintiffs could recover for the diminished value of a post-accident repaired car, “Moeller established [a] mathematical model for determining a figure for aggregate, class-wide damages[.]”<sup>26</sup> *Id.* at 280. And just as HCA argues here, Farmers argued that “[i]t is a violation of due process . . . to allow Moeller to proceed with a plan to obtain a class-wide award of damages because it would allow damages to be awarded before individual class members prove they suffered damage by Farmers.” *Id.* at 279. And just like HCA’s argument, “Farmers’ due process argument relies on *Sitton*[.]” *Id.* at 280.

*Moeller* rejected Farmers’ argument because “*Sitton* is distinguishable from this case. There, the trial court accepted a bifurcated trial plan that ultimately resulted in damages being determined before causation.”<sup>27</sup> 173 Wn.2d at 280. But in *Moeller* the “mathematical model

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<sup>26</sup> In *Moeller* the expert created a mathematical model using a multiple regression analysis unique to that situation. *Moeller*, 173 Wn.2d at 279 (answer to petition for review at 13-15). Here, the employees’ expert explained that the actuarial method is the normal scientific way to determine health care costs for groups of employees when those costs are unknown. CP 152-53.

<sup>27</sup> In *Sitton*, the plaintiffs alleged that State Farm had a bad faith pattern and practice of denying or limiting certain insurance claims in bad faith (personal injury protection or “PIP” claims), and the plaintiffs proposed that in the event a bad faith practice were established, a class-wide damage award could be “automatically awarded” that equaled “the difference between PIP claims made and those paid by State Farm.” 116 Wn.App. at 258. But due to the *Sitton* plaintiffs’ bad faith claim and the way the class was defined in that action, even if a practice of bad faith was established for some class members, others could have been denied PIP benefits for legitimate reasons. *Id.* The Court of Appeals

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for determining a figure for aggregate, class-wide damages . . . would [not] be proved or awarded before causation is determined.” *Id.*

Here, as in *Moeller*, the class action is not a pattern and practice case like *Sitton* where mini-trials were necessary to determine the State’s liability to each class member.<sup>28</sup> Instead, liability is a class-wide matter and it will be determined with employment records for every individual that the State wrongly denied health benefits and the specific months the denials occurred. CP 1282 (“remaining eligibility issues will be addressed by agreement of the parties or, if necessary, through motion practice”); CP 1366 (at “the end of the . . . review process, each agency will have independently determined the eligibility of all the employees identified as potential class members”); CP 1890 (“final, accurate class list”). The trial court thus explained, in an extended colloquy with HCA’s counsel, using the same reasoning as the Supreme Court in *Moeller*, that *Sitton* is quite different from the situation here because the class was already certified

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thus said that State Farm should have an opportunity to dispute liability (“causation”) on individual claims because, even if the company had a pattern of bad faith, it could have denied some class members’ claims on legitimate grounds. *Id.* at 258-59.

<sup>28</sup> HCA argues that in *Sitton* “*this Court vacated a trial plan much like that adopted by the trial court here.*” HCA Br. 17 (emphasis added). HCA’s brief has no record citation for the trial court’s purported “trial plan” because the trial court did not adopt a trial plan. The trial court ruled on motions and left a great deal for further factual development. CP 584-87. The supposed “trial plan” is an HCA fiction to try to give the erroneous impression that this case is similar to *Sitton*.

and liability for both the class and everyone in the class is being determined before damages.<sup>29</sup>

In *Moeller*, the defendant also contended that the plaintiff supposedly made an “admission” that “not everyone in the class suffered damage” and therefore he supposedly could not prove class-wide liability and damages. 173 Wn.2d at 279. Moeller said “he has not actually admitted that some class members have no claim” and “[h]is ‘admission’ was merely a discussion of how he would arrive at a measure of class-wide damages, taking into account any hypothetical class member whose car might have been in a previous accident and thus experienced no diminution in value.” The Supreme Court ruled that “the claimed admission is not particularly relevant” because it concerned “an accurate estimate of class-wide damages” rather than liability. *Id.* at 279-80.

Here, HCA makes the very same argument as the defendant in *Moeller*. HCA repeatedly asserts that the employees stipulated that “some class members suffered no monetary damages” and therefore its individual-by-individual method is required by due process. HCA Br. 3; *see also* HCA Br. 2, 6, 10, 14, n. 27, 29, 30, 36. The trial court rejected this argument because the employees never stipulated, and the trial court

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<sup>29</sup> The trial court explained to HCA’s lawyer that not providing health insurance when HCA was required to provide it established liability and the fact of damage for each individual who was eligible, but denied coverage. VRP [10-26-12] at 18-21. The trial court said, unlike *Sitton*, “we haven’t skipped over anything.” CP 591; VRP [10-26-12] at 21 (quoted on p. 37, *infra*).

certainly did not find, that some class members suffered no monetary damage. Those words are nowhere in the stipulation or in the trial court's order repeating the stipulation.<sup>30</sup> And the trial court found, to the contrary, that all class members were harmed. CP 590-91; see *supra*, pp. 14-19, 25-31.

Instead, very similar to *Moeller*, where the alleged "admission" arose as part of "an accurate estimate of class-wide damages" (173 Wn.2d at 279-80), the employees here, in the context of proving class-wide damages under the actuarial method *after* liability is determined, stipulated only to the obvious facts that in certain months some class members did not incur any health care costs and in other months class members incurred varied costs. CP 47-48, 1107, 1204, 1222. The employees' variable health care costs and the fact that in certain months some class members did not incur costs are accounted for in the class-wide actuarial method because the actuarial method is based on the actual health care costs for the group of employees who received health benefits (the comparable employees in the plan also naturally have variable costs and

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<sup>30</sup> The stipulation and order — in the portions the HCA fails to quote or even mention — actually state that the employee class members always suffered a definite monetary loss each month, *i.e.*, the State failed to pay the employer contributions for health benefits due under RCW 41.05.050(1), one of the statutes that the trial court found the HCA had violated. CP 738, 788, 1957, 1968-69. The stipulation and order thus state (CP 48):

If a person meeting the class definition was eligible for PEBB health insurance in a month and that person's employing agency did not enroll him or her in the PEBB health insurance, the employing agency did not pay to HCA the employer contribution for the health insurance premium.

no costs in certain months). CP 152-55; *Moeller*, 173 Wn.2d at 279-80. (The actuarial method is discussed in greater detail *infra* pp. 42-46.)

Accordingly, just as in *Moeller*, the stipulation does not concern liability and it does not mean the trial court will calculate or award damages before all liability issues are first resolved. The stipulation pertained only to varying out-of-pocket costs within the class and to calculating class-wide damages under the actuarial method. The trial court understood this point -- VRP [10/26/12] at 38: “you are saying the stipulation is about using the actuarial method, not about causation.”<sup>31</sup>

Finally, HCA’s argument in the trial court on *Sitton* was primarily based on its own erroneously generated class list, *i.e.*, it wrongly argued the employees were seeking to obtain damages for individuals who were not denied health benefits. CP 191, 200, 304.<sup>32</sup> If HCA were correct that individuals who were not eligible would be included in calculating damages, then the situation would fall within *Sitton*. But neither the trial court nor the employees intended to provide relief to any individuals who were not wrongly denied health benefits.

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<sup>31</sup> The trial court referred to the evidence concerning the discovery survey dispute in its order on damages. CP 589 (citing 2011 declarations by Wilson, Long, and Boedeker). And the discovery dispute showed that HCA’s expert agreed that the proposed discovery sample would not determine anything about the health care costs for the class as a whole. CP 1153-57, 1200-05, 1207-08.

<sup>32</sup> See discussion of HCA’s overbroad and error-filled “notice class” list, pp. 29-31.

*Sitton* said the error in that case was to calculate class-wide damages without first requiring proof of individual causation. 116 Wn.App. at 258 and n. 33 (discussed in *Moeller*, 173 Wn.2d at 280). That means here that the employees must show individual liability, *i.e.*, that the HCA’s violations of statutes caused each individual class member to be denied insurance in specific months in which they were eligible. HCA recognized that proving individual liability and causation establishes an injury (“fact of damage”) for each person,<sup>33</sup> as did the trial court:

THE COURT: [M]y point is that it was a liability issue [in *Sitton*], not just a damages issue. Had there been a class [in *Sitton*] that was limited to only the people whose PIP claims had actually been wrongly denied, then I would have trouble seeing why there wouldn’t be damages flowing from that.

...

THE COURT: But wasn’t the problem that the Court [in *Sitton*] pointed out that there was just a skipping over of whether or not there had been a bad faith denial of any of the individual class members’ claims?

MR. LEYH [Def. Counsel]: Right, exactly.

THE COURT: But we haven’t skipped over anything.

VRP [10-26-12] at 21-22.

As the trial court said, individual liability and causation are being proven for each class member in specific months in which each was

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<sup>33</sup> See, *e.g.*, CP 191 (“Eligibility for PEBB benefits is a necessary prerequisite to establish the fact of damage for failure to provide such benefits”); CP 200 (“a substantial number of the current Notice Class member can claim no actual damages because in fact they were ineligible for benefits” [emphasis in original]); CP 304 (the “shortcomings” in the actuarial method include “the current notice class lists . . . is materially overstated”).

eligible. CP 1282, 1366, 1890 (quoted below). There is no skipping over of individual liability and causation as there was in *Sitton*.<sup>34</sup>

Because HCA used its own erroneous class list to argue that the fact of damage was not being proven for each person (see p. 37 n. 33, *supra*), the employees were forced to file a motion to enforce the trial court's prior orders requiring HCA to remove the non-class-member employees from the list (CP 1301-44, 1345-57), which the trial court granted with threat of sanctions if HCA did not comply.<sup>35</sup> CP 1790. HCA recently assured the trial court that it is in the "process of deriving the final, accurate class list" (CP 1890), and at "the end of the . . . review process, each agency will have independently determined the eligibility of all the employees identified as potential class members."<sup>36</sup> CP 1366. See also *supra* pp. 6, 29-31 (HCA wrongly using erroneous list to make other arguments); CP 2456-65 (HCA's accountant Ross being used for both data analysis and advocacy against class certification, resulting in numerous

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<sup>34</sup> HCA also refers to a defense lawyer practice manual, *McLaughlin on Class Actions*, for the proposition that plaintiffs cannot skip over proof of individual liability and causation ("fact of damage"). HCA Br. 15-16. As the trial court stated, there is no skipping over here; liability and causation is being first established for each individual before getting to the method of calculating damages and the amount of damages. *McLaughlin* says nothing to the contrary; indeed, it says that after liability is established for class members treated uniformly by the defendant, as here, damages may be proven by a class-wide or statistical basis. 2 *McLaughlin*, §§8.12, 8.16 (7<sup>th</sup> ed. 2011). See CP 175-76 (quotations from practice manual).

<sup>35</sup> The employees first filed a motion to compel class member identification in August 2011, which the trial court granted over HCA's objection. CP 889-988, 1161-62.

<sup>36</sup> HCA's answer admits that *Moore* class members can be identified from State employment records. CP 8, 27.

problems).

Accordingly, even assuming the class members' health care costs were the only possible way to calculate the financial loss to the class, HCA's argument that due process, *Sitton*, and the discovery stipulation require the calculations to be done only through thousands of individual mini-trials, is directly contrary to *Moeller*.<sup>37</sup>

**4. *There Is No Federal Authority That Required the Trial Court to Adopt HCA's Inaccurate Method.***

Disregarding the Supreme Court's holding in *Cockle* and RCW 41.05.050(1), HCA argues that there is some sort of federal common law rule to the effect that any denial of health insurance must be valued based only on out-of-pocket expenses established in individual trials. HCA Br. 3, 14, 20-28. HCA bases its case law argument on selective federal wrongful discharge individual cases that were not class actions, and one

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<sup>37</sup> As *Newberg* states (3 *Newberg on Class Actions*, § 10:5, pp. 486-87 (4th ed. 2002)):

Authority for proof of aggregate damages, when capable of being proved by legally acceptable evidentiary standards, flows directly and logically after classwide proof of liability. . . . If the liability to the class is proved, then class recovery is measured by individual or aggregate proofs of loss or of the defendant's unjust enrichment. There is no constitutional, statutory, procedural, or theoretical bar to aggregate recovery for the class. The defendant cannot argue that it has no liability to the class. That fact has been proved. . . . Moreover, it is settled law that class actions are proper procedural devices even and especially when individual suits are not economically feasible because small or nominal individual claims are involved, or members have small claims relative to the cost of individual litigation. A valid class for nominal individual claims involves recognition at the outset that individual claim proofs are not practical or economically feasible. Therefore, it is to be expected by all that any recovery for the class will involve aggregate proof.

failure-to-hire discrimination class action that was reversed on liability.<sup>38</sup>  
*Id.* at 20-26.

But none of these cases involved employees of the defendant who were denied compensation they earned while working for the defendant. Instead, they all involve individuals who were not working for the defendant due to some wrongful conduct, primarily wrongful discharge.<sup>39</sup> In addition, no case cited by HCA holds that the out-of-pocket-cost method is a due process requirement. On the contrary, many federal courts hold in class actions that the employer premium or contribution is a

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<sup>38</sup> *United States v. City of New York*, 717 F.3d 72 (2d Cir. 2013); *reversing* 683 F.Supp.2d 225 (E.D.N.Y. 2012) (district court's earlier decision on liability). In *City of New York*, after deciding liability, the district court determined that over 2,000 mini-trials were required in the relief phase to resolve the numerous individual issues presented (*City of New York, supra*, 847 F.Supp.2d at 433), including which class members would now be hired as firefighters, which candidates who were not hired were eligible for monetary relief, whether the City had a bona fide non-discriminatory reason for not hiring any specific candidate, whether the candidate had looked for or obtained other suitable employment, and how much back pay should be awarded under the Court's tiered back pay formula. *Id.* at 410-33. In that context the district court decided that the issues relating to health benefits would be litigated in the individual trials along with other issues, including the individual's right to relief. *Id.* at 409. The Court of Appeals reversed the trial court's underlying summary judgment on liability and remanded the action to a different judge to determine liability because of the trial judge's improper conduct in the action. *United States v. City of New York*, 771 F.3d at 89-92, 99-10.

The district court in *City of New York* acknowledged that, even in the context of a discriminatory failure-to-hire case, "the law is less [than] clear with regard to how to value some [fringe] benefits, such as employer-provided health insurance" (847 F.Supp.2d at 409) and "there is disagreement among courts on this exact issue." *Id.* at 422.

<sup>39</sup> Individuals who are discharged from employment or who are not hired due to discrimination generally have the responsibility to mitigate by obtaining jobs that have adequate pay and benefits. But current employees have no duty to mitigate to obtain the pay and the benefits the employer is required to pay while they were working. HCA's approach would unlawfully transfer its statutorily required employer responsibility to provide health insurance onto its working employees.

reasonable measure to value lost health benefits (*see cases cited supra*, p. 18 n. 15).

In addition, as previously discussed pp. 25-31, the underlying presumption that an uninsured employee can only receive out-of-pocket costs is based on the erroneous factual assumption that uninsured individuals have no harm unless they have out-of-pocket expenses.<sup>40</sup> The trial court thus correctly concluded that HCA's selective federal cases do not control the question here — “how to look at a class of people who hadn't received healthcare benefits they were entitled to.” CP 583.<sup>41</sup>

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<sup>40</sup> The Ninth Circuit recognized in a discrimination case that “the method of calculating damages set forth in *Galindo* disadvantages those who cannot afford to pay insurance premiums after being discharged[,]” but it said it was “bound by Ninth Circuit precedent” and therefore required to apply the out-of-pocket method. *E.E.O.C. v. Farmers Bros. Co.*, 31 F.3d 891, 902 (9th Cir. 1994), discussing *Galindo v. Stoodly Co.*, 793 F.2d 1502 (9th Cir. 1986). HCA heavily relies on *Galindo* and similar cases. Br. 23-27.

<sup>41</sup> HCA also cites the Supreme Court's class certification decision in *Wal-Mart v. Dukes*, \_\_\_ U.S. \_\_\_, 131 S.Ct. 2541, 180 L.Ed 2d 374 (2011), as supporting its *Sitton* argument. HCA Br. 16, 20. The trial court correctly understood the situation here is quite different than *Wal-Mart*. VRP [10/26/12] 18-26. The plaintiffs in *Wal-Mart* proposed an enormous national class of about “one and a half million plaintiffs” alleging that the “local managers' broad discretion” over pay and promotion exercised in a “largely subjective manner” violates Title VII by discriminating against women. *Id.* at 2547. The Supreme Court reversed certification, saying the proposed class “wish[es] to sue about literally millions of employment decisions at once.” *Id.* at 2552. Local supervisors' discretion over employment matters “is just the opposite of a uniform employment practice that would provide the commonality needed for a class action[.]” *Id.* at 2554. Federal courts understand *Wal-Mart* is limited to proposed discrimination class actions where there is no company-wide policy identified and every manager has discretion over the challenged actions. *See, e.g., McRenolds v. Merrill Lynch, et al.*, 672 F.3d 482, 488-90 (7th Cir. 2012) (reversing trial court's denial of class certification based on *Wal-Mart* in discrimination action); *Scott v. Family Dollar Stores, Inc.*, \_\_\_ F.3d \_\_\_, 2013 WL 5630636 (4th Cir. 2013) (reversing trial court's “erroneous interpretation” of *Wal-Mart*).

5. ***Assuming Arguendo That Health Care Costs Were the Only Possible Measure of Damages, These Damages Can be Determined on a Class-Wide Basis Using the Scientifically Accurate Actuarial Method.***

Assuming *arguendo* that determining health care costs of the class were the only way to calculate damages here, those damages would be calculated with a scientifically accurate actuarial method, rather than by the impracticable and inaccurate individualized method proposed by HCA.

The trial court did not rule on the actuarial method for determining class-wide damages because it ruled that wages and restitution measures applied, which are not class-wide damages. CP 127, 583-86. The trial court did rule, however, that aggregate (class-wide) damages are appropriate in class actions. CP 591. The trial court said there are disputes about actuarial facts, CP 584-87, and HCA agrees (see p. 24 *supra*).

HCA contends that *Newberg on Class Actions* supports its view that the employees must individually prove their out-of-pocket costs, rather than using class-wide damages to determine health care costs. HCA Br. 16. But *Newberg* states the opposite.<sup>42</sup>

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<sup>42</sup> *Newberg* states:

Aggregate computation of class monetary relief is lawful and proper. Courts have not required absolute precision as to damages and have allowed damages to be proven by reference to the class as a whole, rather than by reference to each individual class member. Challenges that such aggregate proof affects substantive law and otherwise violates the

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More importantly, the Supreme Court has determined that class-wide damages are appropriate for a prevailing class. *Moeller*, 173 Wn.2d at 279-80; *accord, Pellino*, 164 Wn.App. at 697-99. And *HCA* agrees that “aggregate damages are acceptable in a class action so long as the damages do not exceed the reasonable collective damages of the individual members of the class.” *HCA Resp. Mot. to Modify* at 8 n. 18 (emphasis added).<sup>43</sup>

Here, the aggregate loss to the class can be determined with the actuarial method, which is explained by actuary David Wilson.<sup>44</sup> CP 149-60, 439-54. Wilson explained that a “health care actuary’s job is to estimate, among other things, the health costs for groups of individuals when actual claims for health expenses are unknown, usually because the estimates are forecasts for the following year.” CP 152.

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defendant's due process or jury trial rights to contest each member's claim individually, will not withstand analysis.

3 *Newberg on Class Actions*, § 10:5, p. 483 (4<sup>th</sup> ed. 2002). And calculating the class-wide loss is often “more accurate and precise than . . . individual proofs of loss.” *Id.*, § 10:2, 479. *See also* p. 39 n. 37.

<sup>43</sup> *HCA* also cites (Br. 27-28) *Frank Coluccio Const. Co. Inc. v. King County*, 136 Wn. App. 751, 150 P.3d 147 (2007), for individualized proceedings. But *Coluccio* is a very different case involving construction, it is not a class action, and it does not hold there is only one way to measure an employee’s lost health benefits or that due process requires individualized proceedings. The general principle in *Coluccio* (*id.* at 766-67) and what *HCA* acknowledges is the purpose of an award of damages (CP 1998) -- an injured party should be put in the same economic position he or she would have been but for the breach -- supports the actuarial method because that is precisely what the method accomplishes. CP 156.

<sup>44</sup> Wilson submitted seven declarations both explaining the actuarial method and responding to *HCA*’s minor quibbles with the method. CP 149-60, 439-54, 1200-05, 1231-80, 1285-91, 1292-1300, 1843-54.

The actuarial method is the standard scientific way to determine health care costs for groups of employees when these costs are unknown. CP 152-53, 442-443. And the actuarial method for determining the loss to the class is “based on the same data and actuarial principles that the State and Health Care Authority use and rely on to estimate the health care costs for those employees who receive coverage.” CP 159.<sup>45</sup>

Wilson explained that as a matter of actuarial science, “[t]he group of class members omitted from health care coverage is large enough from a statistical standpoint that they would have had the same average health care costs as the State employees with health care coverage had they been covered by the plan” and the distribution of the employees in the plans would have been the same as the covered employees. CP 154. And the data here are superior to the data used in a typical actuarial estimate of projected costs because the State extensively tracked on a calendar year basis the actual health care costs for the group of employees who received health insurance. CP 153. Therefore, “in the present situation, looking back instead of forward, rather than having the covered State employees’

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<sup>45</sup> In its Statement of the Case, with no citation, HCA wrongly says the employees “expressed their intent to use a [premium] ‘proxy’ instead of proving actual damages” (HCA Br. 9), with quotation marks around proxy, implying the employees used this term. HCA then repeats this argument throughout its brief (1, 3, 11, 15, 35). The actuarial method is not a “proxy” method, whatever that may be, and it based on the *actual* health care expenses for the comparable group of employees with health benefits, which is the same dollar amount as the State’s “portion of the premium” paid for health benefits for the class. CP 155.

*projected* health care costs as shown in the funding rate [*i.e.*, premium], there are data showing the *actual* health care costs for the covered employees for each year.” *Id.* (emphasis by Wilson).

Accordingly, the actual health costs for the covered employees can be used to determine what the actual costs for this class as a whole would have been but for State’s breach in failing to enroll them.<sup>46</sup> “The actuarial method is [thus] a *scientifically accurate method* to determine the financial loss to the class here.” CP 441 (emphasis added). “And it is *based on the best evidence available* -- the State’s actual health care costs for employees who were provided benefits.” CP 441-42 (emphasis added). “[M]ost importantly, the actuarial method will result in a *far more accurate determination* of the uncovered health care costs for the class than individual claims due to the numerous problems of establishing the losses of such a large class by a bill-submission method.” CP 159-60; 158-59 (emphasis added).<sup>47</sup>

Therefore, even if health care costs were the only measure of damages, those damages are more accurately determined by the scientifically accurate actuarial method, not by thousands of trials to prove

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<sup>46</sup> Wilson explained that to the extent there were any material demographic differences, between the class of omitted employees and the group of covered employees, *e.g.*, age and gender, then he could account for those differences when calculating the class-wide loss because that is precisely what actuaries do. CP 154 n. 3, 443-47.

<sup>47</sup> See also CP 1131, 1209, 1222-24 (testimony of professor Susan Long agreeing with Wilson).

out-of-pocket medical and dental expenditures. The actuarial method puts the class in precisely the position they would have been but for the State's breach.<sup>48</sup>

HCA contends that it seeks only a simple claims process. HCA Br. 36. But it actually asks for trials (CP 478, 140, MDR at 6, 11, MDR Reply at 2, 4), with class members' oral or written testimony. CP 478. And HCA refers to challenging, *i.e.*, cross-examining, class members on their claims of monetary damage. HCA Br. 2, MDR at 6, 8, 10 (challenge their testimony).<sup>49</sup> HCA's method is argued not to provide fair relief to the class, but to instead deter people in the class from seeking relief.

The problems with HCA's method include, for example, the fact that thousands of employee class members did not know they were wrongly denied health benefits at the time of the breach. Indeed, the employees were only notified the lawsuit existed in 2012 when the trial

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<sup>48</sup> The State argues that a pro rata distribution of the class-wide loss calculated through the actuarial method could create "opportunities for over- and under-compensation." MDR, p. 16. But HCA does not maintain the actuarial method would over-compensate the class as a whole, and the actuarial method is intended to determine the class-wide loss; the actuarial method is *not* a distribution plan, which is a matter the trial court did not rule on because the trial court decided to measure damages by wages and restitution. It is also a matter on which the State has no standing. *3 Newberg on Class Actions*, *supra*, p. 517. There are a wide variety of ways in which the class-wide damages determined with the actuarial method could be allocated. CP 461; *3 Newberg on Class Actions*, *supra*, § 10:12, pp. 506-07.

<sup>49</sup> HCA says the trials could be conducted by special masters, citing *Sitton*. HCA Br. 37. *Sitton* explains that any determination by a special master can be disputed and be subject to a trial *de novo* before a jury. 116 Wn.App. at 260. And HCA filed a jury demand. CP 2493-95. Thus, HCA's "simple claims process" involves possibly *two* trials for every employee, not just one. See Comm. Ruling at 3 (jury trial).

court gave them an opportunity to opt out in order to pursue their claims for relief individually.<sup>50</sup> CP 2459-60. The employees therefore had no reason to save records of health care expenses for years for later use here (unlike a personal injury case). CP 158, 1127.

Due to the duration of this action in the trial court, the case now covers at least 10 years. Thousands of class members would therefore have to recall, or have records to refresh their recollection, that they had a medical or dental expense for themselves or dependents (spouse and children) during the period of employment when the State was required to provide them with health benefits, but wrongly did not. CP 158-59. Employees without files of their old medical, vision, or dental bills would have to obtain records from their providers (assuming they could recall who they were and when the expense occurred), which would require substantial effort and large costs for the employees. CP 158-59. Smaller claims relating to dental, vision and pharmacy bills may be particularly difficult to track down. CP 159.

In addition to the great difficulties in establishing the costs, many employees would be very reluctant to disclose to HCA, class counsel, and the public, through the court system, the medical conditions that led them

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<sup>50</sup> After thousands of employees received the notice, and the opt-out process was nearly concluded, only 64 employees had opted out of the action. CP 129. The notice was sent to not only class members, but also to thousands of employees who were plainly not class members. *See, e.g.*, CP 2454-65. *See also infra* pp. 29-30, 38-39 (discussing HCA's erroneous class list).

and their dependents to seek medical treatment. CP 43, 1213.

With HCA's method each employee would also have to prove not only that the employees had out-of-pocket medical expenses during the time when HCA should have provided health benefits, but also that the expense would have been covered under a HCA plan in effect at that time. CP 140-41. The employees, of course, were excluded from the plans so they would have to obtain copies of the pertinent plans, retroactively choose one, then figure out whether the medical expense would have been covered under that plan. CP 158. In individual trials, they would then have to prove these facts in court subject to cross-examination and to HCA's evidence disputing their claim (HCA Br. 2; CP 159; MDR at 5-6), which is far from normal for class members. *Phillips Petroleum v. Shutts*, 472 U.S. 797, 810, 105 S. Ct. 2965, 86 L. Ed. 628 (1985) ("an absent class action plaintiff is not required to do anything"); *id.* at 809 (an absent "class action plaintiff is not required to fend for himself"). Determining costs individual-by-individual using HCA's method would require many months or years of trial, when damages can be determined far more accurately and efficiently by other methods.

Due to the class members' time, burden and expense in obtaining and proving bills, etc., the effort and cost to pursue the claim would also exceed the value of many employees' claims. Indeed, the trial court previously found that it is impracticable and cost-prohibitive for class

members to pursue their claims individually (CP 15, 113), and this unchallenged factual finding is a verity on appeal. *McCleary v. State*, 173 Wn.2d 477, 514, 269 P.3d 227 (2012).

Many class members would therefore not pursue their claims in individualized proceedings if HCA's method were adopted due to its high cost and burdensomeness. This would then provide a substantial windfall to HCA the wrongdoer, and violate the central purpose of class actions, which is to provide a vehicle for efficient relief for thousands of people in one case, particularly individuals with small claims. *Scott*, 160 Wn.2d at 852; *Phillips Petroleum*, 472 U.S. at 809-810.<sup>51</sup>

Accordingly, the actuarial method is an appropriate and accurate method to determine the loss to the class. Assuming *arguendo* that the Court determined it were unlawful to measure damages as either lost wages or restitution, at most, for HCA, a remand would be necessary to address the outstanding fact issues on the actuarial method and to reach a decision on the method. *Hash v. Children's Orthopedic Hospital*, 110 Wn.2d 912, 915-16, 757 P.2d 507 (1988).

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<sup>51</sup> One of the important functions of a class action is to aggregate claims so that class counsel can be compensated from the common fund. "When attorney fees are available to prevailing class action plaintiffs, plaintiffs will have less difficulty obtaining counsel and greater access to the judicial system." *Bowles v. Dep't of Retirement Systems*, 121 Wn.2d 52, 71, 847 P.2d 440 (1993). The common fund awaits the conclusion of this litigation and class counsel are therefore not seeking attorney fees at this time under RAP 18.1.

CONCLUSION

The employees proposed three reasonable and efficient methods to measure damages: lost wages, restitution, and class-wide health care costs calculated with the actuarial method. HCA proposed an inaccurate, unscientific, and impracticable method, *i.e.*, making each class member prove out-of-pocket costs with documents and “oral and written testimony.” HCA has no authority for its argument that the trial court was *required* to adopt its factually inaccurate method or that the trial court abused its discretion in choosing lost wages and restitution as methods to measure damages. The Court should affirm the trial court, and award costs on appeal to the employees.

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