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SUPREME COURT OF THE STATE OF WASHINGTON

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

Petitioners,

v.

MIKE KREIDLER, Washington State Insurance Commissioner,

Respondent.

INSURANCE COMMISSIONER'S RESPONSE BRIEF

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I. INTRODUCTION

Petitioners Washington State Medical Association and the Washington Chapter, American College of Emergency Physicians (collectively "WSMA"), filed a Petition Against State Officer Writ Of Mandamus, asking the Supreme Court to invoke its original jurisdiction to compel the Insurance Commissioner to "enforce" RCW 48.43.093. CP 223-90. The Supreme Court Commissioner transferred the petition to the superior court on the grounds that the petition did not appear to state a proper claim for mandamus, the claims presented by WSMA were essentially declaratory in nature, and there were potential disputed facts that the Court is not equipped to resolve. CP 5-8.

After transfer, WSMA added a declaratory judgment cause of action to its petition. However, the superior court also declined to entertain the petition on the grounds that WSMA had failed to name as a party a health carrier that would be adversely affected by WSMA's requested relief. Rather than amend its petition to correct this jurisdictional defect and create a justiciable claim, WSMA now asks again for declaratory relief from the appellate court, without a necessary party and on a record that is inadequate to decide the issue.

The Uniform Declaratory Judgment Act, RCW 7.24 (UDJA), does not provide an avenue for WSMA to obtain an advisory opinion

concerning the interpretation of RCW 48.43.093, without naming as a party a health carrier that would be affected by WSMA's requested declaratory ruling. WSMA's request for a writ of mandamus also must fail.

II. ISSUES

1. Did the superior court correctly conclude it lacked jurisdiction over WSMA's claims when WSMA failed to join a necessary party to their request for a declaratory judgment?
2. Does WSMA lack standing to advance the interests of policyholders, and to bring a UDJA claim solely against the Commissioner?
3. Is WSMA's request for a declaratory judgment interpreting RCW 48.43.093 premature, given WSMA's failure to properly invoke the superior court's jurisdiction, thus preventing the superior court from making a record and deciding WSMA's claim?
4. Is the Commissioner's longstanding interpretation of RCW 48.43.093 consistent with the plain language of the statute?
5. Did the superior court properly reject WSMA's request for a writ of mandamus?

III. STATEMENT OF THE CASE

A. Procedural History

On December 9, 2010, WSMA filed an original action¹ in the Supreme Court seeking a writ of mandamus against the Insurance Commissioner. CP 223-52. WSMA asked this Court to order the

¹ *Washington State Medical Association, Washington Chapter, American College of Emergency Physicians v. Kreidler*, Case No. 85388-6.

Commissioner to “enforce” WSMA’s interpretation of RCW 48.43.093. CP 251.

The Commissioner moved to dismiss WSMA’s claims and included a declaration from Elizabeth Berendt that identified disputed facts. CP 41-78, 382-85. Rather than dismiss WSMA’s petition outright, the Court Commissioner transferred WSMA’s petition to the superior court, for three reasons. First, mandamus was doubtful because “[p]etitioners [did] not point to any specific enforcement provision the [Insurance] Commissioner has a duty to employ in this situation,” and the enforcement options that were identified “do not seem to be ministerial acts.” CP 6. Second, WSMA was essentially asking for a declaratory judgment, something not within the Court’s original jurisdiction. CP 7. Finally, the Court Commissioner noted that the Supreme Court is not equipped to settle disputed issues of fact. CP 7.

In superior court, WSMA filed an Amended Complaint adding a cause of action under the UDJA, asking the court to declare that WSMA’s interpretation of RCW 48.43.093 is correct. CP 431. WSMA’s amended complaint did not join any “health carrier” as a respondent.² Verbatim Report of Proceedings (RP) 24:7-17. The Commissioner moved to

² This Response Brief uses the phrase “health carrier” because that is the term used in RCW 48.43.093. “Health carriers” are insurance companies, disability insurers, health care service contractors, and health maintenance organizations. RCW 48.43.005(18).

dismiss the amended complaint on jurisdictional grounds, arguing that WSMA failed to state a claim for mandamus, and failed to join a necessary party under the UDJA. CP 623, RP 20:25-21:1. In support of his motion, the Commissioner referred to a declaration filed with the Supreme Court, a copy of which was in the file transferred to the superior court from the Supreme Court.³ CP 474.

The superior court granted the Commissioner's motion based on WSMA's failure to join any health carrier whose interests would be affected by WSMA's requested statutory interpretation.⁴ CP 618-619. The superior court also dismissed WSMA's claim for a writ of mandamus, stating that WSMA's claim was actually one for declaratory judgment. CP 618; RP 24:20-23.

Neither party noted a motion for summary judgment on the merits of the case, nor did the superior court grant summary judgment on the merits⁵. CP 618. The superior court never addressed whether an adequate

³ The Declaration of Elizabeth S. Berendt was submitted in support of the Insurance Commissioner's Supreme Court Motion to Dismiss, to demonstrate the factual errors in the Declaration of Robert Harkins filed by WSMA in support of its petition for mandamus, and its Amended Complaint. CP 382-430; CP 451-470.

⁴ WSMA also failed to join any patient, or organization representing patient rights, whom the superior court noted may also be necessary parties. RP 24:10-13. However, the superior court's order focused on the failure to join at least one health carrier.

⁵ The superior court treated the Commissioner's motion to dismiss as a Civil Rule 56 summary judgment motion because the Commissioner referenced Ms. Berendt's previously filed declaration. CP 618. However, this reference to the declaration was for the limited purpose of considering WSMA's failure to join a necessary party. CP 618.

record existed to address the validity of WSMA's claims, or whether the material facts are undisputed. The only determination made by the superior court was that WSMA failed to join a necessary party, depriving the court of jurisdiction to hear the merits of WSMA's claims.

Following the superior court's dismissal, WSMA filed this petition for direct review.

B. Factual Statement

1. The Dispute Between WSMA And Health Carriers Pertains To Emergency Room Providers' Billed Charges.

RCW 48.43.093 establishes requirements on health carriers' policies with their insureds. It sets standards for how health carriers should conduct a "review of the necessity and appropriateness of emergency services. . .". See RCW 48.43.093(1). It requires health carriers to "cover" certain emergency services. RCW 48.43.093(1)(a). The statute also imposes a "prudent lay person" standard to prevent claim denials by health carriers that determine, based on hindsight, that emergency services had not been necessary. *Id.* The various protections provided in RCW 48.43.093(1)(a) allow policyholders to seek emergency health care without fearing their emergency claims will be disputed if the condition is not life threatening. CP 383.

The provision in RCW 48.43.093 that requires health carriers to cover emergency health services is subject to contractually defined “cost sharing arrangements” such as copayments, coinsurance, and deductibles, subject to the limitation in RCW 48.43.093(1)(c).

WSMA contends that RCW 48.43.093 requires health carriers to recognize the “billed charges” of emergency room physicians who do not have contracts with the carriers that establish a payment rate. However, RCW 48.43.093 does not specify the rate or fee schedule a health carrier must use as the basis for paying claims. In practice, most insurance policies apply cost-sharing arrangements to “allowed” charges. CP 233. Nothing in RCW 48.43.093 or its related legislative history indicates that the Legislature intended to require health carriers to apply their cost-sharing arrangement to all charges billed by physicians.

There may be situations in which certain physicians are dissatisfied with the contract rate health carriers pay to other contracted physicians, and thus, may refuse to contract with a specific health carrier. Those non-contracted physicians retain the option of seeking payment directly from the patient, commonly referred to as “balance billing,” for the difference between what the health carrier will pay, and what the physician actually charges. CP 383.

The Commissioner does not have regulatory authority over non-contracted physicians, and therefore cannot establish their fees, or require them to contract with health carriers. CP 383-84. However, the Commissioner enforces RCW 48.43.093 in part by ensuring that the contracts between health carriers and their policyholders clearly set forth the policyholders' rights under RCW 48.43.093. CP 385.

2. Disputed Enforcement History.

There are many material facts that remain in dispute or are unsupported in the record. Since WSMA filed its original petition for mandamus, the Commissioner disputed WSMA's version of how the Commissioner's Office (OIC) has enforced RCW 48.43.093.

In its pleadings, WSMA primarily relies on the declaration of former OIC employee, Robert A Harkins. CP 254-72, CP 451-470. Mr. Harkins claims to rely on certain administrative enforcement orders issued by the Commissioner to support his declaration. However, a review of those orders reveals no support for Mr. Harkins' statements. CP 397-440.

The identified orders contain no provision requiring a health carrier to pay "billed" charges for non-contracted providers under RCW 48.43.093. CP 397-440. In fact, only one order addressed the rate health carriers were required to pay providers. CP 416. The order

explicitly provided that in certain circumstances⁶, the health carrier was obligated to pay “allowable charges of the original bill that are clearly identified as emergency room services” CP 416 (emphasis added).

The record contains evidence that the OIC required one insurer, Premera Blue Cross, to pay billed charges for a time⁷. CP 448-50. However, undisputed facts demonstrate that this requirement was imposed under a separate OIC regulation related to the adequacy of the insurer’s network of emergency service providers, WAC 284-43-200.⁸ CP 385. When addressing a question of network adequacy, the OIC acts pursuant to WAC 284-43-200, not RCW 48.43.093. There is no evidence in the record that this requirement has ever been imposed on any other health carrier as part of an enforcement action, by any Insurance Commissioner.

WSMA also relies on an “internal discussion” among OIC employees from 2005 (Br. of WSMA at 6-7) to argue that the Commissioner once interpreted RCW 48.43.093 in the manner preferred by WSMA. However, an “internal discussion” is not a formal

⁶ These provisions apply to situations where the provider submits a single bill for both emergency and non-emergency services.

⁷ The Commissioner concluded in 2002 that Premera Blue Cross was in violation of WAC 284-43-200. CP 448-50.

⁸ WAC 284-43-200 requires that when a health carrier has an inadequate network of providers for a particular covered health care service, the health carrier is required to provide for the service, “at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.” In other words, health carriers with an inadequate number of providers can be required to pay billed charges, as was the case with Premera.

interpretation of a statute, nor is there any evidence that the Commissioner adopted that interpretation in an enforcement action against a health carrier. WSMA admits that the Commissioner's interpretation of RCW 48.43.093 has been in place since 2005 or 2006. Br. of WSMA at 7.

In addition, the Commissioner is currently enforcing RCW 48.43.093, despite the allegations in WSMA's complaint. CP 385. The Commissioner has a process to review and approve health carrier contracts to ensure they comply with state law and regulations. The Commissioner has used the form review process as one way to enforce RCW 48.43.093. CP 385.

3. There Are Disputed Questions Of Fact Related To Harm To WSMA's Members And Patients.

In both its opening brief and its statement of grounds for direct review, WSMA alleges, with no evidentiary support, that the Commissioner's interpretation of RCW 48.43.093 harms both patients and WSMA members. However, the record provides no support for WSMA's statement that its statutory interpretation would provide a greater benefit to providers than the Commissioner's interpretation. WSMA itself has stated that "WSMA members would not directly benefit any more" under WSMA's interpretation than under the Commissioner's interpretation. CP 161.

WSMA's other allegations of harm are also unsupported. WSMA failed to provide evidence that the reimbursement rates provided to nonparticipating providers by health carriers, coupled with the payments received from patients, are not fairly compensating providers. *See* Br. of WSMA at 10. Additionally, no evidence exists that the Commissioner's interpretation prevents patients from seeking emergency room treatment. Br. of WSMA at 9. The record established here does not support WSMA's allegations of harm, and the superior court made no determination regarding WSMA's allegations of harm.

IV. SUMMARY OF ARGUMENT

By failing to join even one health carrier to this lawsuit, WSMA failed to satisfy the jurisdictional requirements of the UDJA, specifically RCW 7.24.110. A health carrier must be joined as a party because a health carrier, not the Insurance Commissioner, has interests that would be adversely affected by the requested relief. WSMA's amended complaint therefore failed to identify an actual controversy, or a genuine opposing interest, between itself and the Insurance Commissioner. In addition, WSMA lacks standing to pursue the allegations it has made against the Insurance Commissioner.

WSMA's request that this court enter a decision on the substance of WSMA's claims, is also premature. The superior court dismissed

WSMA's claims for lack of jurisdiction, and made no determination regarding the factual disputes and legal issues. Further, the interpretation WSMA seeks to impose on absent health carriers ignores the plain language of the statute.

Finally, WSMA's request for mandamus fails because mandamus does not provide a cause of action to direct the Commissioner with respect to discretionary matters.

V. ARGUMENT

A. WSMA Failed To State A Claim For Declaratory Judgment Under The Uniform Declaratory Judgment Act

1. The Superior Court Decision Is Reviewed Under A Mixed *De Novo* And Abuse Of Discretion Standard.

The superior court's refusal to consider a UDJA claim is reviewed under both a *de novo* and an abuse of discretion standard of review. The superior court's legal conclusions regarding whether a case is justiciable under the UDJA is reviewed *de novo*. *To-Ro Trade Shows v. Collins*, 144 Wn.2d 403, 410, 27 P.3d 1149 (2001). Pursuant to *To-Ro*, the superior court's legal conclusion that at least one health carrier must be joined to create a justiciable controversy under the UDJA is reviewed *de novo*.

However, if joinder of a party is not necessary, whether additional parties *may* be joined is a matter left to the discretion of the court. *Williams v. Poulsbo Rural Tel. Ass'n*, 87 Wn.2d 636, 644, 555 P.2d 1173

(1976). *Cf. Nollette v. Christianson*, 115 Wn.2d 594, 599, 800 P.2d 359 (1990) (under the UDJA, an appellate court “may be called upon to determine whether the trial court erroneously exercised its discretion either to consider or refuse to consider such an action”).

If, as WSMA contends, a health carrier is not a necessary party, then the superior court’s decision that an additional party should be joined is a matter that would be reviewed for abuse of discretion. WSMA has not even argued that the trial court abused its discretion. Therefore, under WSMA’s theory of the case, the superior court’s decision should be affirmed.

2. The UDJA Requires Joinder Of At Least One Health Carrier.

Under the UDJA, “[w]here parties whose rights would be affected and whose interests would be prejudiced are not joined, a declaratory judgment cannot be entered and the case must be either dismissed or remanded.” *Williams v. Poulsbo Rural Telephone Ass’n*, 87 Wn.2d 636, 555 P.2d 1173 (1976) (citing *Automobile Club v. Seattle*, 49 Wn.2d 262, 267-70, 300 P.2d 577 (1956)), *overruled on other grounds by Chemical Bank v. Washington Public Power Supply System, et al.*, 102 Wn.2d 874, 887, 691 P.2d 524 (1984).⁹ RCW 7.24.110 states that “all persons shall be

⁹ See also *In re Bridge’s Estate*, 40 Wn.2d 133, 135-36, 241 P.2d 439 (1952); *Blodgett v. Orton*, 14 Wn.2d 270, 273, 127 P.2d 671 (1942); *State v. Fruitland Irrigation*

made parties who have or claim any interest which would be affected by the declaration.” A trial court lacks jurisdiction over a declaratory action if all necessary parties are not joined. *Treyz v. Pierce County*, 118 Wn. App. 458, 462, 76 P.3d 292 (2003), *rev. denied*, 151 Wn.2d 1022, 91 P.3d 94 (2004).

WSMA claims it is not seeking an order that “any insurer violated RCW 48.43.093 or that the Insurance Commissioner is required to take specific action against any insurer.” Br. of WSMA at 16. This argument is similar to one made in *Bainbridge Citizens United v. Washington State Department of Natural Resources*, 147 Wn. App. 365, 198 P.3d 1033 (2008). There, the plaintiff, sought a declaration “that the Department is compelled to enforce WAC 332-30-127 and WAC 332-30-171(8) against alleged trespassers in Eagle Harbor,” but failed to join any alleged trespassers as parties. *Bainbridge*, 147 Wn. App. at 372. Nevertheless, the plaintiff’s complaint did not request that action be taken directly against the trespassers.

The *Bainbridge* trial court held the UDJA complaint was not proper, because the court could not make a complete determination of the controversy without the presence of the alleged trespassers. *Id.* at 373. Only the alleged trespassing individuals could rebut plaintiff’s factual

Dist., 196 Wn. 11, 13, 81 P.2d 844 (1938); *Toulouse v. New York Life Ins. Co.*, 39 Wn.2d 439, 441, 235 P.2d 1003 (1951).

allegations against them or present defenses to the plaintiff's claims. In addition, the alleged trespassers' ability to protect their interests would have been impeded by a judgment in the case. *Id.* Finally, a judgment for the plaintiff would necessarily affect the alleged trespassers' interests. *Id.*

In affirming the trial court, the court of appeals applied a test that married the joinder standards under the UDJA and the civil rules:

A party is necessary if (1) the trial court cannot make a complete determination of the controversy without that party's presence, (2) the party's ability to protect its interest in the subject matter of the litigation would be impeded by a judgment in the case, and (3) judgment in the case necessarily would affect the party's interest.

Bainbridge, 147 Wn. App. at 371-72.

Here, the superior court properly applied the *Bainbridge* test when it determined that health carriers have interests that would be affected by the relief WSMA seeks. WSMA's complaint only cites harm caused by health carriers:

Health insurers appear to have stopped paying billed charges for emergency services provided by non-participating providers, and instead pay only the allowable charges which the health insurers unilaterally decide to pay for such services.

CP 438, Amended Complaint ¶21. WSMA claimed that the result of the health carriers' conduct was that "...[WSMA members] are unable to obtain payment of billed charges from insurers pursuant to

RCW 48.43.093.” CP 438-439, Amended Complaint ¶22. Even WSMA’s requested order would state that “RCW 48.43.093 requires insurers to pay billed charges....” CP 440-41, Amended Complaint ¶34, and ¶B. WSMA concedes that the order they seek will affect the interests of nearly every health carrier. Br. of WSMA at 16. Any order compelling the Commissioner to “enforce” WSMA’s interpretation of RCW 48.43.093 necessarily orders the Commissioner to enforce that interpretation against Washington health carriers.

In addition, WSMA’s Amended Complaint contained numerous factual allegations concerning the practices of health carriers, and their impact on WSMA members. CP 435-36, 438-39. WSMA’s brief also contains allegations characterizing health carriers’ payment practices as the source of alleged harm to physicians and insureds. Br. of WSMA at 9-10. The factual determinations that must be made to confirm these allegations can only be rebutted or confirmed by health carriers. *Bainbridge Citizens United*, 147 Wn. App. at 373. A health carrier must be joined as a party to create the factual record necessary to decide this case because these allegations have not been proven, or even supported, by evidence in the record.

WSMA cites *Glasebrook v. Mutual of Omaha Ins. Co.*, 100 Wn. App. 538, 997 P.2d 981 (2000), and *Hodge v. Raab*, 151 Wn.2d 351, 88

P.3d 959 (2004), for the proposition that a declaratory judgment may be issued “without joining as a party every person to whom those statutes apply.” Br. of WSMA at 16. First, this is consistent with the superior court’s order that at least one, but not all health carriers must be joined. CP 623, RP 23:12-24:6. Moreover, in both cases relied upon by WSMA, the health carriers were actually named as parties. Neither of these cases stands for the proposition that a UDJA claim interpreting the state Insurance Code is proper when no health carrier is named as a party.

Next, WSMA cites *Horan v. Marquardt*, 29 Wn. App. 801, 630 P.2d 947 (1981), for its contention that “The Courts plainly may resolve disputes between consumers and the Insurance Commissioner regarding Washington’ insurance laws, even if no [health carrier] is a party to the case.” Br. of WSMA at 17. *Horan* is distinguishable. First, *Horan* was not a UDJA action. It was a challenge to a rule promulgated by a state agency; at that time, “declaratory judgment” was the term of art for a rule challenge filed under the state Administrative Procedure Act. *Horan*, 29 Wn. App. at 802-803. *See also* former RCW 34.04.070(1), Laws of 1959, Ch 234, §7. In contrast, WSMA filed this action under the UDJA and does not challenge a rule. WSMA is therefore subject to the UDJA’s requirement that parties whose interests would be affected must be joined, as set forth above.

Moreover, in *Horan*, the consumers (*i.e.*, policyholders) were independently represented. Here, WSMA represents providers. WSMA does not represent consumers or even purport to represent consumers.¹⁰ Therefore even WSMA's overstated interpretation of *Horan*, which would allow *consumers* to challenge the Insurance Commissioner's interpretation of a statute without an otherwise justiciable case, is inapposite.

The superior court correctly determined that at least one health carrier who may be representative of the interests of all health carriers must be made a party, in order to satisfy the plain language of RCW 7.24.110. CP 625, RP 24:14-17.

3. Without A Health Carrier, WSMA Cannot Present A Justiciable Controversy Because The Commissioner And WSMA Do Not Have An Actual Dispute, Or Genuine And Opposing Interests.

In addition to requiring necessary parties to be part of the case, the UDJA requires a justiciable controversy in order for the courts to have jurisdiction. *Diversified Industries. v. Ripley*, 82 Wn.2d 811, 814-15, 514 P.2d 137 (1973) ("This court, in applying the Uniform Declaratory Judgment Act, RCW 7.24, has . . . steadfastly adhered to the virtually universal rule that, before the jurisdiction of a court may be invoked under

¹⁰ Discussion of WSMA's lack of standing to bring this action is discussed at V.B below.

the act, there must be a justiciable controversy. . .”). A justiciable controversy is:

- (1) ... an actual, present and existing dispute, or the mature seeds of one, as distinguished from a possible, dormant, hypothetical, speculative, or moot disagreement,
- (2) between parties having genuine and opposing interests,
- (3) which involves interests that must be direct and substantial, rather than potential, theoretical, abstract or academic, and
- (4) a judicial determination of which will be final and conclusive.

To-Ro Trade Shows, 144 Wn.2d at 411 (quoting *Diversified Industries*, 82 Wn.2d at 815). “These elements must coalesce, otherwise the court steps into the prohibited area of advisory opinions.” *Diversified Industries*, 82 Wn.2d at 815. Even assuming that the facts alleged in the Complaint are true, WSMA failed to state a justiciable claim against the Commissioner.¹¹

WSMA’s own statements cast the greatest doubt on whether an actual dispute exists with the Commissioner. First, WSMA argues that the Commissioner’s interpretation of RCW 48.43.093 causes WSMA harm. Then, WSMA argues that “WSMA members would not directly benefit any more” under WSMA’s interpretation than under the Commissioner’s interpretation. CP 161. It is difficult to discern which position WSMA wishes to assert. What is clear is that WSMA simply disagrees with the

¹¹ If all WSMA seeks is an interpretation of RCW 48.43.093, then it seeks an advisory opinion. Without an insurer applying the insurance code and the policy terms to its claims, any interpretation of the Insurance Code is a purely academic dispute, and will result in forcing the court “into the prohibited area of advisory opinions.” *Diversified Industries*, 82 Wn.2d at 815.

Commissioner's longstanding interpretation of how much RCW 48.43.093 requires carriers to pay for emergency services. This disagreement alone is insufficient to create genuine and opposing interests between the Commissioner and WSMA, especially if WSMA's own interpretation would not provide any greater direct benefit to its members. The mere existence of a different interpretation is insufficient to establish a justiciable dispute.

WSMA's real dispute appears to be with the health carriers who pay some of its members less than the billed charges they demand. The only allegations of harm WSMA has made regarding the Commissioner is that he has not taken enforcement action against health carriers who have refused to pay billed charges. CP 437. While the Commissioner's interpretation of RCW 48.43.093 is correct, it is the health carriers, not the Commissioner, that act in a way that directly affects providers. Therefore, it is the health carriers that have a genuine interest in opposing WSMA's interpretation of RCW 48.43.093.

4. WSMA Cannot Present A Justiciable Controversy Because Without At Least One Health Carrier, This Will Not Be A Final Decision.

Another requirement for a justiciable claim under the UDJA is that a judicial determination of the controversy will be final and conclusive. *To-Ro Trade Shows*, 144 Wn.2d at 411 (quoting *Diversified Industries.*, 82

Wn.2d at 815). If WSMA's request for declaratory relief were granted, the judgment would not be the final answer regarding WSMA members' rights to payment, because WSMA failed to join any health carrier or challenge any specific payment practice or transaction. Under the UDJA, "no declaration shall prejudice the rights of persons not parties to the proceeding." RCW 7.24.110. Therefore, even if WSMA were to obtain the declaratory judgment it seeks, litigation on these issues would not conclude. Further litigation would likely occur between the health carriers and the providers over this very issue. Therefore, any judicial determination concerning the interpretation or application of RCW 48.43.093 cannot be final and conclusive, especially without a health carrier.

B. WSMA Lacks Standing To Bring This Action

1. WSMA Lacks Standing To Represent The Interest Of Policyholders.

WSMA lacks standing to bring a UDJA (or any other claim) against the Commissioner on behalf of the policyholder patients. WSMA is an association that represents medical providers, not patients. To have standing to bring a claim on behalf of third parties - in this case, the policyholding patients - WSMA would have to demonstrate 1) an injury-in-fact, 2) a "close relationship" to patients receiving emergency services,

and (3) a hindrance to the patients' ability to protect their own interests. *Mearns v. Scharbach*, 103 Wn. App. 498, 512, 12 P.3d 1048 (2000).

In its complaint, WSMA claims "balance-billing" harms patients. Balance billing occurs when providers bill their patients for the amount their health carriers do not pay under the patients' policies. Neither WSMA nor its members can allege the necessary close relationship to patients who may be required to pay the difference. In fact, it is balance billing by WSMA's own members that is the direct source of the alleged harm to patients. As WSMA has conceded, "one way or another, nonparticipating physicians can get reimbursed for their services." CP 161. In light of this admission, neither WSMA nor its members can allege the necessary close relationship necessary for WSMA to assert claims on patients' behalf. For the purposes of this case, the relationship between physician members of WSMA and the patients they have balance billed, is at best, adversarial. If patient rights are adjudicated in a court of law, patients are entitled to representation from persons other than the same parties responsible for their alleged harm.

2. WSMA Lacks Standing Because RCW 48.43.093 Does Not Address The Rights Of Health Care Providers.

WSMA also lacks standing because RCW 48.43.093 addresses patients' rights not health care providers' rights. "Inherent in the

justiciability determination is the traditional limiting doctrine of standing.” *Branson v. Port of Seattle*, 152 Wn.2d 862, 101 P.3d 67 (2004). The statutory right to bring a claim under the UDJA “is clarified by the common law doctrine of standing, which prohibits a litigant from raising another’s legal right.” *Grant County Fire Prot. Dist. No. 5 v. City of Moses Lake*, 150 Wn.2d 791, 802, 83 P.3d 419 (2004). For this reason, a person’s interest in the dispute over enforcement of a statute must be direct and substantial, as opposed to “potential, theoretical, abstract or academic.” *To-Ro Trade Shows*, 144 Wn.2d at 412.

In *Branson*, the plaintiff rented a car at SeaTac Airport and was charged money to cover the concession fee the Port charged all concessionaires, including rental car companies. 152 Wn.2d at 868. The plaintiff brought a UDJA action challenging the validity of the Port’s concession fees assessed to rental car companies. *Id.* The court refused his UDJA claims on the grounds that “Branson seems to be raising not his own legal right, but that of the concessionaires.” *Id.* at 878. The court further found that “Branson’s complaint would more properly be addressed by a claim against the rental car companies because they, not the Port, actually charged Branson the fee about which he complains.” *Id.*

Similarly, in *To-Ro Trade Shows*, the court found that a show promoter lacked standing to pursue a UDJA claim where its “interest in

seeking declaratory relief lies outside the zone of interests regulated by” the statute it was challenging. 144 Wn.2d at 414. There, the promoter sued the State, alleging that Washington’s RV dealer licensing requirement was invalid as applied to an Idaho dealership that was precluded from participating in the promoter’s exhibition. *Id.* The court found that, “[t]he interest To-Ro is seeking to protect is its own theoretical interest in increasing the number of exhibitors.” *Id.* at 415. The court held that To-Ro’s interest was not in the “zone of interests” protected by the licensing scheme, which was enacted to protect consumers. *Id.* Because the promoter failed to demonstrate that its interests were “direct and substantial” as opposed to “potential, theoretical, abstract or academic,” the court held the promoter had no justiciable claim. *Id.* at 412.

Here, WSMA claims its members (health care providers) should receive higher payments directly from health carriers. CP 438-39. However, RCW 48.43.093 provides no statutory rights to providers. Rather, RCW 48.43.093 addresses what health carriers are required to provide to their policyholders under their insurance contracts. CP 546-47. The “zone of interests” the Legislature sought to protect in RCW 48.43.093 are the interests of policyholders, not health care providers. As in *To-Ro*, allegations that a particular interpretation might

cause indirect financial harm are not sufficient to bring WSMA within the zone of interests protected by RCW 48.43.093.

WSMA lacks a direct and substantial interest in any interpretation of RCW 48.43.093, and therefore lacks standing under the UDJA.

C. Summary Judgment On WSMA's Declaratory Judgment Claim Is Premature Without A Superior Court Determination, All Necessary Parties, And An Adequate Record

WSMA alleges that the superior court erred when it did not grant WSMA summary judgment of its declaratory judgment claim below. Br. of WSMA at 18. In doing so, WSMA insists it was entitled to a summary judgment despite the fact that the factual record was not fully developed and that the superior court lacked jurisdiction due to WSMA's failure to join all necessary parties in the lawsuit.

The superior court applied Civil Rule 56 only to the limited jurisdictional issue: whether one or more health carriers must be parties to this case. CP 623. Review of WSMA's substantive claims by this court would be premature and inadequate on the record made below.

Issues that have not been decided by a trial court are not properly before an appellate court. *W.R. Grace & Co. v. Dep't of Revenue*, 137 Wn.2d 580, 592, 973 P.2d 1011 (1999) (issues upon which trial court made no determination are not ripe for appellate review); *Dep't of Ecology v. Acquavella*, 131 Wn.2d 746, 760, 935 P.2d 595 (1997) (appellate

review is not ripe until the trial court uses a legal standard to make findings based on the evidence). Although WSMA asks this court to reach the merits of its claims and construe RCW 48.43.093, the superior court never considered, let alone decided, how to interpret RCW 48.43.093. Until a superior court, presented with an actual justiciable controversy, interprets RCW 48.43.093, and applies that interpretation to facts in evidence, appellate review of the merits of WSMA's statutory interpretation claim is not ripe. *Acquavella*, 131 Wn.2d at 760.

“The rule is well known and universally respected that a court lacking jurisdiction of any matter may do nothing other than enter an order of dismissal.” *Deschenes v. King Cnty.*, 83 Wn.2d 714, 521 P.2d 1181 (1974), *overruled on other grounds by Clark County Pub. Util. Dist. No. 1 v. Wilkinson*, 139 Wn.2d 840, 991 P.2d 1161 (2000). Once the superior court determined that it lacked jurisdiction, it could not have entered any decision on the merits of WSMA's claim. The superior court recognized that, “if I conclude that there are parties here who are not present but who must be in order for declaratory judgment jurisdiction to attach, then I must dismiss that case. That is the conclusion I reach.” RP 22:10-14.

Moreover, the record in this case is insufficient to reach WSMA's statutory interpretation argument. The parties dispute the enforcement history of RCW 48.43.093. WSMA alleges that health carriers do not

comply with RCW 48.43.093, but WSMA has made bare assertions, and not produced examples of alleged violations into the record. Even though insurance policies establish the “cost-sharing arrangements” that are at the heart of the statutory interpretation dispute, there is not a single insurance policy in the record. WSMA’s allegations of patient and physician harm caused by the Commissioner’s interpretation are disputed as speculative. A decision in WSMA’s favor on such a record would be prejudicial to the carriers who would be affected by such a decision. In short, WSMA asks the court to impose a legal interpretation on an entire industry, without placing facts in evidence relating to health carriers that would be adversely affected by the declaratory order. The superior court correctly rejected WSMA’s attempt to obtain a declaratory judgment against the Commissioner.

The superior court also provided WSMA a clearly marked path back to the courthouse. WSMA need only join one or more health carriers, and the court would exercise jurisdiction over WSMA’s statutory interpretation claim. RP 23:21-24:14. Until WSMA does so, summary judgment of its substantive claims is not ripe for appellate review.

D. WSMA’s Interpretation Of RCW 48.43.093 Is Incorrect

Because review of WSMA’s substantive claim would be premature, the Court should not address WSMA’s interpretation of

RCW 48.43.093. However, to ensure the Court is fully informed the Commissioner sets forth below his interpretation of RCW 48.43.093. The Commissioner's interpretation not only applies the entire text of the statute, but also harmonizes the statute within the statutory framework of the Insurance Code. In contrast, WSMA's oversimplified reading of RCW 48.43.093 fails to interpret words used in the statute, and to address how the statute applies to a typical insurance policy.

1. RCW 48.43.093 Addresses The Cost Sharing Arrangements Health Carriers May Use In Making Benefit Determinations, Not The Rate Providers May Charge.

WSMA's interpretation of RCW 48.43.093(1)(c) is based on the erroneous assumption that RCW 48.43.093(1)(c) addresses billed charges, and requires carriers to accept billed charges. RCW 48.43.093(1)(c) contains no reference to billed charges.

RCW 48.43.093(1)(c) provides in pertinent part:

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

Plainly, RCW 48.43.093(1)(c) does not contain anything that specifies the rate or fee schedule a carrier must use as the basis for payments. This

statute is also silent on the amount that health providers are permitted to charge.

Instead, RCW 48.43.093(1)(c) places limits on the “cost sharing arrangements” carriers are allowed to impose when non-contracted physicians provide emergency services. In practice, the insurance contract, i.e. the insurance policy, establishes the applicable cost-sharing arrangement. “Copayments, coinsurance, and deductibles,” are three types of cost sharing arrangements found in insurance contracts, and are the three types of arrangements specifically mentioned in RCW 48.43.093(1)(c). Understanding these terms, which WSMA’s brief has wholly ignored, is critical to understanding the proper application of this statute.¹²

- A “copayment” is a “fixed amount that a patient pays to a healthcare provider according to the terms of the patient’s health plan.” Blacks Law Dictionary 360 (8th ed. 2004). Copayments are typically paid at the time of service and may vary for different types of health care services.
- A “deductible” is “the portion of the loss to be borne by the insured before the insurer becomes liable for payment.”

¹² Because the record lacks even a single insurance contract, this court can only consider general definitions.

Blacks Law Dictionary 444 (8th ed. 2004). If a policyholder has not yet met the deductible, it is possible that he or she will be responsible for the entire bill.

- “Coinsurance” describes an arrangement “under which the insurer and insured jointly bear responsibility.” Blacks Law Dictionary 815 (8th ed. 2004). It is typically expressed as two percentages (e.g. 80/20), with the first number indicating the amount the carrier will pay, and the second number indicating the amount for which the policyholder is responsible. *See* 12 Couch on Ins. § 180:21.

As a general matter, insurance contracts apply cost sharing arrangements to “allowed” charges. “Allowed” charges are the rates carriers have negotiated with contracted providers to charge patients for their services. Under most policies, any amount billed by non-contracted providers above the allowed charges is the responsibility of the patient.

Most insurance policies apply different copayments, coinsurance, and deductibles to contracted providers and non-contracted providers.¹³ Particularly with coinsurance, the differential in what the health carrier pays can be significant. It is not uncommon for coinsurance to be 80/20 of

¹³ Again, because the record lacks even a single insurance contract, the Commissioner can offer only general statements about health carriers’ policies.

the allowed charge for contracted providers, but 70/30, or even 50/50 of the allowed charge for non-contracted providers. Although insurance policies typically impose a differential coinsurance rate, these differential rates are still based on the “allowed” charges.

RCW 48.43.093 imposes a significant limit on the “cost sharing arrangements” for contracted versus non-contracted providers of emergency services. A health carrier may only impose a different copayment, deductible, coinsurance rate, or other “cost sharing arrangement” up to the point that the difference in what the health carrier pays does not exceed \$50. For example, a policy may contain a coinsurance rate of 80% of the *allowed* charge for care from a contracted provider, but a 70% rate of the *allowed* charge for care from a non-contracted provider. However, if the difference between the two rates exceeds \$50, the health carrier must pay the cost in excess of \$50. Because there are no contracts or specific transactions in the record, there is no evidence regarding how health carriers are actually implementing RCW 48.43.093, and whether health carriers are actually imposing differential cost sharing arrangements.

2. WSMA's Interpretation Of RCW 48.43.093 Does Not Address Language In The Statute.

RCW 48.43.093(1)(c) plainly allows health carriers to “impose reasonable differential cost-sharing arrangements for emergency services rendered by nonparticipating providers...” There is no language in RCW 48.43.093(1)(c) to support WSMA's interpretation that the difference between “allowed” and “billed” charges is a “cost sharing arrangement.” Moreover, WSMA has placed nothing in the record to support an argument that the difference between “allowed” and “billed” charges is a “cost sharing arrangement” addressed in any insurance policy. Because the \$50 limit in RCW 48.43.093(1)(c) applies to “cost sharing arrangements,” WSMA's interpretation must fail.

Although WSMA argues the Commissioner's interpretation renders parts of RCW 48.43.093 meaningless¹⁴, it is WSMA's interpretation, not the Commissioner's, that fails to acknowledge and give meaning to the words used in RCW 48.43.093(1)(c). WSMA provides no discussion or analysis of the terms “cost-sharing arrangements,” “cost-sharing amounts,” and “copayments, coinsurance, and deductibles.” Br. of WSMA at 18-22. Instead, WSMA's interpretation disregards all of these phrases and words contained in RCW 48.43.093. WSMA's interpretation

¹⁴ Br. of WSMA at 19; CP 437.

must be rejected because it fails to interpret and give effect to all parts of RCW 48.43.093.

If the Legislature intends to limit patients' out of pocket expenses when they use non-contracted providers, it knows how to so specify. For example in RCW 48.43.043(3)(b) (relating to cancer screening), the Legislature explicitly provided:

If a health carrier refers an individual to a nonparticipating health care provider pursuant to this section, *screening exam services or resulting treatment, if any, must be provided at no additional cost to the individual beyond what the individual would otherwise pay for services provided by a participating health care provider.*

(Emphasis added). In contrast, RCW 48.43.093 addresses the differential in "cost-sharing arrangements," not patients' out of pocket costs.

In addition, federal laws and regulations, provide methods of calculating reasonable amounts health carriers must pay non-contracted emergency services providers¹⁵, and also allow such providers to balance bill their patients¹⁶. RCW 48.43.093 does not state that emergency room providers are allowed to bill health carriers the amount they choose, and that health carriers would be obligated to pay all but \$50 of the billed amount. However, WSMA's interpretation would allow providers to bill carriers any amount, regardless of whether the amount is reasonable.

¹⁵ 45 C.F.R § 147.138

¹⁶ Patient Protection and Affordable Care Act (H.R. 3590), Pub. L. 111-148, Section 1302(b)(4)(i-ii), (c)(3)(B).

WSMA's allegations that the Commissioner's interpretation will prevent patients from receiving emergency services (Br. of WSMA at 9-10; CP 439) are unfounded. The Commissioner has not taken the position that the purpose of the statute was to "relieve policyholders of the risk of having to pay for emergency services." Br. of WSMA at 20. Such an interpretation would ignore section (1)(c). Rather, the Commissioner has stated the legislative purpose was to prevent insurers from refusing to pay claims simply because a perceived medical problem turned out to be a minor medical issue, rather than a life threatening emergency. Moreover, there is no evidence in the record that even one patient has been discouraged from seeking emergency care for fear of being balance billed.

3. The Commissioner's Interpretation Is Entitled To Deference.

In order to protect the public in matters of insurance, "the legislature created the office of the insurance commissioner and conferred upon that office the duty of enforcing the provisions of the code." *Ins. Co. of North America v. Kueckelhan*, 70 Wn.2d 822, 831, 425 P.2d 669 (1967); RCW 48.02.060. The OIC is responsible for enforcing all the provisions of the insurance code. RCW 48.02.060(2). In order to achieve this mandate, the Commissioner is vested with broad authority. *Omega Nat'l Ins. Co. v. Marquardt*, 115 Wn.2d 416, 427, 799 P.2d 235 (1990);

Federated American Ins. Co. v. Marquardt, 108 Wn.2d 651, 654, 741 P.2d 18 (1987). He not only has the authority expressly conferred by, but also reasonably implied from, the insurance statutes. RCW 48.02.060(1); *Nat'l Fed'n of Retired Persons v. Ins. Comm'r*, 120 Wn.2d 101, 109, 838 P.2d 680 (1992).

Although the courts have the ultimate authority and duty to determine the meaning of statutes, the courts have repeatedly held that substantial weight should be given to an agency's interpretation of statutes that the agency administers. *Pub. Util. Dist. 1 of Pend Oreille Cy. v. Dep't of Ecology*, 146 Wn.2d 778, 790, 51 P.3d 744 (2002); *Brown v. Dep't. of Health*, 94 Wn. App. 11, 12, 972 P.2d 101 (1998); *Premera v. Kreidler*, 133 Wn. App. 23, 37, 131 P.3d 930 (2006). Indeed, where the Commissioner is entrusted with broad discretion and responsibility in administering a law, greater reliance than usual is placed upon his administrative statutory interpretation. *Retail Store Employees Union v. Surveying & Rating Bur.*, 87 Wn.2d 887, 898, 558 P.2d 215 (1976); *Bailey v. Allstate Ins. Co.*, 73 Wn. App. 442, 447, 869 P.2d 1110 (1994).¹⁷ This is especially true where, as in this case, the agency has expertise in the subject matter under review. *Nat'l Ins. Co. v. Marquardt*, 115 Wn.2d at

¹⁷ See also *Renton Educ. Ass'n v. Public Empl. Relations Comm'n*, 101 Wn.2d 435, 443, 680 P.2d 40 (1984); *Dana's Housekeeping v. Dep't of Labor & Indus.*, 76 Wn. App. 600, 605, 886 P.2d 1147, rev. denied, 127 Wn.2d 1007 (1995).

427; *Port of Seattle v. Pollution Control Hearings Bd.*, 151 Wn.2d. 568, 593-94, 90 P.3d 659 (2004); *Thurston Cy. v. Cooper Point Ass'n*, 148 Wn.2d 1, 15, 57 P.3d 1163 (2002).

The OIC also has over 60 years of experience interpreting the Insurance Code, regulating insurance transactions, and individuals and companies that are transacting insurance. Therefore, the Commissioner's interpretations of provisions of the Insurance Code carry significant weight. In fact, the courts have given significant deference to the OIC's interpretation of the terms cost sharing, copayment, coinsurance and deductibles as "these terms fall fully within the OIC's expertise." *Regence Blue Shield v. Office of the Insurance Commissioner*, 131 Wn. App. 639, 650, 128 P.3d 640 (2006). "[A]lthough a commissioner cannot bind the courts, the court appropriately defers to a commissioner's interpretation of insurance statutes and rules." *Credit General Ins. Co. v. Zewdu*, 82 Wn. App. 620, 627, 919 P.2d 93 (1996).

E. WSMA Failed To State A Claim For Mandamus

The superior court correctly dismissed WSMA's mandamus cause of action, and this dismissal should be affirmed on appeal.¹⁸ Enforcement

¹⁸ WSMA's Petition for Direct Review mentions the Supreme Court's original jurisdiction over mandamus claims. Pet. at 12-13. However, neither the Petition nor WSMA's Opening Brief ask the Supreme Court to exercise its original jurisdiction under RAP 16.2 in this appeal. Nor could WSMA make such a request, given the

of RCW 48.43.093 involves the exercise of discretion, which is not a proper subject of mandamus.

1. A Writ Of Mandamus May Not Compel A Discretionary Act.

Mandamus is not appropriate to compel a discretionary act. *Walker v. Munro*, 124 Wn.2d 402, 410, 879 P.2d 920 (1994). Mandamus is appropriate only “where there is a *specific*, existing duty which a state officer has violated and continues to violate...” *Id.* at 408 (emphasis added). A writ of mandamus can direct an officer to exercise a mandatory discretionary duty, but the writ must not dictate to an officer the manner of exercising that discretion. *Peterson v. Dep't of Ecology*, 92 Wn.2d 306, 314, 596 P.2d 285 (1979). Once a specific duty has been identified, the courts still refrain from providing this extraordinary remedy to direct a general course of conduct or intrude into areas vested in the discretion of the public officer. *Walker*, 124 Wn.2d at 407.

WSMA concedes it does not seek an order “that the Insurance Commissioner is required to take specific action against any insurer.” Br. of WSMA at 16. WSMA also concedes that “the Insurance Commissioner has discretion regarding what specific types of enforcement actions to take or not take...” Br. of WSMA at 23. Because WSMA fails

Commissioner’s March 2011 Ruling Transferring Action, concluding WSMA’s claim is not the proper subject on which to exercise original mandamus jurisdiction.

to identify a specific action the Commissioner must perform, and because the only duty identified by WSMA lies wholly within the discretion of the Commissioner, WSMA has failed to state a claim for mandamus.

2. Enforcement Of The Insurance Code Is Discretionary.

The requested writ would compel the Commissioner to “enforce” an insurance statute. However, “enforcement” of a statute is a discretionary duty, as the supreme court held in *National Elec. Contractors Ass'n, Cascade Chapter v. Riveland*, 138 Wn.2d 9, 32, 978 P.2d 481 (1999). In *Riveland*, the superior court dismissed the Department of Labor and Industries (DLI) from a mandamus action, and the Supreme Court affirmed. *Id.* at 32. The Court found DLI had a variety of options when performing its enforcement obligations, including “performing investigations, conducting inspections, and issuing citations.” *Id.* at 31. Even a decision to not enforce a statute is a discretionary decision that is not subject to mandamus. *Id.* at 32. As the Supreme Court noted:

[The Department of Labor and Industries'] enforcement powers include performing investigations, conducting inspections, and issuing citations. [Citations omitted.] As a practical matter, decisions associated with exercising these enforcement powers are discretionary. See, e.g., *Heckler v. Chaney*, 470 U.S. 821, 831, 105 S.Ct. 1649, 84 L.Ed.2d 714 (1985) (holding a presumption of unreviewability of decisions of agency not to undertake enforcement action); *Nerbun v. State*, 8 Wn. App. 370, 376,

506 P.2d 873 (1973) (Department of Labor and Industries' duty to conduct spot inspections of workplaces is not absolute).

138 Wn.2d at 31. Therefore, when DLI exercised its discretion and decided not to enforce certain laws against the State Department of Corrections, mandamus was not proper to order DLI to take any particular enforcement action. *Id.* at 32.

In fact, in a mandamus action, an order to “exercise discretion” to “enforce” a law, without specifying the specific duty involved, has the same effect as dismissal of the action. *Carkeek v. City of Seattle*, 53 Wn. App. 277, 282, 766 P.2d 480, 484 (1989). In *Carkeek*, the petitioners sought a writ of mandamus ordering the city to “enforce” the City’s land use code. *Id.* 279. The City advised the superior court that if it were ordered to exercise its discretion, the City intended to do nothing in this specific instance. *Id.* at 279. The court of appeals concluded that “the trial court could have denied the Carkeeks' request for mandamus altogether” because the order to exercise discretion had the same effect as dismissal. *Id.* at 282.

Like DLI and the City of Seattle, the Commissioner has broad authority as to how to enforce the Insurance Code, and it is within his discretion what specific act he will take. The Commissioner has authority to review and approve contract forms, to ensure that provisions required

by law are contained in the contracts between policyholders and their carriers. RCW 48.18.100. The Commissioner may decide to issue notices to the industry in the form of technical assistance advisories. RCW 34.05.010(8) and (15) (authorizing agencies to issue interpretive and policy statements). He has authority to examine health carriers (RCW 48.02.060(3)(c)), investigate complaints (RCW 48.02.060(3)(b)), or refer matters to a prosecutor (RCW 48.02.080(2)). He is also authorized to engage in collaborative rulemaking efforts with persons that would be affected by rules, in an effort to seek consensus that might avoid litigation. See RCW 48.02.060(3)(a); and RCW 34.05.310(2)(a) (setting forth a process for negotiated rulemaking). The method of enforcement lies within the discretion of the Commissioner. These are discretionary acts, for which a writ of mandamus is not available.

“Once officials have exercised their discretion, mandamus does not lie to force them to act in a particular manner.” *Aripa v. Department of Soc. & Health Servs.*, 91 Wn.2d 135, 140, 588 P.2d 185 (1978) (emphasis added), *overruled on other grounds by State v. WWJ Corp.*, 138 Wn.2d 595, 980 P.2d 1257 (1999). Rather, “mandamus, if appropriate, tells the respondent what to do, but not how to do it.” *Eugster v. City of Spokane*, 118 Wn. App. 383, 405, 76 P.3d 741 (2003), *rev. denied* 151 Wn.2d 1027, 94 P.3d 959 (2004). Where an official has exercised his or her discretion,

an order to “enforce RCW 48.43.093” would have no effect, and would serve no useful purpose. *See Carkeek*, 53 Wn. App. at 282.

The undisputed facts establish that the Commissioner is already exercising his discretion and enforcing RCW 48.43.093 through, in part, the contract review process. CP 385. Therefore, mandamus is not available.

3. Mandamus Cannot Lie In Actions Governed By The Administrative Procedure Act (APA).

Mandamus is unavailable for WSMA’s allegation that the Commissioner should enforce RCW 48.43.093 because the APA is the only appropriate statutory basis for judicial review of such a claim. The APA allows the courts to review “other agency action” as that term is defined by the APA. RCW 34.05.570(4). Specifically, “[a] person whose rights are violated by an agency’s failure to perform a duty that is required by law to be performed may file a petition for review pursuant to RCW 34.05.514, seeking an order pursuant to this subsection requiring performance.” RCW 34.05.570(4)(b). Under RCW 7.16.360, agency action that is reviewable under RCW 34.05 is not a proper subject of a mandamus action.

WSMA’s mandamus claim is no different than a claim under RCW 34.05.570(4)(b) that alleges an agency is required by law to perform

a duty. It is therefore not a proper subject for mandamus, under the plain terms of RCW 7.16.360. Under APA review, a court “shall not itself undertake to exercise the discretion that the legislature has placed in the agency.” RCW 34.05.574(1); *see also Port of Seattle*, 151 Wn.2d at 589. Rather, when reviewing matters within agency discretion, the court’s function is merely to verify that an agency has used its discretion in accordance with law. RCW 34.05.574(1). Because WSMA did not file this action under the APA, judicial review of any claim the Commissioner has failed to enforce a statute is not properly before this Court.

VI. CONCLUSION

The superior court properly determined that before it could exercise jurisdiction to consider WSMA’s statutory interpretation claim, at least one health carrier was a necessary party to WSMA’s suit. WSMA has presented no reason why joinder should not, or cannot occur. The superior court correctly did not reach WSMA’s statutory interpretation claim, and that claim is therefore not ripe for appellate review. Moreover, the Commissioner’s interpretation is consistent with the plain language of

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RCW 48.43.093, and the Insurance Code as a whole. The superior court properly rejected WSMA's claim for mandamus. For all of these reasons, the superior court should be affirmed.

RESPECTFULLY SUBMITTED this 15th day of March, 2012.

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To: Lehnhoff, Meghan (ATG)
Cc: DeLeon, Marta (ATG); Wilkinson, Jean (ATG)
Subject: RE: WSMA v. Kreidler WA ST Insurance Commissioner 86647-3

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From: Lehnhoff, Meghan (ATG) [<mailto:MeghanL@ATG.WA.GOV>]
Sent: Thursday, March 15, 2012 3:11 PM
To: OFFICE RECEPTIONIST, CLERK
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Subject: WSMA v. Kreidler WA ST Insurance Commissioner 86647-3

RE: WSMA, et al., v. Mike Kreidler, WA State Insurance Commissioner

WA Supreme Court No. 86647-3

Dear Clerk:

Attached for filing in the above matter on behalf of Jean Wilkinson and Marta DeLeon are the following documents:

- Insurance Commissioner's Response Brief
- Declaration of Service

<<Declaration-20120315-ServiceOfInsCommRespBrief.pdf>> <<Brief-20120307-Insurance Commissioner.pdf>>

Please contact me with any questions or concerns.

Thank you,

Meghan Lehnhoff

Legal Assistant to

Marta DeLeon, AAG

Gov't Compliance & Enforcement

Office of the Attorney General

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