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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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STATE OF WASHINGTON and HEALTH CARE AUTHORITY,  
Petitioners,

v.

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

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**ANSWER TO MOTION FOR DISCRETIONARY REVIEW**

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Stephen K. Strong, WSBA #6299  
David F. Stobaugh, WSBA #6376  
Stephen K. Festor, WSBA #23147  
Bendich, Stobaugh & Strong, P.C.  
701 Fifth Avenue, #6550  
Seattle, WA 98104  
(206) 622-3536  
*Attorneys for Respondent Class*

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## INTRODUCTION

This class action concerns the State's failure to provide employer-paid health insurance to more than 20,000 State employees. Liability is established. Trial on monetary and injunctive relief is set for June 2013.

In 2012 the parties made cross-motions on how to calculate damages. Plaintiffs proposed three alternative ways to calculate damages: (1) lost wages because employer-paid health insurance is compensation for services, (2) restitution of the funds the State wrongly retained by not providing the class members health insurance, and (3) uncovered health care costs as determined under an actuarial method that uses the same data and actuarial principles the State uses to estimate unknown employee health care costs. The amount owed under each method is approximately the same. Ex. 1 to Answer, ¶¶22-23.

The State contended that the *only* way to calculate damages is by more than 20,000 individual mini-trials in which class members would submit oral testimony and documents about their health costs and medical conditions. Plaintiffs presented undisputed testimony by an expert actuary that the State's "proposed bill-submission 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.*" Ex. 2 to Answer, ¶6 (emphasis added); ¶¶7-19

(no state actuary is a witness); 37-41 (summarizing problems with State's proposed method).<sup>1</sup>

The trial court rejected the State's motion for 20,000 mini-trial because it is "wrong as a matter of law and fact." Ex. 5 to Mot., ¶10. Judge Shaffer agreed with plaintiffs that monetary relief should be determined on a class-wide basis rather than through individual mini-trials with oral testimony and documents. *Id.*, ¶9.

Judge Shaffer decided that employer contributions towards health benefits are a "form of wages" under Washington law. Ex. 5 to Mot., ¶13 (incorporating oral decision); Ex. 3 to Mot. pp. 43-45. Restitution also applies as an alternative remedy due to the windfall the State received "by not paying any premiums on behalf of class members[.]" *Id.*

Judge Shaffer denied plaintiffs' motion, however, because the current class list (a list she previously ordered the State to prepare) was over-inclusive (Ex. 5 to Mot., ¶¶1-2) and the "actuarial evidence" concerning the omitted class, as compared to the insured State employees,

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<sup>1</sup> David Wilson is a health care actuary with over 30 years of experience in determining health insurance costs. Mr. Wilson 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 Supervising Actuary for CalPERS (health care benefits) in California. In both roles, it was his job to analyze the experience data of the plans to project future expenses and to recommend the monthly funding rate or premium for the plan paid by government employers for eligible employees. Mr. Wilson's current work is focused on creating mathematical models for valuing health care risks, and the majority of the work is projecting health care costs for some population. Ex. 1 to Answer, ¶¶1-8.

was therefore not yet fully before the Court. Ex. 3 to Mot., p. 46.

The State seeks discretionary review of the trial court's decision denying its motion. But the State does not assign error to Judge Shaffer's rulings that the amounts that it should have paid for health insurance each month are wages and that the remedy of restitution applies, nor does it explain why the individual bill-submission method that Judge Shaffer rejected be used to calculate either wages owed or restitution.

Plaintiffs oppose the State's attempt to obtain premature appellate review concerning one part of a partial interlocutory order, *i.e.*, denial of the State's motion for partial summary judgment. Immediate appellate review would interfere with the orderly administration of justice because plaintiffs filed this case in June 2006 and, after many delays, the trial is set for June 3, 2013. This case will likely be over before the Court could decide the interlocutory appeal, even if it accepted review. And if damages are considered on appeal they should be considered in the context of the larger action and all issues disposed of at one time.

Plaintiffs also oppose the State's motion because it is legally baseless. The trial court did not abuse its discretion by deciding health benefits are a "form of wages" and "premiums actually paid by the employer to secure the benefits are going to be the best measurement for wages lost" because the trial court's decision is supported by Washington

law. *Cockle v. DLI*, 142 Wn.2d 801, 807-08 & 814-18, 16 P.3d 583 (2001) (employer-paid health benefits are wages and the “value” to an employee is the amount of the employer contributions towards the benefits); *Bates v. City of Richland*, 112 Wn.App. 919, 939-40, 51 P.3d 816 (2002) (“wages” are any compensation due to an employee by reason of employment and include retirement benefits).

The trial court also did not err in deciding that restitution is appropriate as an alternative remedy because it is basically undisputed that the State would otherwise receive a windfall by retaining the employer contributions for health insurance that it unlawfully failed to pay for the class members -- the State’s only response was that it supposedly did not receive a windfall because the offending State agencies did not “budget” to pay the contributions. Dkt. No. 441, Davidson Dec. 9/27/12, ¶¶3-4.

The trial court’s decision on wages and restitution is also supported by the fact that calculating damages by those methods will arrive at a result that is approximately the same as determining the uncovered health care costs for the class as a whole, as determined under the actuarial method, which uses the same data and actuarial principles the State uses to calculate employee health costs when those costs are unknown. Ex. 1 to Answer, ¶¶22-23.

The trial court therefore did not err by declining to adopt the

State's motion for 20,000 mini-trials on class members' uncovered health costs when the actuarial method for determining those costs on a class-wide basis will "result in a far more accurate determination of the uncovered health care costs for the class than individual claims[.]" Ex. 1 to Answer, ¶32. It is also undisputed as a factual matter that more than 20,000 individual mini-trials is "not a scientifically valid method" to determine the class-wide loss and the method would result in an "inaccurate calculation." Ex. 2 to Answer, ¶6. No authority compelled the trial court to adopt the State's unmanageable and inaccurate method to calculate damages.

#### **STATEMENT OF FACTS**

The State provides employer-paid health benefits for eligible employees. For each eligible employee, the State pays the same monthly employer contribution toward health benefits, which the State calls the "funding rate" or premium. Ex. 1 to Answer, ¶¶14-15.

The funding rate is determined each year by the State's actuaries based on the estimated health costs for the group of covered employees. And the estimated medical costs are based on the previous year's costs coupled with projections about what the costs will be for the next year. Based on the estimated costs for this group, State actuaries set the amount that each state agency must pay for each eligible employee for health

benefits, *i.e.*, the funding rate. The State's actuaries are quite good and the "funding rate" is always very close to the covered employees' actual health care costs. Ex. 1 to Answer, ¶¶15-23.

The trial court determined that the State's omitted employer contribution towards employee health benefits -- the "funding rate" -- is a reasonable measure to calculate the loss to the class. Ex. 5 to Mot., pp. 43-46. The trial court, however, believed that there might be "actuarial evidence" that the funding rate for the group of omitted class members could possibly be different from the funding rate for the group of covered employees due to potential demographic differences in age and gender. The trial court left this issue unresolved. *Id.*, pp. 46-47.

The State also stipulated that the omitted employer contribution or "funding rate" is the amount of money the State unlawfully retained by not enrolling the class members in the health insurance plans. Ex. 2 to Mot., ¶4. The trial court decided that the State would receive a "windfall" if it kept this money and restitution is therefore an appropriate alternative remedy. Ex. 3 to Mot., ¶¶43-44, 46.

Actuary David Wilson testified that the monthly employer contribution the State failed to pay on behalf of eligible class members is approximately the same amount as the average monthly uncovered health care costs the class members incurred due to being omitted from the health

insurance. Ex. 1 to Answer, ¶¶22-23. Specifically, Mr. Wilson testified that in the present situation — looking backward instead of forward — the State’s data show for each year precisely what the health care expenses were for the covered group and the average monthly cost per employee. And the actuarial method, which utilizes the same data and actuarial principles the State’s actuaries use to calculate the funding rate, shows the class members’ uncovered health care costs should be approximately the same as the State’s omitted employer contribution. *Id.*, ¶¶16-23.

Professor Susan B. Long, a professor of statistics and quantitative methods at Syracuse University, agreed with Mr. Wilson. Ex. 3 to Answer, ¶¶ 10; Ex. 4 to Answer, ¶¶ 54-57. Both Mr. Wilson and Professor Long also testified that the State’s proposed method of calculating the loss to the class by individual bills and oral testimony would be highly inaccurate and seriously understate the loss to the class. Ex. 1 to Answer, ¶¶28-32; Ex. 2 to Answer, ¶¶6; Ex. 3 to Answer, ¶¶ 10, 23; Ex. 4 to Answer, ¶23. The State did not dispute their testimony and presented no evidence that its bill submission method for 20,000 class members would be either accurate or manageable. Indeed, the State said that obtaining answers from a lot more than 60 class members about their medical conditions and costs — the same information that it proposes that all class members provide in its bill submission method — would be

“unmanageable and unduly burdensome” (Dkt. No. 292, p. 10) and its own expert witness testified it was not “feasible” to obtain that information from “potentially thousands of class members.” Dkt No. 296, Boedecker Dec., ¶7.

## ARGUMENT

### **I. Interlocutory Review is Disfavored, and This is Particularly Applicable Here Because Not Only is There No Error, But Also Because the Trial in This Almost Seven-Year Old Case is Scheduled for Only a Few Months From Now.**

An order denying summary judgment is not an appealable order and discretionary review is not ordinarily granted. *DGHI Enters. v. Pacific Cities, Inc.*, 137 Wn.2d 933, 949, 977 P.2d 1231 (1999). Appellate review occurs after trial in an appeal from a final judgment. *Id.* Washington has a strong policy against piecemeal appeals (interlocutory appeals of orders) because such appeals interfere with the orderly administration of justice. *Minehart v. Boys Ranch*, 156 Wn.App 457, 462, 232 P.3d 591 (2010). The Court in *Minehart* explained (*id.*):

Interlocutory review is disfavored. *Maybury v. City of Seattle*, 53 Wn.2d 716, 721, 336 P.2d 878 (1959). “Piecemeal appeals of interlocutory orders must be avoided in the interests of speedy and economical disposition of judicial business.” *Id.* Pretrial review of rulings confuses the functions of trial and appellate courts.

“Interlocutory review is [therefore] available in those rare instances where the alleged error is reasonably certain and its impact on the trial is manifest.” *Minehart*, 156 Wn.App at 462.

Here, the State seeks discretionary review of a partial interlocutory order denying both sides' motions and review will interfere with the orderly administration of justice and judicial economy because the trial is set for June 3, 2013 in this almost seven-year-old case and the trial will likely be over before the Court could issue an opinion, if it were to accept review. Any review should occur after the trial so that this matter can reach a more speedy resolution.

**II. The Trial Court Did Not Commit Probable Error by:  
(1) Following the Supreme Court's Decision in *Cockle* on How to Value the Loss of Health Insurance, and (2) Deciding Restitution is an Appropriate Alternative Remedy.**

The State asserts that Judge Shaffer committed "probable legal error" and "departed from the accepted and usual course of proceedings." Mot., p. 2, citing RAP 2.3(b)(2) & (3). But the State is not even close to meeting the stringent standard for showing that the trial court's purported error is "reasonably certain." *Minehart*, 156 Wn.App at 462. Indeed, the State inconsistently argues that "no Washington appellate court opinion has decided the proper measure of damages for denial of employer-paid health insurance." Mot., p. 15.

Moreover, in *Cockle*, the Supreme Court held that an employer's contribution to health benefits constitutes "wages." *Cockle, supra*, 142 Wn.2d at 807-08(2001) (relying on, among things, the ordinary meaning of the term "wages" in the dictionary); see also *Bates, supra*, 112 Wn.App.

at 939-40 (retirement benefits are wages because the benefits are compensation due by reason of employment).

The Supreme Court said in *Cockle*, quoting Justice Marshall, “[w]hile *an employer’s contribution* may 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 benefits.*” *Id.* at 820 n.10 (citation omitted; emphasis added). The Supreme Court in *Cockle* expressly found the amount of the employer contribution for employee health insurance each month represents the “value” of the benefit to the employee. *Id.*

The trial court said that the “*Cockle* Court looked very broadly at what wages are under Washington law” and 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.” Ex. 3 to Mot., p. 43. The trial court did not err by relying on *Cockle* in deciding how to value the lost health insurance here.<sup>2</sup>

The State also does not challenge the trial court’s decision that restitution is an appropriate alternative remedy. Ex. 3 to Mot., pp. 43-44,

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<sup>2</sup> Even in the line of inapplicable federal discrimination cases that the State relies on, there are number of federal court decisions holding that the lost employee health benefits are valued by the lost employer contribution. See *infra* p. 13 n. 4.

46. Indeed, the State stipulated that it retained the funds it should have paid for the class members' health insurance: "If a person meeting the class definition was eligible for PEBB [Public Employee Benefit Board] 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 [Health Care Authority] the employer contribution for the health insurance premium." Ex. 2 to Mot., ¶4. The State's only response to the fact that it would receive a windfall and be unjustly enriched if it retained these funds was that the offending State agencies did not "budget" for the employer contribution (Dkt. No. 441 Davidson Dec. 9/27/12, ¶¶3-4), but that is irrelevant as to whether the State retained the employer contribution that it was lawfully required to pay.

**III. A New York District Court Decision Does Not Compel the Superior Court Here to Adopt an Unmanageable and Inaccurate Method to Calculate the Loss to the Class.**

Because it wrongly argues there are "no Washington" cases that value lost health insurance, the State cites some federal cases, primarily a failure-to-hire discrimination case in a district court in New York. Mot., pp. 15-16 (citing *United States v. City of New York*, 847 F. Supp. 2d 395 (E.D.N.Y. 2012)). The State argues that under this district court case the trial court was *legally required* to have over 20,000 individual mini-trials to calculate the loss to the class here.

The district court's decision in *City of New York* does not compel

Judge Shaffer to adopt the State's proposed unmanageable and inaccurate method to calculate damages through individual bills and oral testimony. *City of New York* is based on completely different facts and a different claim. Here, the class member employees were working for the State at the time the State breached its statutory duty to provide the employees the health benefits as part of their overall compensation. In *City of New York* the individuals were not denied health benefits during a time period when they were working for the employer because they were *never hired* by the employer due to discrimination.

Because the claim was a discriminatory failure-to-hire claim, the New York district court determined that over 2,000 mini-trials were required in the relief phase to resolve the numerous individual issues presented (*id.* 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. 847 F. Supp 2d. at 409.<sup>3</sup>

The New York district court also *never considered the issues presented here*. For example, there is no discussion in *City of New York* that shows the plaintiffs presented undisputed evidence that the method proposed by the defendant would be highly inaccurate and that there are more accurate ways to calculate the loss to the class. There is also no discussion of how the State's proposed method would result in a windfall to the wrongdoing defendant and the State would profit from its wrongdoing.

The district court in *City of New York* also acknowledged that "the law is less clear with regard to how to value some [fringe] benefits, such as employer-paid health insurance," 847 F. Supp. 2d at 409, and "there is disagreement among courts on this exact issue." *Id.* at 422.<sup>4</sup> The State's argument concerning the federal authority on how to "value" lost health

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<sup>3</sup> The other cases that the State cites (Mot. pp. 17-18), are individual actions involving either wrongful discharge or failure to hire. None of them involve the situation here, a class of employees who were denied compensation *while working*.

<sup>4</sup> In the line of discrimination cases cited in the State's motion, pp. 17-18, there are many cases holding the employer contribution represents the lost value to the employee. *E.g.*, *E.E.O.C. v. Dial*, 469 F.3d 735, 744 (8th Cir. 2006) (lost health benefits is valued for employees in a class action is "the amount of health care premiums that would have been part of their employment package had they not suffered discrimination"); *Fariss v. Lynchburg Foundry*, 769 F.2d 958, 965-66 (4th Cir. 1985) ("proper measure of value" of lost insurance is not "the proceeds of the insurance" but instead the "definite and regular premiums, which ordinarily provide the basis for a damages calculation."); *Jones v. Kayser-Roth Hosiery, Inc.*, 748 F. Supp 1292, 1295 (E.D. Tenn. 1990) (in class action brought by discharged former employees, court decided that "the cost to [the employer] is a reasonable method for calculation of the value of the medical insurance benefit"). Judge Shaffer noted there were federal cases going both ways. Ex. 3 to Mot., p. 40.

insurance is not only exaggerated, but the Supreme Court expressly held the employer premium represents the “value” of the benefit to the employee. *Cockle*, 142 Wn.2d at 816-20 & 820 n. 10.

Accordingly, Judge Shaffer correctly rejected the State’s argument that more than 20,000 mini-trials are legally required to determine the loss to the class when that method would both be unmanageable and result in an inaccurate calculation (Ex. 3 to Motion, p. 40):

Let me first say something rather strong about the appropriate measure of damages here that I am now convinced of having read your case law. I don’t agree with the defendants that there’s a strong, consistent rule that when healthcare benefits aren’t paid that the appropriate approach is an individualized one of assessing whether somebody got their own replacement health insurance and whether they had actual healthcare costs. The best I can say about the federal case law that’s been provided to me is there’s a split in authority. There are plenty of federal cases indicating that it’s perfectly appropriate in this kind of class action to look at the plaintiffs in aggregate, not individually.<sup>[5]</sup> And there are a lot of things wrong with the assumption that one should look at the plaintiffs individually, which don’t exist and didn’t exist in cases like *Sitton* and *Walmart*, and for that matter some of the other cases cited to me today.

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<sup>5</sup> The State argued below that individualized determinations for 20,000 class members are required in class actions but the very authorities that the State submitted to the trial court hold the opposite. The case the State cited (Dkt. No. 436, Def. Resp., p. 23), *Hickory Securities Ltd v. Argentina*, 2012 WL 3291796 (2d Cir. 2012), notes that “[t]he use of aggregate damages calculations is well established in federal court and implied by the very existence of the class action mechanism itself.” *Id.* at \*2, quoting *In Re Pharm. Indus. Average Wholesale Price Lit.*, 582 F.3d 156, 197-98 (1st Cir. 2009). *Hickory* noted aggregate damage calculations need only “ensure the damage awards roughly reflect the aggregate amount owed to the class,” *i.e.*, they need only “produce a reasonable approximation of the actual loss.” *Id.* at \*3.

**IV. The Trial Court Did Not Commit “Probable” Error in Deciding That *Sitton* is Not Pertinent Because, Unlike *Sitton*, the Class Here is Certified, Liability is Established, and All That Remains is to Determine Monetary Relief.**

The State argues that under *Sitton v. State Farm*, 116 Wn. App. 245, 63 P.3d (1988), more than 20,000 individual mini-trials with bills and oral testimony are required. Mot. pp. 4, 8-11. Judge Shaffer did not commit probable error nor abuse her discretion in rejecting this argument.

*Sitton* did not concern what constitutes a reasonable method to calculate damages, but instead concerned a trial plan in which class-wide damages would be decided *before* liability was determined. Specifically, in *Sitton* the plaintiffs alleged that State Farm had a *pattern and practice* of denying or limiting certain insurance claims in bad faith (personal injury protection or “PIP” claims). 116 Wn.App. at 248-49. 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.” *Id.* at 258. But under the plaintiffs’ bad faith claim, 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 said that State Farm should have an opportunity to dispute liability on individual claims because, even if the company had a pattern of bad faith, it could have denied some claims on legitimate grounds. *Id.*

This class action is not a pattern or practice case like *Sitton* (or *City of New York*) where mini-trials were necessary to determine liability to each class member. Instead, it is undisputed here that liability is a class-wide issue of law and all class members were wrongly denied health benefits in specific months when they were eligible.<sup>6</sup>

The State also cites the Supreme Court's class certification decision in *Wal-Mart v. Dukes*, 131 S.Ct. 2541 (2011). Mot., p. 11. 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. The Supreme Court reasoned that Wal-Mart's decision to give 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. Therefore, class-wide damages could not be determined under the Title VII statutory scheme before the employer had an opportunity to dispute liability by

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<sup>6</sup> Judge Shaffer explained in an extended colloquy with the State's counsel that *Sitton* is quite different from the situation here in *Moore* because the *Moore* class was already certified and liability for the class was already determined. Ex. 3 to Mot., pp. 18-21.

“show[ing] that it took an adverse employment action against an employee for any reason other than discrimination[.]” *Id.* at 2560-61.

In contrast to *Wal-Mart* (and *Sitton*), liability for the *Moore* class is *already established*. It is undisputed that the *Moore* class members were wrongly denied health benefits for which they were eligible, and the issue is only the appropriate method of calculating damages. “The factual and legal underpinnings of *Wal-Mart* -- which involved a massive discrimination class action and different sections of Rule 23 -- are clearly distinct from those of this case. *Wal-Mart* therefore neither guides nor governs the dispute before us.” *Behrend v. Comcast Corp.*, 655 F.3d 182, 203 n. 12 (3rd Cir. 2011) (rejecting defendant’s argument that *Wal-Mart* prohibited plaintiffs’ class-wide damages model). Accordingly, *Sitton* and *Wal-Mart* do not compel the Superior Court to adopt the State’s inaccurate bill-submission method.

**V. Plaintiffs Never “Stipulated” That Some Class Members Suffered “No Monetary Damage”; Indeed, All Class Members Did Not Receive the Wages They Were Due, Uninsured Individuals Have Deferred Health Care Costs, and the State’s Argument Really Relates to How the Class-Wide Loss is *Distributed*, Not How the Loss is *Calculated*.**

The State maintains that plaintiffs “stipulated” that some class members “suffered no monetary damage[.]” Mot., pp. 1, 6, and 19. But plaintiffs only stipulated to the obvious fact that in some months some class members “incurred no health care costs because those class members

did not receive any health care services[.]” Ex. 2 to Mot, ¶3. The fact that some individuals incurred no health care expenses in some *specific* months does not mean that the class members “suffered no monetary damages” nor that the trial court was compelled to adopt the State’s unmanageable and inaccurate method to calculate damages.<sup>7</sup>

First, the Supreme Court in *Cockle, supra*, and federal courts (*supra*, p. 13 n. 4) have valued lost employer-paid health benefits as the lost employer contributions, which the State stipulated it did not provide. Ex. 2 to Mot., ¶4. The class members thus suffered monetary damages because the State did not provide them the compensation it owed them (and the State was unjustly enriched by retaining it).

The State’s argument that class members with no health care costs in a particular month have “suffered no monetary damage” is also contradicted by its own undisputed evidence that uninsured individuals often delay necessary medical care. And this delay is “directly correlated to deferred costs and lost health and longevity for the uninsured because the lower expenses are due to the inability to access preventive services,

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<sup>7</sup> “Aggregate computation of class monetary relief is lawful and proper” and normal in class actions. 3 *Newberg on Class Actions*, p. 483 (4<sup>th</sup> ed. 2002). “Challenges that such aggregate proof affects substantive law and otherwise violates the defendant’s due process or jury trial rights to contest each members claim individually, will not withstand analysis[.]” *Id.*

timely care, and medical treatment.”<sup>8</sup>

The State’s argument on this point is also largely based on its argument that many class members supposedly have only one or two months of missing health insurance. Mot., pp. 6, 14. But probably the vast majority of these individuals are not class members, as plaintiffs agreed, and the individuals are instead wrongly included on the class member list due the State’s errors in compiling the list. Dkt. 462, pp. 7-8.

In addition, even if damages were by calculated by the class members’ uncovered health care costs, plaintiffs presented extensive undisputed evidence on how this could be accomplished on a class-wide basis under the actuarial method and this method would be much more accurate than the State’s proposal for unmanageable individual bills and oral testimony from more than 20,000 class members on health care costs and medical conditions. Ex. 1 and Ex. 2 to Answer.

The State’s real argument on this point is how the class-wide loss is *distributed* to individual class members. The State quotes the New York district court case for the argument that “pro rata distribution” of an

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<sup>8</sup> The authoritative study relied on by the State’s expert is, what he said, “the best evidence on the costs of being uninsured in the United States.” Ex. 1 to Answer, ¶26. The study found 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 (Wash. D.C.: National Academies Press 2003), p. 3.<sup>8</sup> Ex. 1 to Answer, ¶¶26-27.

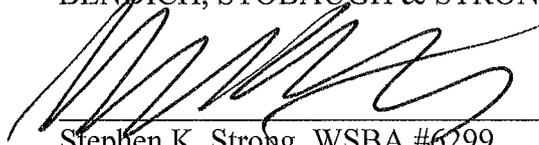
aggregate loss could create “opportunities for over- and under-compensation[.]” Mot., p. 16. Although the State can argue how the class-wide loss is *calculated* (and its argument here is the class-wide loss should be calculated by 20,000 mini-trials), it has no standing to complain how that loss is *distributed* to the individual class members. 3 *Newberg on Class Actions, supra*, p. 517 (“[w]hen aggregate damages for the class are awarded, the litigation is ended from the defendant’s standpoint except for the payment of the judgment or appeal therefrom.”). And the Court has not even ruled on distribution yet. The State’s “fact of damage” argument is thus wrong for several independent reasons.

#### CONCLUSION

The Court should deny the State’s motion for premature review.

Respectfully submitted February 1, 2013.

BENDICH, STOBAUGH & STRONG, P.C.



---

Stephen K. Strong, WSBA #6299  
Stephen K. Festor, WSBA #23147  
David F. Stobaugh, WSBA #6376  
*Attorneys for Plaintiffs*

# EXHIBIT 1

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KING COUNTY  
SUPERIOR COURT

Honorable Catherine Shaffer  
Hearing: October 26, 2012  
Time: 10:00 a.m.  
With oral argument

**SUPERIOR COURT OF WASHINGTON FOR KING COUNTY**

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

NO. 06-2-21115-4 SEA

Plaintiffs, )

v. )

HEALTH CARE AUTHORITY and )  
STATE OF WASHINGTON, )

Defendants. )

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ATTORNEY GENERAL OFFICE  
SEATTLE

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**DECLARATION OF DAVID WILSON *RE* MEASURE OF DAMAGES**

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1 David Wilson testifies as follows:

2 **Overview**

3 1. My name is David Wilson. I am an actuary with a Master's degree in statistics. I  
4 have worked in the health insurance arena for over 30 years.

5 2. My firm and I have been retained by Bendich, Stobaugh & Strong, PC, to review  
6 information relating to the case of *Moore v. Health Care Authority and the State of Washington*.  
7 In *Moore*, certain Washington State employees did not receive health benefits during their  
8 employment with the State of Washington. I have been asked to determine how to resolve the  
9 financial aspects of the lost benefit coverage in a manner that is economically and actuarially  
10 sound.

11 **Experience**

12 3. In 2004 I founded and became President of Windsor Strategy Partners, LLC  
13 (WSP) based in Princeton, New Jersey. The firm assists clients in quantifying and pricing care  
14 management strategies by performing such services as analyzing and quantifying large scale  
15 healthcare data, including healthcare cost, utilization data, and claim distributions. The firm's  
16 clients include insurers, reinsurers, care management organizations, healthcare providers, and  
17 government agencies. A large part of the work at WSP is creating mathematical models for  
18 valuing health care risk, and the majority of our work is projecting health care costs for some  
19 population. The mathematical models that we create can project future costs based on prior  
20 history and the anticipation of any changes. The models can also help understand changes in  
21 potential costs for different plan designs or network contracting, e.g., what would the different  
22 cost be between a \$500 deductible plan with some co-pays as compared to a \$2,500 deductible  
23 plan with no co-pay.

24 4. Prior to WSP, from 1994-2003, I was the CEO and Managing Director of the  
25 Apex Management Group, an actuarial firm based in Princeton that I co-founded. At Apex I led  
26 the firm's efforts in consulting in the areas of health care reinsurance and insurance.

27 5. Before I co-founded Apex, I was a Principal at Foster Higgens in Princeton from

1 1989-1993, and in 1992 I became the firm's Chief Health Care Actuary. I led the Foster firm's  
2 national efforts in consulting with insurance organizations.

3 - 6. While at Foster Higgins, I was the lead consultant to the State Health Benefits  
4 Plan in New Jersey, a plan with over 1,000,000 members. As the lead consultant, I was  
5 responsible for any and all analysis of the funding for the plan. It was my job to analyze  
6 experience data of the plan and to develop funding rates and projections. These projections and  
7 funding rates would then be presented in a budget to the state health benefits committee for  
8 approval and ultimate inclusion in the state budget.

9 - 7. I also became the first Supervising Actuary of CalPERS (health care benefits) to  
10 reside outside the State of California. As Supervising Actuary of CalPERS, similar to my work  
11 for the New Jersey state health plan, I was responsible for making funding recommendations  
12 and determining the funding rate for the plan by analyzing the experience data of the members.

13 8. I am a frequent speaker at professional industry meetings, and I served as a  
14 business faculty member for the Society of Actuaries Intensive Seminar in Applied Statistics  
15 from 1991 through 1999. I was also a guest lecturer at the Woodrow Wilson School at  
16 Princeton University in the fall of 2004.

17 9. I have previously submitted three declarations in this action, dated June 9, 2011,  
18 September 14, 2011, and December 9, 2011. I then had my deposition taken on December 13,  
19 2011. This declaration is a condensed version of my previous testimony.

20 10. My complete bio, and a list of my papers and speeches since starting WSP, is  
21 attached to my June 9, 2011 declaration.

22 **Data and Class Information**

23 11. I reviewed numerous data files and court documents relating to *Moore v. HCA*.  
24 This material is set forth in my prior declarations and in plaintiffs' discovery answers to the  
25 State.

26 12. The materials I reviewed include the State's responses to plaintiffs' second set of  
27 discovery asking for information about the costs and expenses for the employee health benefits

1 at issue here. The State's discovery answers, and the spreadsheets provided with the discovery  
2 answers, shows the State maintains detailed records concerning the specific amount of money  
3 that the State spends on health care expenses for state employees.

4 13. I understand that the precise class size is currently unknown at this time, but  
5 based on the notice issued by the Court and data supplied by the State to class counsel, there are  
6 around 4,000 employees per year who did not receive the health benefits for which they were  
7 eligible and the average length of lost benefits is around four to five months.

### 8 OPINION

#### 9 **The Actuarial Method for Determining the Aggregate Loss to the Class.**

10 14. A health care actuary's job is to estimate, among other things, the health costs for  
11 groups of individuals when actual claims for health expenses are unknown, usually because the  
12 estimates are forecasts for the following year. Actuarial estimates are derived by use of a  
13 number of interrelated subjects, including probability, mathematics, statistics, finance, and  
14 economics. The estimated health care claims for groups of people are used to determine the  
15 premiums paid for health coverage (and the plan's co-pays, deductibles, etc.), and the premiums  
16 therefore represent a proportionate individual part of the estimated cost of the insured claims for  
17 the group plus a small administrative cost for administering claims. For health insurance, it is  
18 typical that premiums are expressed as a monthly amount to be paid by the employer and/or an  
19 individual for coverage that month. The monthly premium is based on a forecast for the next  
20 year's annual average health care costs, divided by 12.

21 15. Here, consistent with actuarial principles, each year the State and HCA set the  
22 funding rate or monthly premiums for health benefits for State employees "in consultation with  
23 their contracted actuary" based on "a projection of how much it will cost to provide PEBB  
24 benefits for eligible employees in some future fiscal year." State's Answer to Interrogatory No.  
25 9, Pl. Second Interrogatories and Requests to Defendants.<sup>1</sup> And the premiums set by the State

26 <sup>1</sup> The complete set of this discovery was attached to my December 9, 2011 declaration.  
27

1 represent the best estimate of the projected expenses for the covered employees for that year.  
 2 The State also "tracked on a calendar year basis" the "actual costs paid for practically all the  
 3 [PEBB benefits]." *Id.*, State's Answer to Interrogatory No. 3.<sup>2</sup>  
 4 16. Accordingly, in the present situation, looking back instead of forward, rather than  
 5 having the covered State employees' *projected* health care costs as shown in the funding rate,  
 6 there are data showing the *actual* health care costs for the covered employees for each year.  
 7 The State's discovery response shows items included as PEBB benefits and the "actual costs"  
 8 for those benefits on a "per month basis, and on a per PEBB-eligible State employee (state and  
 9 higher education) basis" (State's Answer to Interrogatory No. 3, Pl. Second Interrogatories and  
 10 Requests to Defendants):

11 Benefits Included in "PEBB Benefits"

12 Calendar Year	Medical	Dental	Life	LTD	Retiree Subsidy	HCA Admin Cost
13 2003	\$445.83	63.27	5.38	2.70	19.19	4.25
14 2004	\$487.89	66.92	5.38	2.70	22.11	3.28
15 2005	\$550.96	67.41	5.61	2.70	25.97	4.85
16 2006	\$593.78	68.50	4.74	2.70	30.12	6.33
17 2007	\$615.29	70.96	4.30	2.45	33.70	8.88
18 2008	\$624.07	70.69	5.23	2.25	36.18	8.20
19 2009	\$673.75	74.03	5.07	2.00	36.96	7.66

20  
 21 17. The actuarial method for determining the uncovered health care costs of the class  
 22 here includes only the monthly costs the State actually spent in each year on medical and dental  
 23 benefits (the medical and dental columns above). The method does not include the monthly  
 24 costs the State would have spent on life insurance, disability insurance, the subsidy for retired

25 <sup>2</sup> The "funding rate" is determined on a fiscal year basis because it is set by the Legislature as part of the  
 26 fiscal year budget, while the actual costs are tracked on a calendar year basis due to the fact that this is "the  
 27 timeframe for which the insurance contracts are negotiated." State's Answer to Interrogatory Nos. 3 and 11, Pl.  
 Second Interrogatories and Requests to Defendants.

1 PEBB-enrolled employees on Medicare, or the HCA administrative cost for administering the  
2 PEBB program. For example, in calendar year 2003 the average monthly cost for health  
3 benefits on a per-month basis was \$509.10 (\$445.83 medical + \$63.27 dental) and in calendar  
4 year 2004 the cost was \$554.81 (\$487.89 medical + \$66.92 dental).

5 18. Here, I understand that there were over 14,000 total class members who were  
6 omitted from employer-paid health benefit coverage during the time period from approximately  
7 2003-09, and there were around 4,000 class members omitted for coverage per year on average  
8 (some in multiple years). In contrast, the total number of State employees who received health  
9 benefit coverage in each of these years exceeded 113,000 employees.

10 19. The group of class members omitted from health care coverage here is large  
11 enough from a statistical standpoint that they would have had the same average health care costs  
12 as the State employees with health care coverage had they been covered by the plan. From a  
13 statistical standpoint, the distribution of employees to each plan and tier in each calendar year  
14 would also have been approximately the same for the class as it was for the State employees  
15 who received the health benefits in the same calendar year.

16 20. Assuming no material demographic differences between the omitted class  
17 members and the State employees with coverage,<sup>3</sup> the class is large enough from a statistical  
18 standpoint that the class of omitted employees would therefore have had the same average  
19 monthly health care costs as the covered employees. The aggregate uncovered health care costs  
20 for the class here can thus be actuarially determined by multiplying for each year the average  
21

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22 <sup>3</sup> It is theoretically conceivable that the class members could have different demographics from the state  
23 employee group as whole in a particular year in a way that would have affected the projected expenses in the  
24 "funding rate" or the actual average health care costs tracked by the State, e.g., if every class member were a 58  
25 year-old male, the premium could be higher due to the expected medical costs for such a group. Plaintiffs' counsel  
26 asked the State to "[e]xplain in detail how the average age and gender of the class members who did not receive  
27 state employee medical benefits under the Court's orders would have effected, if at all, the 'average monthly cost of  
employee benefits' in Ex. 1 [to the discovery] and/or the 'Fiscal Year Funding Rate' for 'PEBB benefits' in Ex. 2 [to  
the discovery]." State's Answer to Interrogatory No. 9, Pl. Second Interrogatories and Requests to Defendants. The  
State, however, has not provided information to show any differences. If the State did provide such data, I could  
easily adjust the premium or estimated health care costs to take into account any material differences in  
demographics when calculating the aggregate loss to the class.

1 monthly health care costs incurred by the State employees in the benefit plans by the number of  
2 the months the omitted employees did not receive those health benefits.

3 21. In addition, because calculating 2006 health care costs, for example, is based on  
4 actual-cost data for the State employee group in 2006, without any adjustments for the next year  
5 for such items as inflation in health provider charges, using the actuarial method based on the  
6 actual costs to calculate the class members' average health care costs for a past year such as  
7 2006 is even more accurate than forecasting costs for a following year.

8 22. Calculating the aggregate loss to the class based on their uncovered health care  
9 costs also comes to the same average per month cost as the State's portion of the premium the  
10 Court should have paid for those employee health benefits. For example, the State's discovery  
11 answers explain that the "Average monthly cost of employee medical benefits" is that portion  
12 of the premium paid by the State/higher education employer to provide medical benefits for  
13 each of its eligible employees who have not waived coverage" and the "Employer share of Avg.  
14 Monthly Premium for Dental Benefit" (State's Answer to Interrogatory No. 4, Pl. Second  
15 Interrogatories and Requests to Defendants):

	Calendar Year						
	2003	2004	2005	2006	2007	2008	2009
Employer Share of Average Monthly Cost of Employee Medical Benefit	445.83	487.89	550.96	593.78	615.29	624.07	673.75
Employer Share of Average Monthly Premium for Dental Benefit	63.27	66.92	67.41	68.50	70.96	70.69	74.03

22 23. The "portion of the premium paid" by the State for health benefits (*id.*), is thus the  
23 same monetary amount as the State's portion of the "actual [health care] costs" incurred by  
24 State employees with health benefits. (See the State's actual health care costs as shown in the  
25 chart on page four ¶16 of this declaration.)

26 **Expenses for Uninsured Employees and Insured Employees.**

27 24. The State's primary quibble with using the actuarial method is that the State

1 asserts the health care costs of uninsured workers are less than insured workers. Def. Resp. to  
2 Pl. Mot. on Continuing Class Cert., p. 24, citing declaration of Dr. Robert Feldman Dec., ¶¶3-10  
3 (“differences in health care spending and utilization between people with and without  
4 insurance”). In other words, the State asserts that the class members who were uninsured would  
5 have had lower health care expenses than those employees who actually received health  
6 insurance, with all other things being equal. This argument is based on the assumption that  
7 uninsured people are unable to afford health care and therefore avoid seeing health providers.  
8 There are a number of errors with the State’s position.

9 ¶ 25. The first problem with the State’s position is that a comparison between the  
10 expenses of insured and uninsured workers is misplaced because the breach here is the State’s  
11 failure to provide health benefits. And but for the State’s breach, the class of employees  
12 omitted from health care coverage would have incurred on average the same health care costs as  
13 the class of employees who received coverage. To the extent the State is arguing that the class  
14 should receive an award that is less than the covered health care costs that they would have  
15 received had they not been wrongly omitted from coverage, the result would be contrary to what  
16 the State says is the purpose of an “award of damages” -- “[a]n award of damages for violation  
17 of a statute or contract is to put the injured party in the same economic position he or she would  
18 have been in but for the breach - here, the failure to provide health care benefits.” Defendants’  
19 CR 56(f) Motion to Continue Plaintiffs’ Summary Judgment Motion, June 27, 2011, p. 8  
20 (Exhibit B to my December, 9, 2011 declaration).

21 26. More importantly, the State cites a study of the expenses for insured and  
22 uninsured populations that expressly recognizes that even if there are lower *present* expenses  
23 for the uninsured compared to the insured, the lower present expenses are directly correlated to  
24 deferred costs and lost health and longevity for the uninsured because the lower expenses are  
25 due to the inability to access preventive services, timely care, and medical treatment. In  
26 addition to noting that this leads to increased deferred costs because deferred care is often more  
27 expensive and less effective, the study concludes that “the economic value of the healthier and

1 longer life that an uninsured child or adult forgoes because he or she lacks health insurance  
2 ranges between \$1,645 and \$3,280 for each additional year spent without coverage.” Institute  
3 of Medicine, Hidden Costs, Value Lost: Uninsurance in America (Wash. D.C.: National  
4 Academies Press 2003), p. 3, cited by Dr. Feldman in paragraph 9 of his November 22, 2011  
5 declaration as “the best available evidence on the costs of being uninsured in the United  
6 States.”

7 27. Accordingly, even assuming that uninsured class members might have had lower  
8 present expenses than the employees with health insurance, according to what the State cites as  
9 the “best available evidence” (Feldman Dec., ¶9), any lower health costs by the class due to  
10 being uninsured results in both higher deferred costs and diminished health and longevity due to  
11 lacking coverage for even a relatively short time. The State’s approach would therefore  
12 significantly underestimate the loss to the class here because it would fail to take into account  
13 both the deferred costs due to delayed care and the economic loss in foregoing a healthier and  
14 longer life.<sup>4</sup>

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18 <sup>4</sup> Another problem with the State’s position is that the report the State cites does not take into account the differing  
19 demographics of the uninsured versus the insured. The report states (p. 38) that “[t]he differences in service  
20 utilization costs between uninsured and insured individuals . . . have not been adjusted for differences between the  
21 two groups in age composition and family income[.]” Institute of Medicine, Hidden Costs, Value Lost:  
22 Uninsurance in America (Wash. D.C.: National Academies Press 2003), p. 38. And this is important because  
23 according to demographic reports of the uninsured in the United States based on the Census Bureau’s Current  
24 Population Surveys, prepared by the United States Department of Health and Human Services, the uninsured are  
25 disproportionately young adults under age 34. According to these reports, in 2004 63% of the uninsured were under  
26 age 34 and in 2006 more than 66% of the uninsured were under age 34.

27  
28 These reports can be found on the internet at: <http://aspe.hhs.gov/health/reports/05/uninsured-cps/index.htm> and  
29 <http://aspe.hhs.gov/health/reports/07/uninsured/index.htm>

30 Younger individuals are generally healthier and have lower expenses than older individuals in the regular  
31 workforce, who are in turn disproportionately more often insured and have higher expenses. Comparing expenses  
32 between these two groups is what appears to have happened in the study relied on by the State (*i.e.*, comparing the  
33 expenses of younger uninsured individuals with those older insured individuals), and this is not the same as  
34 comparing two groups of employees with the same demographics, one group with insurance and one group that was  
35 supposed to have insurance in the same time period, but did not, which is the situation in this class action.

1           **The State's Proposed Collection of Individual Bills Would be Both Unmanageable**  
2           **and Result in an Inaccurate Calculation of the Lost Health Benefits**

3           28. I understand that the State once proposed that the loss to the class be calculated  
4 through thousands of individual claims in which each person must come in and document the  
5 costs of health services during the months the class member was not provided health insurance.  
6 The State's 2010 discovery answer on this point stated (State's Answer to Interrogatory No. 15,  
7 Pl. Second Interrogatories and Requests to Defendants):

8           **INTERROGATORY NO. 15:** Please describe in detail how the State proposes  
9 damages be calculated in this action.

10           **ANSWER:** . . . . [T]he damages in this action is the actual economic loss  
11 suffered by each class member as measured by either: a) The incremental cost of  
12 procuring reasonable substitute and comparable medical insurance coverage  
13 during the month(s) the class member was eligible without having received  
14 benefits, less the amount the class member would have paid as the subscriber  
15 contribution if coverage had been provided under a PEBB plan; or b) If the class  
16 member did not procure substitute insurance coverage and thereby mitigate his or  
17 her losses as required, the cost of any medical services received during the  
18 month(s) the class member was eligible without receiving benefits, less any  
19 applicable co-pay under the then-extant PEBB plans, and so long as the medical  
20 services would have been covered services under the then-extant PEBB plans, less  
21 the amount the class member would have paid as the subscriber contribution if  
22 coverage had been provided under a PEBB plan. These damages can be  
23 calculated and proven by the members' submission of bills, invoices or other  
24 reliable documentary evidence of the cost of substitute insurance or medical  
25 services as outlined above.

26           29. There are many problems with the State's suggested bill-submission method.  
27 First, there is the great problem of determining what medical or otherwise ancillary benefit  
28 events actually occurred during the lost coverage months. Employees would have had to  
29 maintain medical cost and benefit records for a period of many years. Although employees with  
30 large expenses may have retained some documentation regarding their losses, many employees  
31 will still not have such documentation, particularly from a time period seven, eight, or nine  
32 years ago. And it is even less likely that employees with smaller covered expenses will have  
33 retained such documentation.

34           30. The reality is that finding and reimbursing all incurred and documented claims is

1 not practical. Trying to obtain documented, reliable claim information would require significant  
2 efforts and large costs for both the affected employees and the providers/administrators of the  
3 benefits. In some cases the employees may also have died or may have become physically or  
4 mentally unable to pursue such a fact finding endeavor. And providers may have moved,  
5 merged, gone out of business, had billing records destroyed, or have difficulties in obtaining the  
6 old documentation. Smaller claims relating to dental, vision and pharmacy bills may be  
7 particularly difficult to track down.

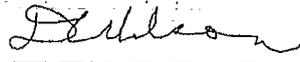
8 31. Employees who did not maintain medical, dental, pharmacy, and billing records  
9 will have substantial difficulty in retrieving supporting evidence of medical treatment costs after  
10 the passage of so many years, even if they remember where they went to see health providers  
11 during the omitted months in years past. And employees with both small and large claims will  
12 presumably be able to supplement documentation with, or use in the place of documentation,  
13 testimony regarding their expenses. Such individual testimony would then likely be challenged  
14 by the State and this potential adversarial process for more than 14,000 class members would be  
15 a quite unmanageable and time-consuming process. Indeed, earlier in this action when the State  
16 sought discovery from a "sample" of 60 class members concerning this precise information  
17 (medical bills, other coverage, etc.), the State specifically agreed that obtaining this information  
18 from a class of thousands of persons "would be unmanageable and unduly burdensome." Def.  
19 State Mot. for Leave to Conduct Discovery on Sample of Putative Class Members, Aug. 17,  
20 2011, p. 10.

21 32. In contrast to the State's proposed bill-submission method, the actuarial method  
22 for determining the aggregate loss to the class as a whole can be implemented quickly and  
23 accurately without the large problems associated with submitting more than 14,000 individual  
24 claims. The actuarial method is also based on the same data and actuarial principles that the  
25 State and the Health Care Authority use and rely on to estimate the health care costs for those  
26 employees who receive coverage. And, most importantly, the actuarial method will result in a  
27 far more accurate determination of the uncovered health care costs for the class than individual

1 claims due to the numerous problems of establishing the losses of such a large class by a bill-  
2 submission method.

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

5 Dated: September 13, 2012 at Princeton Junction, New Jersey  
6 (City) (State)

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8 \_\_\_\_\_  
9 DAVID WILSON

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# EXHIBIT 2

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SUPERIOR COURT

Honorable Catherine Shaffer  
Hearing: October 26, 2012  
Time: 10:00 a.m.  
With Oral argument

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SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

DOUGLAS L. MOORE, MARY CAMP, GAYLORD CASE, and a class of similarly situated individuals,	)	
	)	NO. 06-2-21115-4 SEA
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	
HEALTH CARE AUTHORITY and STATE OF WASHINGTON,	)	
	)	
Defendants.	)	

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**REPLY DECLARATION OF DAVID WILSON  
RE MEASURE OF DAMAGES**

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Summary of Testimony ..... 1  
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Conclusion ..... 13

1 David Wilson testifies as follows:

2 1. My name is David Wilson. In September 2012 I submitted a declaration on the  
3 measure of damages and the actuarial method for determining the loss to the class as a whole.  
4 I submit this declaration in response to declarations submitted by the State concerning the  
5 actuarial method.

6 Summary of Testimony

7 2. The State submits no testimony by an actuary or statistician saying that the  
8 actuarial method is not a scientifically valid way to determine the class-wide loss here. Rather  
9 than dispute the scientific validity of the actuarial method, the testimony by the State's  
10 witnesses address three inputs in the method: (a) including health care costs other than  
11 "medical expenses," (b) potentially different demographics between the class and the PEBB-  
12 enrollees, and (c) including the average number of spouses and dependents (average tiers). I  
13 disagree with the State's contentions, except for possibly demographics, but I have not yet  
14 reviewed the data the State used in its demographic comparison. It is my understanding that  
15 the data were provided to plaintiffs just last week and the data are also in unusable form  
16 (information for more than 30,000 individuals in pdf form).

17 3. Even assuming the Court agreed with the State on any or all three of the points it  
18 raises, however, that would not affect the scientific validity of the actuarial method. Instead, it  
19 would just mean that some adjustments would have to be made to the inputs. The State has  
20 also already provided, or could provide, plaintiffs the data for these adjustments if one or more  
21 were found necessary.

22 4. The State's witnesses acknowledge the adjustments could be made if necessary,  
23 but they say it would be "extremely difficult" and involve "complex calculations." Feldman  
24 Dec., ¶8; Ross Dec. ¶33(d). But making these types of "complex calculations" is precisely the  
25 expertise of an actuary.

26 5. The actuarial method is a scientifically accurate method to determine the  
27 financial loss to the class here. And it is based on the best evidence available -- the State's

1 actual health care costs for employees who were provided benefits.

2 6. In contrast, the State's proposed bill-submission method would be highly error-  
3 prone and inaccurate due to having to rely on the memories of class members regarding many  
4 minor events in particular months up to nine or 10 years ago. Many class members would not  
5 participate in such a process due to its burdensomeness and to protect sensitive medical  
6 information about themselves and their families. The State's bill-submission method is not a  
7 scientifically valid method to determine the financial loss to the class and it would result in an  
8 inaccurate calculation.

9 **No Witness for the State is an Actuary**

10 7. The State submits declarations by three individuals concerning the actuarial  
11 method, but significantly not one of these individuals is an actuary. For example, HCA  
12 employee Kim Grindrod is a "Rate Analyst" at the PEBB, and I understand she has a  
13 bachelor's degree from the Evergreen State College. Stephen Ross is an accountant. Roger  
14 Feldman is a professor who has degrees in economics.

15 8. The State's witnesses who testify concerning the actuarial method do not appear  
16 to have the experience or qualifications of an actuary nor are they qualified to offer opinions  
17 on the actuarial method. Rather than just an accounting degree, bachelor's degree, or an  
18 economics degree, actuarial science is a specific scientific discipline that is based on a number  
19 of interrelated subjects, including probability, mathematics, statistics, finance, and economics.

20 9. In contrast to the State's witnesses, I am a Fellow of the Society of Actuaries, I  
21 am a member of the American Academy of Actuaries, and I have a master's degree in  
22 statistics. I served as faculty member for the Society of Actuaries Intensive Seminar in  
23 Applied Statistics from 1991 through 1999. And I have worked as an actuary for more than 30  
24 years, including serving as the lead actuary for the health benefit plans covering state  
25 employees in New Jersey and California.

26 10. It is worth noting that the State has actuaries that work and perform analyses on  
27 the health benefits at issue, but the State submits no testimony by these individuals.

1 Presumably, the State's actuaries know the actuarial method is a valid scientific method to  
2 determine the financial loss to the class here or the State would have submitted testimony by  
3 one of its actuaries disputing this point. These actuaries also know that if the points raised by  
4 the State had any merit, e.g., demographics, including health care costs other than "medical  
5 expenses," etc., then the actuarial method could account for these items when calculating the  
6 loss to the class. Indeed, the State does not dispute my testimony that "[t]he actuarial method  
7 is also based on the same data and actuarial principles that the State and Health Care Authority  
8 use and rely on to estimate the health care costs for those employees who receive coverage."  
9 Wilson Dec., 9/13/12, ¶32.

#### 10 Demographics

11 11. I previously testified that if there were material demographic differences  
12 between the omitted class members and the covered group receiving health insurance, this  
13 could affect the actual health care costs for the class compared to the covered group, e.g., "if  
14 every class member were a 58 year-old male, the premium could be higher due to the expected  
15 medical costs for such a group." Wilson Dec., 9/13/12, p. 5 n. 3. I pointed out, however, that  
16 in response to plaintiffs' discovery the State had not provided any information to show any  
17 demographic differences. I also said that "[i]f the State did provide such data, I could easily  
18 adjust the premium or estimated health care costs to take into account any material differences  
19 in demographics when calculating the aggregate loss to the class." *Id.*

20 12. The State now questions this based on demographic information provided to  
21 plaintiffs 12 days *after* I signed my declaration. Hyde Declaration 9/28/12, ¶3 (State provided  
22 demographic information to plaintiffs on September 25th). I understand the demographic data  
23 the State provided plaintiffs last week regarding the notice class is also in unusable pdf form.

24 13. Despite the fact that the data came in an unusable form and *after* my declaration  
25 was submitted, Professor Roger Feldman asserts that "Mr. Wilson does not appear to have  
26 even attempted to analyze the demographics of the existing class in this case." Feldman Dec.,  
27 ¶8. But of course I had not previously attempted to analyze the demographics of the class

1 because the State had never previously provided the data.

2 14. Professor Feldman also states that, based on this tardy data, "the demographics  
3 of the notice class differ materially from the demographics of the PEBB group." Feldman  
4 Dec., ¶5; *id.* ("materially different"). Accountant Stephen Ross also states that the "*Moore*  
5 notice class is considerably younger than the population of the PEBB group[.]" Ross Dec.,  
6 ¶33(b). Mr. Ross says a "younger insured population will incur less health care costs than an  
7 older population" (*id.*) and Professor Feldman says that due to the "demographic differences, it  
8 is very likely that the costs of the notice class members would be materially lower than the  
9 PEBB subscriber pool." Feldman Dec., ¶6.

10 15. There are a number of problems with Mr. Ross's and Professor Feldman's  
11 testimony. First, it is unclear what actual demographic differences there are between the *class*  
12 and the PEBB enrollees. The "notice class" that was used for Mr. Ross's demographic  
13 analysis includes many individuals who are not class members, as Mr. Ross repeatedly points  
14 out in his testimony. There appears to be some remaining issues related to identifying the  
15 prevailing class members and the parties will need to do more work to accomplish this task.  
16 After these issues are resolved and the data are provided in usable form, I could compare the  
17 demographics of the prevailing class members to the PEBB-enrollees to determine if there  
18 were any material differences.

19 16. Assuming for the current motion, however, that the PEBB-enrollee group as a  
20 whole is older than the group of omitted class members, this could conceivably make a  
21 difference in the amount of the class members' uncovered health care costs. This difference,  
22 however, could be accounted for in the actuarial method. Plaintiffs previously asked the State  
23 in discovery "how the average age and gender of those class members who did not receive  
24 state employee medical benefits under the Court's orders would have affected, if at all, the  
25 'average monthly cost' and 'Fiscal Year Funding Rate.'" Interrogatory No. 9, Plaintiffs'

1 Second Set of Discovery.<sup>1</sup> The State objected to answering the discovery, but it did say that  
2 “the older the pool of state employees, the more it costs to provide the medical benefit for  
3 those employees because an older population, on average, consumes more medical services.  
4 Similarly, a larger relative number of women of child-bearing years in the pool, the higher the  
5 costs of providing the medical benefit will be.” State Response to Interrogatory No. 9,  
6 Plaintiffs’ Second Set of Discovery.

7 17. Accordingly, as the State said (¶16), even if the class is younger than the PEBB-  
8 enrollee group, as Mr. Ross contends, because a larger number of these younger employees are  
9 presumably women of child-bearing age who on average consume more medical services, it  
10 would offset in some way the fact that older individuals on average consume more medical  
11 services. Both Mr. Ross and Professor Feldman do not take this fact into account in their  
12 declarations.

13 18. In addition, although Professor Feldman states that due to “demographic  
14 differences” the costs for the “notice class” would be “materially lower” than the PEBB  
15 subscriber pool, he does not state what he considers is a “materially” lower cost. Feldman  
16 Dec., ¶6. Indeed, Professor Feldman is not an actuary and it highly unlikely that he could  
17 precisely determine what effect, if any, the demographics have on the costs.

18 19. Both Professor Feldman and Mr. Ross acknowledge that an actuary could  
19 determine what impacts, if any, the demographics would have on health care costs. They say,  
20 however, that it would be “extremely difficult” (Feldman Dec., ¶8) and involve “complex  
21 calculations.” Ross Dec., ¶33(d). But the job of an actuary is precisely to perform these exact  
22 types of “extremely difficult” and “complex calculations.”

23 20. If the data were to show that the class members had different average  
24 demographics that would materially affect the average health care costs used in the actuarial  
25 method, I can adjust the health care costs to account for the different demographics. By way

26  
27 <sup>1</sup> The complete set of this discovery was attached to my December 9, 2011 declaration.

1 of example, here are two sound approaches I could use to make an adjustment based on  
2 differences in demographics. Both are consistent with standard actuarial practice. The first is  
3 to analyze the State's experience over a number of years by demographic class. The data  
4 required are exposures by class and incurred claims by class for each year analyzed. Actuaries  
5 usually define "class" as gender and quinquennial (5-year) age group. Average costs per  
6 member in each class are calculated. One age/gender class is set to one (the "anchor") and the  
7 other classes are expressed in relative terms. The typical anchor class is males age 40 to 44 or  
8 males age 45 to 49. All other classes are expressed in relative terms to the anchor class. This  
9 method requires using the detailed claims data from the State's plan as to claims by age and  
10 gender as well as the exposed lives by age and gender class for each experience year. Relative  
11 differences in medical costs between populations are then expressed as the ratio of the  
12 weighted demographic factors by proportionate exposure in each class for the particular  
13 populations, *i.e.*, the age index or factor for the population weighted.

14 21. The second approach that could be used to adjust for any demographic  
15 differences is to use a recognized "rate manual" that provides the same class relativities  
16 derived from a very large data set and calculate the same relative differences by first  
17 calculating a factor for the total state population covered in the target experience year and  
18 comparing to the factor calculated for the population of workers who were wrongfully denied  
19 coverage by the State plan. Our firm produces such a rate manual utilizing claims experience  
20 and detailed exposure information from a subset of Verisk Health's normative database. This  
21 subset represents approximately 3,000,000 members and over \$20,000,000,000 of claims. If  
22 the relative value for the State is 1.05 and the relative value for the membership class denied  
23 coverage is 1.0, then it would be appropriate to adjust the State funding. The expected value  
24 of this reduction to average cost could be estimated by taking the weighted averages of the age  
25 indices for the two populations, the population that received benefits and the population that  
26  
27

1 was wrongly denied benefits. In this example we would reduce our target cost by applying the  
2 ratio of 1.0/1.05 to the State cost.

3 22. It is too soon to tell in this litigation whether there are material differences in the  
4 demographics between the class members who prevailed and the PEBB-enrollees because the  
5 State has not completed the list of class members accurately and the State has not yet provided  
6 the data for even the "notice class" in usable electronic form. Even assuming the class were  
7 younger than the group of PEBB-enrollees, it is unclear how this would affect the average  
8 health care costs, if at all, because women of child-bearing age are larger consumers of  
9 medical services than the average. I would need to analyze the age and gender data for the  
10 prevailing class members and PEBB-enrolled group to determine if an adjustment to the  
11 actuarial method was necessary.

12 23. If an adjustment were necessary due to demographics, I could make an  
13 appropriate adjustment based on widely-accepted actuarial principles. The State's testimony  
14 concerning demographics does not invalidate the scientific validity of the actuarial method.  
15 Instead, it is just one input for which an adjustment could be made if necessary.

16 **Health Care Costs Other Than "Medical Expenses"**

17 24. In addition to demographics, the State says that the State's actual health care  
18 costs for employee medical and dental benefits includes not only "medical expenses," but also  
19 costs for insurer overhead, profit, etc. HICA employee Kim Grindrod testifies that "the costs  
20 for the state's self-insured plan, the Uniform Medical Plan . . . include an amount to  
21 compensate the third-party administrator of that plan who processes claims and payments to  
22 various providers. Subsumed in that third-party administrator fee is a profit margin or  
23 operating margin for the administrator." Grindrod Dec., ¶7. Also for the insured plans, the  
24 premiums include "profits for for-profit medical carriers or operating margins for non-profit  
25 medical carriers, administrative overhead costs," and other amounts. *Id.*, ¶10. Professor  
26 Feldman says the insurance carrier overhead amounts are "tracked in the medical benefits  
27

1 industry as the Medical Loss Ratio (MLR)” and the MLR can “vary widely” from “60% to  
2 100% or more annually” -- *i.e.*, 60% to 100% of the premium is spent on claims. Feldman  
3 Dec., ¶10.

4 25. The point raised by the State is material only if the class members can recover  
5 strictly for “medical expenses” rather than health care costs. I’m not sure why the State  
6 contends the class members can recover only “medical expenses.” Class members who  
7 purchased medical insurance had to pay premiums that included not only “medical expenses,”  
8 but also the costs associated with that insurance such as administrative overhead costs and  
9 profit margins. We believe it is reasonable to expect that the State plan’s administrative  
10 expense load is significantly less than any private insurance the class members could have  
11 purchased. The ACA legislation now requires a minimum loss ratio of 80% in the individual  
12 and small group markets. And for class members who had “medical expenses” without  
13 insurance coverage, the class members would have had to pay full retail for the services,  
14 which is much more costly than the discounted rates negotiated by the State and the managed  
15 care organizations with whom the State contracts. The value the class members lost when the  
16 State omitted them from health benefits is the State’s cost for the class members’ health care  
17 costs, which includes both medical expenses and the costs associated with providing those  
18 medical services.

19 26. Assuming for the sake of argument, however, that the State’s point had merit --  
20 *i.e.*, using “medical expenses” instead of the actual costs -- plaintiffs’ discovery asked the  
21 State to provide information concerning the “percent or portion of the average monthly cost of  
22 ‘employee medical benefits’ that was spent on ‘medical expenses’” and the “percent or portion  
23 of the average monthly cost of ‘employee medical benefits’ that was spent on ‘non-medical  
24 expenses.’” Interrogatory No. 5, Plaintiffs’ Second Set of Discovery. Plaintiffs defined  
25 “medical expenses” as “those expenses that cover the actual claims or services for employees”  
26 and “non medical expenses” as those expenses “not for the actual claims or services for  
27 employees[,]” Plaintiffs’ Second Set of Discovery, p. 5. Plaintiffs’ discovery also asked the

1 State to “describe in detail all systems, methods, analyses, and databases the State used to  
2 track ‘medical expenses’ and ‘non-medical expenses[.]’” *Id.*, Interrogatory No. 11.

3 27. In response to plaintiffs’ discovery, the State said that it did not have any  
4 information about the “cost breakdown for the insured plans,” although it “does receive and  
5 track some information for non-medical expenses” and this is used for setting the fiscal year  
6 funding rate for the health benefits. *Id.*, State Response to Interrogatory No. 5 and No. 11.  
7 The State “object[ed] to providing any greater detail regarding the source data for [this]  
8 information” from the insured plans. *Id.*, State Response to Interrogatory No. 11.

9 28. The State, however, provided this information for its self-insured plan, the  
10 Uniform Medical Plan (UMP). For the UMP, the State has detailed information regarding the  
11 “total amount of claims for medical expenses” and the “amounts incurred . . . for non-medical  
12 expenses.” *Id.*, State Response to Interrogatory No. 5. And the State provided plaintiffs  
13 electronic spreadsheets with data that the State acknowledges “*illustrates to a certain degree*  
14 *the ratio of medical and non-medical expenses within the overall cost to provide the employee*  
15 *medical benefits.*” *Id.* (emphasis added).

16 29. The data the State has for the UMP show for each year the total amount spent on  
17 non-medical expenses, *i.e.*, the total amount spent on UMP benefits administration and  
18 internal operations. Below is an excerpt from the data provided by the State to plaintiffs, for  
19 fiscal years 2006 and 2007 (the State has the same data for other years):

Uniform Medical Plan Expenditures		FY2006	FY2007	Biennial Total
721	Claims	\$513,820,478	\$574,834,153	\$1,088,654,631
439	UMP Benefits Administration	16,505,594	17,746,451	34,252,045
418	UMP Internal Operations	2,646,002	3,064,133	5,710,135
721	Change in PSR	5,613,413	5,665,728	11,279,141
721	IBNR Reserve Adjustments	(6,840,990)	2,966,933	(3,874,057)
	Uniform Medical Plan Total	531,744,497	604,277,397	1,136,021,894

25 30. The ratio of overall non-medical expenses to direct medical expenses can be  
26 determined here by taking the costs for the UMP administration and internal operations and  
27

1 dividing that by the UMP Medical Plan total.<sup>2</sup> For example, in fiscal year 2006 the non-  
2 medical expenses constituted 3.6% of the plan:  $((\$16,505,594 \text{ [administration]} + \$2,646,003$   
3  $\text{[internal operations]}) \div \$531,744,497 \text{ [Medical Plan Total]} = .036$  [amount of fund spent on  
4 non-medical expenses]). In fiscal year 2007, the non-medical expenses also constituted 3.4%  
5 of the plan:  $((\$17,746,451 \text{ [administration]} + \$3,064,133 \text{ [internal operations]}) \div \$604,277,397$   
6  $\text{[Medical Plan Total]} = .034$  [amount of fund spent on non-medical expenses]). Because a  
7 large number of State employees are enrolled in the UMP each year, tens of thousands of  
8 eligible employees, it is reasonable to use the medical expense and non-medical expense ratio  
9 from that plan if it were necessary.

10 31. Accordingly, in response to the State's doubts about using its own actual cost to  
11 provide health benefits to eligible State employees, I do not see the need to separate "medical  
12 expenses" from health care costs because what the class members lost here was the total health  
13 care costs rather than specific claim costs. But to the extent it were determined that it was  
14 necessary to include only "medical expenses," rather than the actual health care costs to  
15 provide those benefits, I could do so by using the data the State provided for the UMP.

#### 16 Tiers of Coverage

17 32. In my declaration I testified that "[f]rom a statistical standpoint, the distribution  
18 of employees to each plan and tier in each calendar year would also have been approximately  
19 the same for the class as it was for the State employees who received health benefits in the  
20 same calendar year." Wilson Dec., 9/13/12, ¶19. The "tier" of coverage refers to whether the  
21 coverage is for a "single employee, employee + spouse, etc." State Response to Interrogatory  
22 No. 4, Plaintiffs' Second Set of Discovery.

23 33. The State does not submit any testimony that my statistical analysis is wrong.  
24 Instead, Mr. Ross states that the actuarial method "overstates class-wide damages" because  
25

26 <sup>2</sup> In the table the PSR is the Premium Stabilization Reserves and the IBNR is the Incurred But Not  
27 Reported Reserves, which both relate to medical expenses.

1 "[i]t is based on all tiers of coverage (subscriber, subscriber/spouse, subscriber/children,  
2 subscriber/spouse children) rather than subscriber only" and he "understand[s] that damages in  
3 this lawsuit are limited to those suffered by subscribers." Ross Dec., ¶33(a). Mr. Ross does  
4 not say why damages are limited in this action to subscribers. He nevertheless states, due to  
5 his view that the lawsuit is limited to individual or subscriber coverage only and input from  
6 "Milliman, Inc., (the HCA's actuarial consultant)," that he was told this was actuarially  
7 considered "significant, to extreme" and would be expected to have a "substantial and material  
8 impact" on the cost to provide class member health benefits compared to the PEBB covered  
9 group. *Id.*, ¶33(c).

10 34. I do not dispute Milliman's opinion. If the lawsuit were limited to subscriber  
11 (individual) coverage only it would have a significant impact on the health care costs for the  
12 class. But since the State is required in its plans to provide employer-provided health  
13 insurance to not only each eligible employee, but also to the eligible employee's spouse and  
14 children, the actuarial method assumes the dependent benefits are financial benefits that the  
15 class members (employees) lost by being omitted from the health insurance plans. The State  
16 also assumes this same financial benefit to eligible employees as shown by the fact that when  
17 the State calculates the "average monthly cost of employee medical benefits" it uses "the  
18 average monthly cost of the premium per employee to the State/higher education employer  
19 across all tiers and plans, as weighted by the proportional share of each plan and tier in each  
20 calendar year." State Response to Interrogatory No. 4, Plaintiffs' Second Set of Discovery.  
21 Mr. Ross's approach would fail to make the omitted employees whole for their losses and the  
22 approach would certainly be unfair since the covered employees received benefits for spouses  
23 and children.

24 35. Even assuming Mr. Ross were correct, HCA rate analysis Kim Grindrod states  
25 that how the different tiers are calculated is a "mathematical function." Grindrod Dec., ¶8.  
26 "The first medical tier represents the cost to the HCA for a single employee." *Id.* "The  
27 second medical tier, employee and spouse or qualified domestic partner, is equal to two times

1 the first medical tier cost less \$10.” *Id.* “The third medical tier, employee and children, is  
2 equal to 1.75 times the first medical tier cost.” *Id.* “The fourth medical tier, employee,  
3 spouse, or qualified domestic partner, and children, is equal to 2.75 times the first medical tier  
4 cost less \$10.” *Id.*

5 36. Accordingly, similar to the other items Mr. Ross has raised, assuming  
6 Mr. Ross’s point regarding tiers had any merit, the actuarial method could account for this  
7 item because in the end it is just a “mathematical function” to determine how the item affects  
8 health care costs.

### 9 State’s Proposed Bill-Submission Method

10 37. I previously testified that “the actuarial method will result in a far more accurate  
11 determination of the uncovered health care costs for the class than individual claims due to the  
12 numerous problems of establishing the losses of such a large class by a bill-submission  
13 method.” Wilson Dec., 9/13/12, ¶32. The problems associated with the bill-submission  
14 method were discussed in my September 2012 declaration (*id.*, ¶¶28-32), my second  
15 declaration concerning the State’s proposed survey of class members to obtain bills (Wilson  
16 Dec., 9/14/11, ¶1-14), and the declaration by statistician and professor Susan Long, which I  
17 expressly agreed with in my September 2011 declaration (*id.* at ¶9).

18 38. The State submits no evidence that its proposed bill-submission method will  
19 more accurately determine the loss to the class than the actuarial method. Instead, the State  
20 submits a declaration by an employee of a “professional records retrieval service company”  
21 who says that he could obtain medical records and billing records for class members if they  
22 “submit a form listing the medical service providers they received services from since 2003  
23 along with a signed Health Insurance Portability and Accountability Act (HIPAA) release.”  
24 Jenkins Dec., ¶3.

25 39. Leaving aside the fact that Mr. Jenkins’ testimony erroneously assumes perfect  
26 record-keeping by medical providers, it addresses only one of the many problems associated  
27 with the bill-submission method. As I previously testified, the first problem with the State’s

1 approach is that class members would have difficulty remembering the health care providers  
2 they saw in months seven, eight, and nine years ago, especially for minor events. Wilson  
3 Dec., 9/13/12, ¶31. Another problem is there would be “major inaccuracies due to lack of  
4 responses,” “lack of diligence, and other causes.” Wilson Dec., 9/14/11, ¶9. Indeed, many  
5 class members would undoubtedly see individual claims as overly burdensome with the  
6 opportunity for little gain. And many class members would not want to sign a HIPAA waiver  
7 and disclose medically sensitive information regarding themselves and their family members.

8 40. In addition, even for those class members who could remember their medical  
9 providers from many years ago and who chose to subject themselves to an individual claims  
10 process, it would be very expensive to retrieve medical records from providers throughout the  
11 State for potentially tens of thousands of individuals and to have paralegals summarize those  
12 records, as Mr. Jenkins proposes. Jenkins Dec., ¶¶3-4. If the class members were required to  
13 pay for these costs, it would undoubtedly constitute a significant portion of their loss and they  
14 would not be made whole.

15 41. Due to the many problems associated with the individual bill-submission  
16 method, it is not a scientifically valid method to determine the financial loss to the class here.  
17 In contrast, the actuarial method is a scientifically valid method to determine the class-wide  
18 loss. And not only is the actuarial method scientifically valid, but it is also highly accurate and  
19 efficient.

### 20 Conclusion

21 42. The State has no evidence that the actuarial method is not a scientifically valid  
22 method to determine the class-wide loss here. The State instead quarrels with some of the  
23 inputs into the method based on three arguments: (a) alleged different demographics between  
24 the class and the group of PEBB-enrollees, (b) health care costs including more than “medical  
25 expenses,” and (c) including the same distribution of tiers (spouses and children) as those with  
26 coverage. Assuming any one or all of these points had merit, the actuarial method could  
27 account for these items through adjustments. Accordingly, the actuarial method will provide a

1 scientifically sound and efficient method to determine the financial loss to the class as a  
2 whole.

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

5 Dated: October 4, 2012 at Princeton Junction New Jersey  
6 (City) (State)

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8 DAVID WILSON  
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# EXHIBIT 3

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KING COUNTY  
SUPERIOR COURT

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AUG 23 2011 Honorable Catherine Shaffer

Hearing: August 25, 2011

DANIELSON, FINE, BOYD  
LEYH & TOLLESON Oral Argument Requested

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AUG 23 2011

ATTORNEY GENERAL OFFICE  
SEATTLE

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

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

NO. 06-2-21115-4 SEA

Plaintiffs, )

DECLARATION OF SUSAN B. LONG

v. )

HEALTH CARE AUTHORITY and )  
STATE OF WASHINGTON, )

Defendant. )

Susan B. Long testifies as follows:

1. I am a statistician and an Associate Professor of Managerial Statistics at the Martin J. Whitman School of Management at Syracuse University, where I have taught undergraduate, graduate and Ph.D. seminars in statistics and research methods. I have a doctorate in Sociology from the University of Washington, with a dual major in Quantitative Methods and Criminology. After receiving my doctorate, I completed postdoctoral studies in Statistics at Princeton University. Early in my career, I was a Visiting Fellow at the National Institute of Justice, U.S. Department of Justice, a Visiting Scholar at the Bureau of Social Science Research, and a Visiting Scholar at the Center for Engineering Information at City University of London in England. Since 1980 I have been a faculty member at Syracuse University. From 1984-1992 I served as the Director of the Center for Tax Studies there. Since 1989, I have been the Co-Director and co-founder, of the Transactional Records Access

1 Clearinghouse (TRAC). TRAC is a data gathering, data research and data distribution center at  
2 Syracuse University. TRAC gathers electronic data from internal government data systems,  
3 assesses its accuracy and reliability, transforms this data into usable forms, and then distributes  
4 the information along with TRAC's research findings. Users of TRAC's information services  
5 include scholars, journalists, attorneys, public interest groups, Congressional committees and  
6 government agencies. I therefore have knowledge and expertise in both statistical research  
7 methods and the use and analysis of government-created electronic records.

8 2. I understand that this case is brought on behalf of a class of State employees who  
9 the State treated as if they were not eligible for employer-paid health insurance, but the Court  
10 determined in a series of decisions that the employees were eligible.

11 3. I have reviewed from the standpoint of statistical methodology the declaration of  
12 Stefan Boedecker, who has a suggestion for a survey of 60 State employees, the proposed  
13 interrogatories to be sent to 60 selected employees that constitute the survey questions, and the  
14 State's brief, which states how the State intends to use the information in the survey. (These  
15 survey questions are attached to this declaration.) I also reviewed the June 9, 2011 Declaration  
16 of David Wilson, a statistician and health care actuary, filed in this case. The State's proposed  
17 survey of 60 employees could not obtain "90% confidence level" (or anywhere near) with a  
18 +/-10% precision on what Mr. Boedecker calls the "relevant attributes" of the large class of  
19 several thousand State employees that Mr. Boedecker says the sample would represent (§8).

20 4. Leaving aside the sample selection, which I address below, the State uses the 90%  
21 confidence level and a margin of error of +/- 10% as if it would define the relative accuracy of  
22 the survey results. But this is not correct because it does not account for what statisticians call  
23 "nonsampling sources of error" that would materially affect the accuracy of the results here.

24 5. I conducted a series of national surveys of tax attorneys, CPAs, IRS-enrolled tax  
25 return preparers, and tax educators when I was Director of the Center for Tax Studies. I have  
26 also taught seminars at the doctoral level covering the proper design and conduct of surveys.

1 Deciding on the sample size and how the sample is to be selected are only a very small part of  
2 the factors that need to be carefully considered if a survey is to produce useful and valid results.

3 6. In doing surveys it is important to validate any survey instrument before its use.  
4 Validation involves a variety of things. For example, one may find that terms are being used in  
5 the survey that the person being asked does not understand. Or the survey may ask for  
6 information that the person does not have knowledge of. If one does not consider and design the  
7 questions carefully so that those surveyed can understand the questions and easily answer them,  
8 a survey can end up with meaningless results. Survey design and administration requires its own  
9 expertise. No matter how individuals are chosen for the sample, one cannot just send out  
10 questions and assume you will get meaningful results unless the survey, its questions as well as  
11 its administration, also limit "nonsampling sources of error."

12 7. Experience has taught that as surveys require more time and effort on the part of  
13 the respondent to fill out, response rates rapidly fall off. Thus, in validating a survey instrument,  
14 it is important to first estimate how long it will take a respondent to fill out the questionnaire.  
15 Will it take 5 minutes? 10 minutes? 20 minutes? There is an extensive survey literature that has  
16 examined the impact of survey length (in terms of time it takes to fill out a survey) and the fall  
17 off in response, or respondents supplying "garbage answers" just to fill things out. A survey  
18 instrument needs to be carefully examined to see if, answers to the questions have a reasonable  
19 chance of gaining meaningful information without requiring too much time.

20 8. In addition, because of the extensive use of surveys for commercial and marketing  
21 purposes, it has become increasingly difficult to get people to respond — even to well-designed  
22 surveys with questions that are easy to answer and do not take much time. But if responses are  
23 not received for every individual in the sample, then the results are not from a "random sample"  
24 and all the care that went into selection of an appropriate random sample may be for naught.

25 9. In doing a survey, it is particularly challenging to contact individuals selected out  
26 of some time period in the past, and contact them today, because even if one had address and  
27 phone numbers for that past period, a significant number will no longer be valid — people move,

1 change their names, or even die. Thus, those individuals will not respond and again, survey  
2 results will not in fact reflect a "random sample". And again statements about relative accuracy  
3 or level of confidence based on the sample size and the randomness of sample will not apply to  
4 the results obtained.

5 10. Because of the practical difficulties in obtaining meaningful results from surveys  
6 of individuals, alternative sources for comparable information are often sought by scientists and  
7 others. Are there other comparable groups of individuals about which this information is known  
8 which can be used and are there administrative record systems available from which comparable  
9 information could be derived? If so, scientists and others use this type of information rather  
10 than surveys. Indeed, there has been a pronounced shift by scientists to the use of administrative  
11 record systems to utilize information they contain, with the growth in computerized record  
12 systems and the growing array of statistical tools now available, rather than using surveys to  
13 obtain data.

14 11. Here, the State's proposed survey questions have many of the "nonsampling  
15 sources of error" that statisticians and other scientists try to eliminate in order to obtain  
16 meaningful results. Rather than a simple factual survey, the State's proposed discovery seeks  
17 answers concerning the case from the absent class members that there is no likely way for them  
18 to answer and every response, if an accurate response were obtained, would probably be "I don't  
19 know." For example, because I understand the class members have not been given any notice  
20 concerning the case, the class members here apparently have no idea this litigation is even  
21 occurring or what the case is about. Yet, the State's proposed discovery to class members would  
22 ask them for "the time period of June 1, 2000 through December 31, 2009, please identify those  
23 months during which you allege you were eligible to receive Public Employee Benefits Board  
24 (PEBB) health care benefits, but during which time you allege that your employer erroneously  
25 failed to provide such benefits." Proposed Inter. No. 1. The class members presently have no  
26 knowledge of this case, of the eligibility criteria, and probably do not recall their work hours in

1 particular months many years ago. They would therefore likely have no idea how to answer this  
2 question concerning their "eligible" months for a nine-year time period that started 11 years ago.

3 12. The State's proposed discovery then asks for each month the class member  
4 identified in response to Interrogatory no. 1, "please identify which PEBB-offered plan that you  
5 allege you would have selected." Proposed Inter. No. 5. Again, the class members will probably  
6 have no idea how to answer this question because not only will they not know their work  
7 histories from many years ago and the months they allege they were eligible for insurance, but  
8 they will also not know what PEBB plans were even in effect in say 2001 or 2004, let alone  
9 which plan they would have selected if the State had let them pick a plan at that time. "I don't  
10 know" would again be the most likely answer if a truthful answer were supplied.

11 13. The State's proposed discovery then asks the class members to state, among other  
12 things, "the dollar amount of your out-of-pocket expenses for health care services that would  
13 have been covered by a PEBB plan in effect and existence during that month." Proposed Inter.  
14 No. 6. Again, the class members will have no idea how to answer this question. Indeed, where  
15 is the class member supposed to find the coverage of any PEBB plan in effect in say, 2000, 2003  
16 or 2005? The answer again from class members would likely be "I don't know," or they would  
17 simply give up and not fill out and return the survey at all.

18 14. Similarly, the State's proposed discovery asks the class members without defining  
19 or explaining the terms whether they were for each month a "non-permanent employee," a  
20 "career seasonal employee," "part-time faculty" or "none of the above." Proposed Interrogatory  
21 No. 2. Again, without some explanation, the class members would likely not know how to  
22 answer the questions.

23 15. All of the State's proposed survey questions have grave deficiencies. The  
24 combination of these deficiencies means that the magnitude of these "nonsampling sources of  
25 error" would prevent the survey from providing meaningful or scientifically valid results.  
26 Indeed, any peer review of the survey would find that the survey is so replete with these  
27

1 "nonsampling sources of error" that what is proposed could not be considered a scientifically  
2 valid survey.

3 16. Turning to the sample design, Mr. Boedecker says a sample of 60 class members  
4 is sufficient to determine the "relevant attributes" of the class members. Mr. Boedecker says  
5 (§§5-7), the "relevant attributes" include "the nature and extent of medical services received [for  
6 each person] during any month" and whether a "premiums-based or comparable employee  
7 measure" is an "adequate proxy" of the losses for the class to a "reasonable degree of scientific  
8 certainty." Boedecker Dec, ¶11. Although he is vague, Mr. Boedecker appears to be referring to  
9 dollar amounts of health expenses in each month and apparently the other "relevant attributes"  
10 must be the other information items in the proposed survey questions (*i.e.* the State's proposed  
11 interrogatories). Apparently, the 60 individual survey is intended to show that the health  
12 insurance expenses incurred by the class members for the months that they did not receive health  
13 insurance are less on average than the total of employer-paid health insurance premiums that the  
14 State would have paid each month if it had enrolled them in the plans, *i.e.* not an "adequate  
15 proxy" of the average expenses.

16 17. Mr. Boedecker's discussion of a "90% confidence level" and a margin of error of  
17 +/-10% is worded vaguely as to the specific attributes he wishes to measure and how those  
18 attributes are to be measured. But his proposed sample size of 60 people is certainly too small to  
19 provide accurate information with respect to the "relevant attributes" he identifies, particularly  
20 the medical expenses incurred for the class members for those months when they should have  
21 received employer-paid health insurance from the State, but did not. His proposal to use a  
22 stratified sample does not alter this conclusion. I explain this later in paragraph 24 and 25.

23 18. Sample size depends on variance in the population of the variable or attribute  
24 sought to be measured. More simply, it depends on how the values of the attribute are  
25 distributed among the members of the population (here the class members). For statistical  
26 purposes, class members have to be clearly defined and the sample selected from a complete  
27 listing with all class members known. The attributes to be measured are very important in

1 determining the sample size needed for the level of precision sought. If one survey is used (as the  
2 State proposes here), then the attribute that has the most variation determines the needed sample  
3 size for any absolute level of precision sought.

4 19. Even assuming no nonsampling sources of error, a small sample size such as 60 is  
5 too small to provide the level of precision and confidence level specified in this context.. For  
6 example, even to estimate such a simple attribute as the proportion of males versus females at  
7 "90% confidence," for the class with a +/- 10% precision level based on a simple random  
8 sample, one needs a sample size larger than 250 individuals, and if you wanted "95%  
9 confidence" — the more common standard used scientifically — with a +/- 10% precision level  
10 a sample of over 350 individuals is required.

11 20. Again, assuming no sources of nonsampling error, a small sample, such as 60,  
12 may be appropriate when the variable that one is trying to measure does not have much  
13 variability within the population from which the sample is drawn (here, the class members). But  
14 as the variability increases, one needs a larger sample size if one wants the level of precision and  
15 the confidence level that the State seeks.

16 21. Here the State apparently wants to measure the dollar amount of health care  
17 expenses for the class, but because one would expect the dollar amount to vary widely from one  
18 individual to the next each month, a much larger sample size than 60 is needed. One would  
19 expect that a few individuals would have very high expenses in a particular month, while other  
20 individuals would have small expenses and most individuals would have none at all. Those few  
21 individuals with large expenses, however, could account for the lion's share of medical costs that  
22 month for a large group of employees. (Indeed, the health insurance is based on this fact; health  
23 insurance is based on the pooling of risks.) If each individual has an equal chance of selection, it  
24 is easy to see how a sample size as small as 60 out of several thousand class members might well  
25 end up with no one who had large medical expenses that month. The resulting estimate would  
26 provide a highly inaccurate estimate of the average or total medical expenses that had taken  
27 place for the class. Thus, a sample size much greater than 60 is needed to determine the medical

1 expenses incurred by the class because the amount of expenses would be expected to have a very  
2 large variance.

3 22. I do not have enough information about the variance of expenditures among  
4 individuals to determine the proper sample size here, but 60 is far too small, given the design  
5 proposed. Healthcare actuaries such as the plaintiffs' expert witness, David Wilson, are both  
6 expert statisticians and actuaries that have knowledge of the facts about the variance among  
7 individuals for medical expenditures and the distribution of those expenditures and thus he could  
8 determine the proper sample size (of course assuming that there were no nonsampling sources of  
9 error that invalidate the sample results on other grounds). But certainly 60 individuals would be  
10 too small of a sample, given the design proposed.

11 23. Mr. Wilson in his declaration at pages 4-7 explains how the actual expenditures  
12 for the class could be accurately determined, based on the State's actual expenditures for covered  
13 employees. (As I explained earlier in ¶10, scientists frequently use such sources of information  
14 to determine characteristics of groups rather than using a survey because surveys are often filled  
15 with nonsampling error that makes them not meaningful.) Mr. Wilson explains, unless the class  
16 members were demographically different from those employees who were covered, the average  
17 monthly expenditures for the class members would be the same as the expenditures for the  
18 employees that the State provided employer-paid insurance. I agree with Mr. Wilson. Mr.  
19 Wilson testifies that if the class were demographically different from the covered employees, he  
20 could easily account for the difference in determining the expenditures for the class as a whole (I  
21 assume this is true because that is in part what healthcare actuaries do), but he says that no such  
22 differences have been identified. And I also know of no such differences here.

23 24. Stratification is used by statisticians to reduce sample size by reducing variability  
24 through the appropriate designation of strata. But one can only use stratification to reduce  
25 variability if one has knowledge of the characteristics that are related to the variability of the  
26 attributes — here the size of medical expenses for the class. Thus, if the State knew that class  
27 members in a particular employing agency all had very high medical expenditures, while those

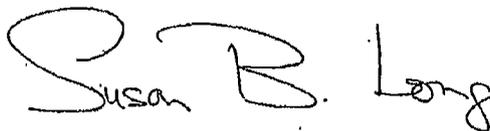
1 in a different agency had no expenditures, stratification could be used to reduce sample size.  
2 But here the State says that it does not have any information on class member expenditures and  
3 also there is no information that suggests that the medical expenditures for class members  
4 would vary by employing agency. Mr. Boedecker does not identify any of the other  
5 characteristics he proposed to use for stratification and thus he has not shown how they would  
6 be able to reduce the needed sample size to 60.

7 25. Stratification is also used if one wants to accurately measure the medical expenses  
8 for individual strata. However, then *each* strata would have to have a sufficiently large sample  
9 size to deliver the level of precision and confidence the State has specified. . In general, the size  
10 of a sample required is not reduced simply because the sizes of strata are less than the size of the  
11 class as a whole. As a result, rather than reducing the sample size needed, using the survey to  
12 derive measures for each strata would greatly multiply the overall sample size needed. Further,  
13 Mr. Boedecker's minimum sample size of three for any strata would be clearly inadequate.

14 26. The State's proposed survey questions are filled with nonsampling sources of  
15 error and the State's proposed sample size of 60 is also too small to produce meaningful or  
16 accurate information about the medical expenditures for the class or about the other "relevant"  
17 attributes. For these reasons the proposed survey would not produce accurate meaningful  
18 information.

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

21 DATED: August 23, 2011, in Bellevue, Washington..

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24 SUSAN B. LONG

# ATTACHMENT

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STATE OF WASHINGTON  
KING COUNTY SUPERIOR COURT

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

Plaintiffs,

v.

HEALTH CARE AUTHORITY, STATE  
OF WASHINGTON,

Defendants.

NO. 06-2-21115-4 SEA

DEFENDANTS' INTERROGATORIES  
TO [PUTATIVE CLASS MEMBER]

TO: [Putative Class Member];

AND TO: Stephen K. Strong and Stephen K. Fester, of Bendich, Stobaugh & Strong, P.C.,  
Plaintiffs' Attorneys

Pursuant to CR 26 and 33, Defendant Health Care Authority (HCA) by its undersigned  
attorneys requests that [Putative Class Member] answer fully, under oath, within thirty (30)  
days of service upon him/her, the following interrogatories. Defendant HCA requests that such  
answers be made in accordance with the definitions, rules of construction, and instructions set  
forth below.

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9. When, after a reasonable and thorough investigation, you are unable to answer any interrogatory or some part thereof because of lack of information available to you, please specify, in full and complete detail, the reason the information is not available to you and what has been done to locate such information.

10. With respect to any document that is withheld, whether under claim of privilege or otherwise, provide the following information:

(i) the date, identity and general subject matter of the document, and the grounds asserted in support of the failure to produce the document;

(ii) the identity of each person (other than stenographic or clerical assistants) participating in the preparation of the document;

(iii) the identity of each person to whom the contents of the document were communicated orally by copy, by distribution, reading or substantial summarization;

(iv) a description of any document or other material transmitted with or attached to the document;

(v) the number of pages in the document;

(vi) the particular Request(s) and subpart(s) to which the document is responsive; and

(vii) whether any business or non-legal matter is contained or discussed in the document.

11. If any document that would have been responsive to any request has been lost or destroyed since its preparation or receipt, identify the document, state the particular request(s) to which it would otherwise be responsive, and set forth in detail the circumstances of the loss or destruction of the document(s).

12. These discovery requests are continuing, and you are required to supplement your responses with respect to any information within the scope of these requests that may be

1 located or acquired following your initial response. If additional information is discovered  
2 between the time of responding and the time of trial, these requests are directed to that  
3 information. If such information is not furnished, Defendant HCA will move at the time of  
4 trial to exclude from evidence any information requested and not furnished.

5 **INTERROGATORIES**

6 **INTERROGATORY NO. 1:** For the time period of June 1, 2000 through December 31,  
7 2009, please identify those months during which you allege you were eligible to receive Public  
8 Employees Benefits Board (PEBB) health care benefits, but during which time you allege that  
9 your employer erroneously failed to provide such benefits.

10 **ANSWER:**  
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16 **INTERROGATORY NO. 2:** For each month identified in Interrogatory No. 1, above, please  
17 state whether you were: (1) a nonpermanent employee; (2) a career seasonal employee; (3)  
18 part-time faculty; or (4) none of the above.

19 **ANSWER:**  
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24 **INTERROGATORY NO. 3:** For each month identified in Interrogatory No. 1, above, please  
25 state whether you: (a) self-paid the premium to maintain coverage under the PEBB plan; (b)  
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1 used some form of paid leave so that your employing agency continued to pay the employer  
2 share of the PEBB premium; or (c) did not have health care coverage by a PEBB plan.

3 ANSWER:  
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10 INTERROGATORY NO. 4: For each month identified in Interrogatory No. 1, above, and  
11 for which you had no health insurance coverage *through a PEBB plan*, please state:  
12 (a) whether you procured or received health care coverage under any other form of health care  
13 insurance and, (b) if you did have such coverage, (i) the name of the subscriber; (ii) the name  
14 of the insurer and (iii) the dollar amount of the monthly premium that you paid for your  
15 coverage.

16 ANSWER:  
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22 INTERROGATORY NO. 5: For each month identified in Interrogatory No. 1, above, and  
23 for which you had no health insurance coverage *through a PEBB plan*, please identify which  
24 PEBB-offered plan that you allege you would have selected.

25 ANSWER:  
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**INTERROGATORY NO. 6:** For each month identified in Interrogatory No. 1, above, and for which you had no health insurance coverage *under a PEBB plan or any other insurance plan*, please state: (a) the dollar amount of your out-of-pocket expenses for health care services that would have been covered by a PEBB plan in effect and existence during that month; (b) a list of the health care services you received; and (c) the name of the health care provider or institution that provided those services to you.

**ANSWER:**

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 2011.

ROBERT M. MCKENNA  
Attorney General

TODD R. BOWERS, WSBA #25274  
Senior Counsel  
ROBERT A. HYDE, WSBA #33593  
Assistant Attorney General  
Attorneys for Defendants

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**ATTORNEY VERIFICATION**

Answers, Responses, and Objections submitted this \_\_\_\_ day of \_\_\_\_\_, 2011.

BENDICH, STOGBAUGH & STRONG, P.C.

\_\_\_\_\_  
STEPHEN FESTOR  
Attorneys for Plaintiff

**VERIFICATION**

STATE OF WASHINGTON )  
                                  ) ss.  
COUNTY OF \_\_\_\_\_ )

\_\_\_\_\_, being first duly sworn on oath, deposes and says:

I have read the foregoing interrogatories and requests for production of materials to plaintiff and the answers and responses provided above. I know the contents of the answers and responses, and I believe them to be true, correct, and complete.

SUBSCRIBED AND SWORN TO Before me this \_\_\_\_ day of \_\_\_\_\_, 2011.

\_\_\_\_\_  
Notary Public in and for the  
State of Washington  
Residing at \_\_\_\_\_  
My Commission Expires: \_\_\_\_\_

# EXHIBIT 4

RECEIVED  
JUDGES MAIL ROOM

2011 SEP 15 PM 3:59

KING COUNTY  
SUPERIOR COURT

Honorable Catherine Shaffer  
Hearing: September 23, 2011  
With oral argument as set out  
in the Court's Order of  
August 29, 2011

SEP 15 2011

RECEIVED

SEP 15 2011

DANIELSON, HARRIGAN  
LEYH & TOLLEFSON

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

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

NO. 06-2-21115-4 SEA

Plaintiffs, )

SECOND DECLARATION  
OF SUSAN B. LONG

v. )

HEALTH CARE AUTHORITY and )  
STATE OF WASHINGTON, )

Defendant. )

Susan B. Long testifies as follows:

**Qualifications and Previous Testimony**

1. I am a statistician and an Associate Professor of Managerial Statistics at the Martin J. Whitman School of Management at Syracuse University, where I have taught undergraduate, graduate and Ph.D. seminars in statistics and research methods. I also directed the University's Center for Tax Studies where I conducted a series of national surveys of tax attorneys, CPAs, IRS-enrolled tax return preparers, and tax educators and I have taught seminars at the doctoral level covering the proper design and conduct of surveys. Thus, I am familiar with the requirements for survey research.

2. I submitted in this case a declaration on August 23, 2011. This declaration supplements my previous declaration.

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### Summary of Testimony

3. Although the State contends that it seeks survey interrogatories from “a randomly-selected, statistically significant sample of class members to learn what their actual damage experience has been and compare that to Plaintiffs’ proposed proxy of employee premium rates,” the State’s witness Stefan Boedecker conceded that the survey cannot be used to estimate damages for the whole class because the sample size is far too small. Mr. Boedecker conceded the purpose of the survey was not to establish medical expenses (even though the State’s brief said the opposite). Mr. Boedecker said the survey’s purpose was only to estimate simple percentages, such as what percentage of class members obtained substitute insurance. Although Mr. Boedecker now states that the survey is intended to make only simple proportional comparisons, the revised survey does not ask those types of questions. Rather, it asks questions about the *amount* spent per month for insurance and the *amount* spent for out-of-pocket expenditures. It also asks for the name of the insurance company, the name of the treating physician and what medical condition the individual received treatment for. These are *not* proportion-type questions.

4. Moreover, if in fact the State was asking those types of questions, Mr. Boedecker’s sample size of 60 is too small to be used to make even such simple comparisons as the proportion of the class members who are male versus female. Indeed, based on the formula that he uses (the same one I use) a sample size of 68 is needed, not 60 as proposed by Mr. Boedecker, to obtain even a ballpark idea of this percentage. By “ballpark idea” I mean one that has a very wide range of 20 percentage points (+/- 10 percentage points). And even here you would expect your sample result to be wrong [the range would not include the correct percent for the class] one out of ten times (90% confidence) even if you received an accurate answer from every person surveyed.

5. The State’s proposed low confidence level of 90% and its wide range of 20 percentage points is not normally acceptable in scientific research. Scientific research normally uses at least a 95% confidence level, and needs something a lot more precise than this very

1 imprecise ballpark-type estimate with a 20 percentage point range to be considered useful or  
2 meaningful.

3         6.         Mr. Boedecker's sample of 60 is also not a simple random sample which the  
4 formula we both used is based on, and thus what he proposes to do could achieve even less  
5 accurate results because he says he is basing selection of class members for the sample in part  
6 on undefined strata and unstated attributes.

7         7.         But even this "ballpark" percentage estimate with a one in ten chance still of  
8 being wrong requires that everyone surveyed actually responds and further always provides  
9 complete and correct answers to the survey questions. As a practical matter, this never occurs.  
10 "Nonsampling error" is the name statisticians give to the failure to achieve complete and  
11 accurate responses from those included in the sample. Unfortunately, the State's second set of  
12 survey questions has the same (non-sampling-error) flaws that the first survey had. It asks the  
13 class members questions that it is difficult to conceive they could possibly answer and other  
14 questions that they can answer only with substantial time and effort if they by happenstance  
15 retained medical expense records for various months in various years from as many as eleven  
16 years ago. The State also asks the class members for highly personal medical information, such  
17 as what medical conditions they were treated for, the costs of these treatments, and the name of  
18 their treating physician for which there would be a natural reluctance to provide on a survey. For  
19 all these reasons many class members who receive the survey will probably not respond. And  
20 common sense (confirmed by extensive research) tells us that the very individuals that had  
21 special medical conditions requiring extensive treatment would be among those least likely to  
22 respond. Thus, these nonresponders will vitiate the randomness of the sample (even if it were  
23 truly random in the first place), thereby further rendering the data obtained in the survey not only  
24 not meaningful, but misleading as well.

25         8.         While the State's survey asks for highly personal information about medical  
26 treatments received and medical expenditures, the State's survey does not comply with the basic  
27 requirements for conducting survey research involving human subjects.

1 9. For all these reasons, the State's proposed survey will not produce any  
2 meaningful information and will be burdensome and highly intrusive to the absent class  
3 members who know nothing about this case. At best, the survey would not produce any  
4 meaningful information beyond what is known, *i.e.*, some class members had insurance in some  
5 months and some did not, and some class members had medical expenses in some months and  
6 some did not.

7 10. Plaintiffs' health care actuarial expert David Wilson explained (pp. 4-7 in his  
8 declaration) how the medical expenditures (monetary loss for the class as a whole) can be easily  
9 and accurately calculated using comparable employee data, *i.e.*, the actual medical expenditures  
10 for State employees enrolled in the State's plans at the same time as the class members. These  
11 actual medical expenditures are in turn used by the State to determine the amount that the  
12 employing State agency must pay HCA for the employee health insurance for each month to  
13 cover these employees' actual expenditures. Because both groups are large, the actual  
14 expenditures for the group of covered employees at the same time can be used to determine the  
15 actual medical expenditures for the group for non-covered employees at that time. And it is also  
16 the easiest way to determine the loss for the class, which flows from the Court's decision that the  
17 State violated its duty to enroll the class members.

18 **In Response to My First Declaration the State's Witness Now Agrees that the**  
19 **State's Proposed Survey Cannot Provide Any Factual Information**  
20 **About the Class' Medical Expenses.**

21 11. In my first declaration I reviewed from the standpoint of statistical methodology  
22 the declaration of Stefan Boedecker, who had a suggestion for a survey of 60 State employees,  
23 the State's proposed interrogatories to be sent to 60 selected employees that constitute the survey  
24 questions, and the State's brief, which states how the State intends to use the information in the  
25 survey.

26 12. The State stated that it sought discovery from "a randomly-selected, statistically  
27 significant sample of class members to learn what their actual damages experience has been and  
compare that to Plaintiffs' proposed proxy of employer premium rates." The State's Motion For

1 Leave to Conduct Discovery, p. 3. The State further explained that its representative sample will  
2 “demonstrate that plaintiffs’ proposed class-wide approach to damages is not a reasonable proxy  
3 for actual damages” (*Id.*, p. 5) and that “the amount of damages allegedly suffered is necessary to  
4 evaluate whether plaintiffs’ proposed ‘proxies’ for actual damages are reasonable and  
5 appropriate.” *Id.* p. 10.

6 13. The State’s witness, Mr. Boedecker, who created the sample design, further stated  
7 in his declaration (¶¶5-7) that the purpose of the statistically-significant sample is to determine  
8 “the nature and extent of medical services received during any month in which a putative class  
9 member was eligible but did not receive state-funded health care” and “the degree to which a  
10 premium-based or comparable employee measure of actual damages can serve as an adequate  
11 proxy for those damages.” Mr. Boedecker said that his proposed sample design using 60 class  
12 members would establish those points “to a reasonable degree of scientific certainty.”  
13 Boedecker Dec. ¶11.

14 14. Accordingly, in my first declaration I reviewed Mr. Boedecker’s proposed sample  
15 design with the State’s stated purpose in mind and explained in my testimony that a sample of 60  
16 is far too small to establish the losses for the class. Long Dec., ¶¶ 16-21. And one cannot  
17 reasonably compare the survey’s results for 60 people to the premium or comparable employee  
18 approach that the plaintiffs’ health care actuary expert David Wilson had testified would  
19 establish the loss for the class. *Id.* See Wilson Dec. pp. 4-7, explaining that method. I agreed  
20 with Mr. Wilson’s method which is based on the State’s actual data for health care expenditures  
21 by State employees at the same time as the class members. Long Dec., ¶23.

22 15. After I submitted my declaration, Mr. Boedecker submitted a second declaration  
23 in reply. In that reply declaration, Mr. Boedecker acknowledged that a sample of 60 is indeed far  
24 too small to provide any meaningful estimate of the medical expenses for the class (let alone an  
25 estimate of the loss “to a reasonable degree of scientific certainty”). Thus, Mr. Boedecker agreed  
26 that the State’s proposed interrogatories would not provide any useful or significant results on  
27 expenses for the class. Mr. Boedecker testified in his reply declaration: “**It is not the scope of**

1 **the discovery sample to estimate medical expenses.”** (Boedecker Dec. [8/24/11], ¶5) and **“the**  
2 **State does not intend to engage in amount sampling”** which he said would be needed to  
3 estimate medical expenses for the class. *Id.* ¶6 (emphasis added). And he also testified that  
4 **“[n]o claim was ever made that a sample of size 60 would enable the estimation of dollar**  
5 **amounts at 90% confidence with precision of +/-10%.”** Boedecker Dec. [8/24/11] ¶9(b)  
6 (emphasis supplied).

7 16. Mr. Boedecker thus conceded that the State’s proposed survey (or interrogatories  
8 to class members) *could not* provide any meaningful information about the class members’  
9 actual medical expenditures and that the survey cannot accomplish the purpose for which the  
10 State seeks discovery, *i.e.*, to survey a “randomly-selected, statistically significant sample of  
11 class members to learn what their actual damages experience has been and compare that to  
12 Plaintiffs’ proposed proxy of employer premium rates.” State Motion for Leave to Conduct  
13 Discovery, p. 3.

14 17. Although Mr. Boedecker’s reply declaration specifically acknowledged this fact,  
15 the State strongly continued in its Reply Brief to state that its survey is intended to learn the  
16 class’ actual damages so that it can show the class members’ proposed method of determining  
17 the classes’ losses is inaccurate. State’s Reply on Mot. for Leave to Conduct Discovery, p. 5.  
18 The State said: “The State needs the actual damages experience [of class members] . . . to  
19 demonstrate that Plaintiffs’ proposed proxy of the employer portion of the premiums is  
20 inaccurate” and “to test whether plaintiffs’ proxy measure of damages, unpaid premiums, is a  
21 reasonable substitute for proof of actual damages.” State’s Reply on Mot. for Leave to Conduct  
22 Discovery, p. 5.

23 18. Actually, both Mr. Boedecker, the State’s witness, and I agreed that the State’s  
24 proposed discovery cannot possibly provide any meaningful information to make such a  
25 comparison because the 60-member sample is far too small to make any meaningful statement  
26 about the amount of the class’ medical expenditures. Long Dec., ¶¶ 16-21; Boedecker Reply  
27 Dec., ¶¶ 5, 6 and 9b.

1           19.     The Court denied the State's motion for discovery, but allowed the State to renew  
2 its discovery motion if it could "devise a survey which poses relevant questions which surveyed  
3 persons are likely to be able to answer." Order of August 29, 2011 (underlining by the Court).

4                                   **The State's Revised Survey Is a "Damages Survey"**  
5                                   **Even Though Its Witness Says It Is Not.**

6           20.     The State has provided the plaintiffs with its revised interrogatories titled  
7 "Questionnaire to Potential Class Members" (attached to this declaration), and the State's  
8 attorney notified the plaintiffs' counsel that the revised survey "will essentially amount to a  
9 damages survey of a sample of the [class] list" the State will be providing plaintiffs' counsel  
10 under the Court's order. September 2, 2011 email from Todd Bowers to Steve Festor. The State  
11 also said that the State's previous motion for discovery and its reply had already explained the  
12 purpose of the survey and the particulars for the proposed survey (*i.e.*, 90% confidence level and  
13 a range of 20 percentage points (+/-10 percentage points) with a sample size of 60). September  
14 6, 2011 email from Todd Bowers to Steve Festor.

15           21.     The State is thus still contending that its survey "will amount to a damages  
16 survey" of the whole class, when its own witness who created the sample design acknowledged  
17 that the survey cannot possibly do this because the sample size is far too small. Mr. Boedecker is  
18 right that a sample of 60 class members cannot provide any meaningful information about class  
19 member expenditures. Boedecker Dec. [8/24/11], ¶¶5, 6 and 9(b).

20                                   **The State's Revised "Damages Survey" Asks Questions that the Class**  
21                                   **Members Cannot Answer and Other Questions that They Can**  
22                                   **Answer Only With Substantial Time and Effort.**

23           22.     My previous declaration addressed "nonsampling sources of error," which can  
24 materially affect the accuracy of survey research. Long Dec., ¶¶5-15. "Nonsampling sources of  
25 error" include characteristics that could cause the recipients of the survey to not respond and  
26 therefore the initial statements about confidence level based on the sample size and randomness  
27 of the sample no longer apply. When individuals do not respond, the sample size is effectively  
reduced and the sample is no longer random because the nonresponders are not the same as

1 responders. This is a very serious problem in survey research. Nonsampling errors also include  
2 asking questions in a way that the recipients who do respond do not provide meaningful  
3 information. The State has modified its questions a little bit, but substantial nonsampling sources  
4 of errors are still present, which will materially affect the sample, assuming the sample size was  
5 correct, which it is not.

6 23. As stated in my first declaration, ¶7, the longer the survey takes to complete, the  
7 lower the response rate will be. Here, the State's proposed questionnaire will take a substantial  
8 amount of time to complete, even assuming that the individuals had easily accessible records of  
9 medical expenses and health insurance coverage that the State asks them to provide. But most  
10 individuals will not recall what insurance plan they had or what medical expenses they incurred  
11 in a specific month in particular past years, from 2000 to 2009, nor will they ordinarily have  
12 retained records on long-past medical insurance plans and medical expenses. And even if they  
13 did, these records, which could be from 5-10 years ago, may not be easily found or obtained  
14 from others, such as the insurance company or health care providers. Thus, the recipients of the  
15 survey will likely not fill out the survey questionnaire because it is quite burdensome and  
16 difficult to do so, particularly since they are not told they will benefit from completing the  
17 questionnaire (and of course there is no reason for them to think it will be a benefit to them).  
18 Their answer thus will often be that he or she does not know the answer or, more likely, to  
19 simply not complete the questionnaire. Similarly, because the State asks for highly personal  
20 health information, the individual would be inclined for that reason as well not to complete the  
21 questionnaire or to simply answer "I don't know." The occasional individual who remembers  
22 having no problems in a year can answer more easily than one who had significant medical  
23 problems, causing a major bias in the resulting estimates. Certainly those who died and probably  
24 had significant health issues before their death will not respond.

25 24. The questionnaire also asks the survey recipients to state hypothetically what  
26 health insurance plan they would have selected from the State's plans in particular months or  
27 particular years. The recipients could not possibly answer this question unless they were also

1 given copies of the plans in effect for each month. But even if they were given the relevant plans  
2 for each month and year, figuring out which plan they could have selected require reading  
3 hundreds of pages and could be quite time-consuming and also hypothetical. Thus, the likely  
4 response would be "I don't know," to leave the question blank, or to simply not fill out the  
5 questionnaire.

6 25. The State's survey also asks each class member whether they would "have waived  
7 PEBB health care coverage during the above-listed months if they had been offered the  
8 opportunity to enroll in such coverage." In addition to being hypothetical, the class members  
9 will have no idea what the State is asking. To possibly answer the question they would need  
10 substantially more information in order to meaningfully answer the question even hypothetically.

11 26. Although the State's witness Mr. Boedecker admits that the survey cannot provide  
12 any meaningful information about the amount of medical expenses, the State's survey continues  
13 to ask for the precise amount of expenditures, and the exact treatments received for those  
14 expenditures even though such detail will provide nothing of value and will only make it more  
15 likely that the individuals will not respond. (Those questions also show that despite Mr.  
16 Boedecker's assurances to the contrary, the State is still seeking damages information for the  
17 class even though it knows that the information will be meaningless.)

18 27. Also, the State's proposed questionnaire uses the check-the-box approach, but  
19 when one does that in a survey, one is supposed to tell the subject what he or she should do if he  
20 or she does not know the answer or the options listed don't apply, e.g., leave the question blank,  
21 make their best guess, write in "I don't know," etc. Thus, when checked boxes are used, a box  
22 for "I don't know" and, where appropriate, "not applicable" are normally provided, but there are  
23 no such boxes in the State's proposed survey. Regardless of which approach the survey recipient  
24 is told to follow, the accuracy of the response, if any, is affected by the approach, which in turn  
25 affects the accuracy of the survey, which in turn produces a nonsampling source of error.

26 28. Because of these nonsampling source error problems, the response rate to the  
27 State's proposed questionnaire will probably be quite low, even if the compulsory language used

1 by the State were permissible in a questionnaire to class members. But even if the response rate  
2 were as high as 50%, that would still materially affect the margin of error (also called "level of  
3 precision") because of the bias created by the number of non-responders. In survey research one  
4 cannot assume that the non-responders are the same as the responders. In fact, we know that the  
5 non-responders are different somehow (that is why they did not respond). Statisticians call this  
6 "bias." To try to account for bias, statisticians seek a way to determine how much this may have  
7 impacted their results. For example, in the question of whether or not a person purchased other  
8 insurance, to provide a conservative estimate of the possible biasing effects one assumes that the  
9 non-responders could have all answered "yes" versus all answered "no." As an illustration, let  
10 us assume that of those surveyed half answered this question – a response rate that many  
11 experienced survey researchers might consider doing quite well to achieve. If half of those  
12 responding said they purchased alternative insurance while half did not, a conservative estimate  
13 would be that between 20 and 80 percent (50 percent +/- 30 percentage points), purchased  
14 insurance, a resulting spread of 60 percentage points. To the 20 percentage point spread or  
15 "margin of error" proposed by Mr. Boedecker, an additional 40 percentage points has to be  
16 added to provide a conservative estimate of the resulting bias possible because not everyone sent  
17 back their answers. Had the original sample percentage been 20 percent instead of 50 percent,  
18 the resulting range would stretch from 5 percent to 65 percent. It is difficult to imagine the  
19 utility of such imprecise results.

20 **Even If the State Used the Right Sample Size of 68, Rather Than 60**  
21 **That is Proposed, the Low Confidence Level 90% and the Wide Range**  
22 **20 Percentage Points Will Not Produce Meaningful Information**  
23 **About Simple Proportions (Let Alone Medical Expenses).**

24 29. Mr. Boedecker is using the wrong sample size, even for simple percentage  
25 comparisons he says the survey is intended to review. His formula is the same one I use, and  
26 requires a sample size of 68, not the 60 that he proposes. Before I explain this fact, I need to first  
27 explain some important statistical terminology.

1           30.     Mr. Boedecker said in his first declaration that for the State survey, he was using  
2 a sample design with a 90% confidence level (also called “confidence interval”) and a “margin  
3 of error” (also called “level of precision”) of “+/-10%.” Boedecker Dec. [8/16/11] ¶9.

4           31.     I explained in my first declaration (¶19) that even for a simple proportion  
5 comparison (which is something like proportions of males and females in an occupation, not  
6 something like determining the *amounts* of expenditures for the class) that the sample size would  
7 need to be much greater than 60.

8           32.     Mr. Boedecker states in ¶7 of his reply declaration that my “statement that the  
9 size of an attribute sample must be over 250 persons in order to achieve a 90% confidence  
10 interval with a margin of error +/-10% is simply incorrect.” He states that using “the formula for  
11 a simple random sample and plugging in the values suggested by Professor Long yields a +/-  
12 5.2% precision level.” *Id.*

13           33.     Mr. Boedecker and I are really using the same mathematical formula, which is set  
14 forth in paragraph 8 of his 8/24/11 reply declaration. The difference is linguistic, whether the  
15 “+/-10%” margin of error is being used by Mr. Boedecker in a “relative” sense or in an “absolute”  
16 sense. His usage of these terms is contrary to normal practice. The general practice in statistics is  
17 that when an “absolute” sense is meant, the expression is “+/-10 percentage points,” while if a  
18 “relative” sense is meant, it is left as simply “+/- 10%.” -- the expression used by Mr. Boedecker.  
19 Mr. Boedecker did not specify “percentage points,” but used simply “10%,” and stated that he  
20 intended to determine the class’s loss, which is measured in dollars.

21           34.     There is a major difference in these terms. A margin of error of +/-10% when  
22 used in an “absolute” sense, that is as “percentage points,” means that one takes the sample mean  
23 (*e.g.*, 50%) and adds and subtracts 10 percentage points, which establishes the range. This is  
24 often used in political polling, *e.g.*, the poll finds that candidate A is at 48% and candidate B is at  
25 52%, with a margin of error of 3 percentage points (3%), which means that A, at 48%, is within  
26 the range of 45 to 51%, while B, at 52%, is within the range of 49 to 55% (the total range is 6  
27

1 percentage points [6%]). Note that to use a margin of error in this fashion, one's original sample  
2 value must itself be measured as a percentage.

3 35. A margin of error of +/-10% when used in a "relative" sense means that you take  
4 the sample mean, multiply it by 10% and then add and subtract that number to find the range.  
5 For example, if the median is \$50, that number is multiplied by 10%, which equals \$5, and the  
6 \$5 is then added and subtracted for the range, i.e. \$45 to \$55. The relative sense of the term  
7 "+/-10%" is definitively required when one is measuring dollars, as Mr. Boedecker said he was.

8 36. Mr. Boedecker has now clarified that he meant plus or minus 10 percentage points  
9 and that the survey cannot be used to estimate the dollar loss for the class. Applying Mr.  
10 Boedecker's clarification and using Mr. Boedecker's formula (the same formula I used),  
11 assuming the true proportion is 50/50 (as he and I both do), using his 90% confidence interval  
12 and applying his clarification that he means +/-10% in the absolute sense (percentage points)  
13 yields the following sample size for estimating percentages which he says he is proposing:

14 For a range of 20 percentage points (*i.e.*, when the mean is 50 percent or half, it could be  
15 anywhere from 40 to 60 % with +/-10 percentage points) the minimum sample size needed is 68,  
16 not 60 as he proposes.

17 37. Thus, even with Mr. Boedecker's clarification, his sample size of 60 is still too  
18 small even to make a simple proportion or binary percentage comparison that he says he  
19 proposes. Moreover, a range of 20 percentage points (+/-10 percentage points) is far too wide a  
20 range to provide meaningful information and certainly would normally never be used for  
21 scientific purposes, nor can it be meaningful "to a reasonable degree of scientific certainty," as  
22 Mr. Boedecker said he intends. Boedecker Dec. [8/16/11], ¶11. To be meaningful the range of  
23 error certainly must be lower than 20 percentage points. (In addition, as discussed below at  
24 ¶¶40-41, the level of confidence should also be higher.)

25 38. Again, using Mr. Boedecker's formula and his clarification yields the following  
26 sample sizes for lower ranges of error in a binary or proportion comparison:



1           43.     Mr. Boedecker thus did not use either 2 or 3 standard deviations in his formula. If  
2 he had, he would have needed to select at least a 95% confidence interval and have plugged  
3 (Boedecker Dec. ¶8(b)) in 1.96 or 2 into his formula. Had he done so, Mr. Boedecker would  
4 have found he needed a sample size of 96 (if 1.96) or 100 (if used 2.0). Even increasing his  
5 sample size to 96 or 100, he is still left with his very low level of precision of estimate (+/- 10  
6 percentage points) unchanged, leaving a wide error range of 20 percentage points. This means  
7 even if there were no sources of nonsampling error and variability, one still does not have a very  
8 good idea of what the actual proportion in the class is, and in a discrimination context it would  
9 be harder to rule out the observed differences in proportion from a chance occurrence. To also  
10 increase the level of precision to even a fairly wide +/- 5% margin of error (range of 10  
11 percentage points) and have a 95% confidence level, then the sample size needed would be 384.  
12 And, of course, this is still restricting the sample's use to the limited purpose of estimating does  
13 something binary occur or not, not how *large* a difference is it, or what the medical expenses for  
14 the class were, which would require an even much larger sample size because medical  
15 expenditures have, as Mr. Boedecker agrees (Boedecker Dec. ¶ 6, ¶9(a)), much wider variability.

16           44.     Mr. Boedecker also did not address the grave nonsampling errors that are present  
17 in the State's proposed survey (Long Dec., ¶¶4-15). The State's initial proposed survey  
18 questions were replete with the problems that give rise to large nonsampling errors and the  
19 revised questionnaire does not solve these problems. Thus, even if Mr. Boedecker were right  
20 that a sample size of 60 was adequate, the survey would not achieve anything close to the 90%  
21 confidence level with a 10% margin of error (range at 20 percentage points) because of these  
22 additional substantial nonsampling errors.

23           45.     Thus, the State's proposed sample of 60 class members is far too small even for  
24 meaningfully estimating proportions (assuming the State was actually asking proportion  
25 questions), and it is also far too small to estimate the monetary loss for the class as a whole, so  
26 that the loss found by the survey could be compared to the approach stated by David Wilson in  
27

1 pages 4 through 7 of his declaration (which is what the State said the survey is intended to  
2 achieve).

3 46. Moreover, Mr. Boedecker stated in his 8/24/11 reply declaration, ¶9(c) that the  
4 stratification of the sample he proposes is “to ensure a proportional allocation across agencies  
5 which would not be guaranteed by a simple random sampling approach.” But the formula Mr.  
6 Boedecker used for estimating sample size is based upon using a simple random sample. And  
7 what Mr. Boedecker fails to acknowledge is that what he proposes to do could achieve even less  
8 accurate results than a simple random sample and that this depends upon all of the specifics of  
9 how he is forming his strata, selecting his sample from them, and how characteristics vary  
10 among these strata. We are left in the dark about these important matters since all he says is that  
11 he is basing selection of class members for the sample in part on undefined strata and unstated  
12 attributes

13 **The State’s Survey Does Not Comply With**  
14 **the Requirements For Conducting Survey Research With Human Subjects**

15 47. The State’s survey does not comply with the requirements for survey research  
16 conducted with human subjects. But before I explain this, I first need to provide some  
17 background about these ethical standards required for research that involvs human subjects.  
18 These requirements grew out of public concern generated by troubling reports documenting  
19 many incidents where serious harm had occurred to individuals who participated in past  
20 scientific research. In this country, the National Research Act (Pub. L. 93-348) was signed into  
21 law on July 12, 1974. This Act created the National Commission for the Protection of Human  
22 Subjects of Biomedical and Behavioral Research to study these matters and recommend ethical  
23 principles that should guide such research in the future. This along with public concern led to  
24 the adoption of rules, many codified and required by law, designed to protect human subjects in  
25 scientific research. Researchers *must ensure* that the welfare of human subjects participating in  
26 their research is protected. A basic tenet of these required protections is that “informed consent”  
27 must be obtained before any individual participates in such research.

48. Under these standards, the individuals who are being surveyed must be told the

1 purpose of the survey, who is conducting the survey, how their answers will be used, who will  
2 have access to their answers, whether they can personally benefit from answering, and whether  
3 they can be harmed in any way if they answer or don't answer. The essence of these  
4 requirements is that sufficient information must be provided in a neutral way so that the subject  
5 can give his or her informed consent prior to participating in the survey, including the proposed  
6 use(s) of the information provided and the access that may be provided to this information to  
7 others or the public more generally.

8         49. My understanding is that class members from whom the survey sample of 60  
9 individuals is to be drawn have received no notices or other information about the case. The  
10 proposed questionnaire does not inform the individuals selected for the sample adequate  
11 information about the case so that they can reasonably answer the questions (as a party could,  
12 with legal advice), and certainly not enough information to allow informed consent. For  
13 example, the State does not tell the selected individuals why they were selected, whether they  
14 will benefit from participating in the survey, whether they can be harmed by participating in the  
15 survey, how their answers will be used, who will have access to their answers, what they should  
16 do if they cannot answer the questions (*e.g.*, should they estimate, should they not answer the  
17 question, not respond to the survey, etc.).

18         50. The concern over protections afforded survey respondents is particularly  
19 heightened here since the State is seeking highly personal and private information that  
20 individuals would not normally disclose to the public, *i.e.*, what medical treatments the  
21 individual received in particular months, how much those treatments cost, how much the  
22 individual spent for health insurance in particular months, which health insurance company or  
23 plan the individual had, the name of the health care providers who provided the health services,  
24 and more.

25         51. Thus, the State's proposed survey does not comply with the basic requirements  
26 for survey research involving human subjects.

1                   **The State's Survey Will Not Provide Information that Is Meaningful**  
2                   **Beyond What Is Already Known and Agreed to By the Plaintiffs.**

3           52.     As indicated in my first declaration, the State is quite vague about what attributes  
4 it purposes to measure. But from my view of the State's questions and leaving aside that sample  
5 size of 60 is too low, with a low 90% confidence level and with a very wide 20 percentage point  
6 range of error, and all the substantial additional sources of nonsampling error, the only  
7 information that the State could conceivably obtain from the survey is that some class members  
8 purchased insurance in some months and some did not, and some class members had out-of-  
9 pocket costs for medical expenses for some months and some did not. Because the sample size  
10 is so small (even if the correct sample size of 68 were used), the confidence level is low 90% and  
11 the percentage range of error is so wide – 20 percentage points – the survey information will not  
12 be meaningful even to estimate the percentage of the class that had these expenses. Moreover,  
13 when one factors in the fact that some or many individuals will not respond, the survey  
14 information becomes even more meaningless, as I explained in ¶¶22-28.

15           53.     Thus the survey information could not provide the State with any meaningful  
16 information beyond what I understand the plaintiffs have provided in their discovery answers  
17 and what the plaintiffs agree, namely that some employees bought insurance in some months and  
18 some class members did not in some months and some class members had medical expenditures  
19 in some months and some did not in some months.

20                   **The State's Existing Data of Comparable Employees Provide the Best**  
21                   **and Most Accurate Way to Determine the Loss for the Class.**

22           54.     Because the many limitations of survey data, some of which are described above,  
23 statisticians and scientists turn to surveys not as their first resort, but their last. That is, surveys  
24 are used *only* when other approaches for gaining the information needed are unavailable (or too  
25 costly to utilize). The best source of information of what has occurred is the original data  
26 recording these events.

27           55.     As David Wilson explained, records were maintained of the actual medical  
expenditures of State employees who were properly enrolled in the State's plans during these

1 years. Moreover, this information has already been analyzed and, as he explained, it determined  
2 the monthly amount that the employing State agency must pay HCA for the employee's health  
3 insurance for each month in a year to cover those employees' actual health care expenditures.  
4 Clearly then, these premiums encapsulate the detailed actual record of these those medical  
5 expenses. A scientist would certainly never conduct a sample survey to try to estimate these  
6 actual medical expenditures, he or she would utilize these actual records – encapsulated in the  
7 monthly premiums paid – to cover those expenditures.

8         56. The State is also the employer of the class members. The only difference is that  
9 the State failed to enroll some employees, the class members, and make the required monthly  
10 payments on their behalf for insurance. Because both groups are large, the actual expenditures  
11 for the group of covered employees at the same time is the best information available to estimate  
12 the class members' actual medical expenses. A scientist would not substitute the faulty memory  
13 and undoubtedly incomplete records about medical expenses of a small sample of the class  
14 members for the much more accurate record provided of actual medical expenditures for *all*  
15 enrolled State employees.

16         57. Thus, the monetary relief for the class of employees as a whole can be easily  
17 calculated by determining the number of eligible months for each class member for each year  
18 and multiplying that by the dollar amount that the State should have paid for health care (minus  
19 the costs of administration) for that month for that year. The total of those monthly amounts  
20 equals the actual medical expenditures for the class as a group, *i.e.*, the monetary loss to the class  
21 as a whole. This monetary loss for the class as a group flows directly from the determination  
22 that the State failed in its duty to enroll the class members and to make payments on their behalf  
23 for health insurance. This monetary amount equals the class' total actual losses. I understand  
24 that the actual distribution procedure or formula for individual class members could be different  
25 than the monthly amounts for each individual to allow for individuals to obtain more or less than  
26 the average amount where appropriate.

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

3 DATED: September 14, 2011, in Bellevue, Washington.

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SUSAN B. LONG

# ATTACHMENT

**STATE OF WASHINGTON  
KING COUNTY SUPERIOR COURT**

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

Plaintiffs,

v.

HEALTH CARE AUTHORITY, STATE  
OF WASHINGTON,

Defendants.

NO. 06-2-21115-4 SEA

QUESTIONNAIRE TO POTENTIAL  
CLASS MEMBERS

Certain employees of the State of Washington are eligible for health insurance through the State. This insurance is provided to eligible employees through the Public Employees Benefits Board (PEBB).

You have been identified as a potential class member in this lawsuit, which alleges that the State of Washington improperly failed to provide PEBB health insurance to certain workers with non-traditional work schedules. The King County Superior Court has authorized the submission of this questionnaire to you.

An analysis shows that you may have been entitled to PEBB health insurance during the following month(s): \_\_\_\_\_.

The questions below relate solely to this month(s).

The State of Washington asks that you fully complete the questionnaire, sign it, and then return it in the self-addressed stamped envelope included herewith.

Name: \_\_\_\_\_

1. For some or all of the month(s) listed above, please state whether you (check all that apply):

- Self-paid the entire premium to maintain health insurance coverage under a PEBB insurance plan;
- Used some form of paid leave (e.g., vacation, sick leave, etc.) to maintain your PEBB health insurance;
- Obtained health insurance through another source;
- Did not have health insurance.

2. If you had health insurance during some or all of the above listed month(s) from a source other than a PEBB plan, please state:

(a) The month(s) in which you had insurance from a source other than a PEBB plan:

\_\_\_\_\_

(b) The name of the insurance company or insurance plan:

\_\_\_\_\_

(b) Whether you were the subscriber of that plan, or a dependent of another person who was the subscriber on the plan: \_\_\_\_\_

(c) The dollar amount of the monthly premium that you paid for your coverage:

\_\_\_\_\_

3. If you did not have any insurance from any source during some or all of the above-listed month(s), which PEBB health insurance plan would you have selected if you had the opportunity to do so at that time?

\_\_\_\_\_

Name: \_\_\_\_\_

4. Would you have waived PEBB health care coverage during the above-listed months if you had been offered the opportunity to enroll in such coverage? (Y/N)

\_\_\_\_\_.

5. If you had no health insurance through any source during some or all of the above-listed month(s), please state:

(a) Whether you received any health care services (Y/N): \_\_\_\_\_

(b) The dollar amount you paid for those services: \_\_\_\_\_.

(c) The health care services you received (general description):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ ; and

(d) The name of the health care provider(s) or institution(s) that provided those services to you: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_.