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NO. 69661-1

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

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

Respondents,

v.

STATE OF WASHINGTON and HEALTH CARE AUTHORITY,

Appellants.

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I. INTRODUCTION

This appeal presents the issue of what is the proper measure of damages where an employer fails to provide eligible employees with the opportunity to enroll in employer-sponsored health care. Plaintiffs brought this action for monetary relief under Civil Rule 23(b)(3) on behalf of a class of part-time state employees who claim that the State improperly denied them the opportunity to enroll in a Public Employees Benefits Board (“PEBB”) health insurance plan. Plaintiffs’ only remaining claim in this case is for monetary damages caused by the State’s failure to provide class members the opportunity to enroll in various health insurance plans, and thus the proper methodology for determining damages is a critically-important issue.

The proper measure of damages for a failure to provide health insurance benefits is straightforward: it is the actual monetary damages incurred by the employee, such as the out-of-pocket expenses the employee incurred in purchasing substitute health insurance, or the cost of medical services that would have been covered by PEBB insurance during the time he or she was eligible for, but denied the opportunity to acquire benefits. The trial court, however, rejected the out-of-pocket measure of determining actual damages, and instead accepted a “proxy” championed by the Plaintiffs, whereby the class damages would be determined by

multiplying the unpaid monthly insurance premiums by the total number of months class members were eligible for but not offered health insurance.

The “out-of-pocket” measure of damages is consistent with a stipulation by the parties in this case and the trial court’s order on that stipulation, finding that some class members suffered no monetary damages because they neither purchased substitute insurance nor medical services during the months they were eligible for but not enrolled in PEBB health care. The out-of-pocket measure of damage ensures that class members who did suffer damages will be compensated for what they spent for substitute insurance or health care, while also ensuring that class members who did not incur any such expenses (because, for example, they were healthy) do not receive a windfall unrelated to any actual loss.

The out-of-pocket measure of damages also comports with this Court’s decision in *Sitton v. State Farm Mut. Auto. Ins. Co.*, 116 Wn. App. 245, 63 P.3d 198 (2003), and due process because it requires each class member to prove that he or she suffered an actual monetary loss caused by the State. It also protects the State’s due process right to defend this action by challenging individual class members’ claims of monetary damages.

Finally, although there are no Washington cases directly on point, the out-of-pocket measure of damages is consistent with the substantial majority of other jurisdictions that have addressed this issue, as well as analogous Washington cases involving the failure to provide insurance in other contexts. These cases all hold that the measure of loss for the failure to provide insurance is the actual loss incurred such as any out-of-pocket expenses incurred in procuring substitute insurance or paying medical costs that otherwise would have been covered.

By rejecting the out-of-pocket measure of damage and instead adopting Plaintiffs' "premiums-based" proxy in lieu of requiring actual damages, the trial court committed reversible error for two primary reasons. First, the Plaintiffs' premiums-based measure of damage cannot be squared with the parties' stipulation and the subsequent finding by the trial court that not all class members actually suffered monetary damage, because some class members did not purchase substitute insurance or have to pay out-of-pocket for medical services.¹ A premiums-based measure of damage would improperly award each class member monetary damage for the number of months he or she was without coverage, even though a significant portion of the class is known to have suffered no actual

¹ The evidence is that more than 50 percent of the class here was without health insurance for only a short period of time – 60 days or less. *See, e.g.*, CP 489.

monetary loss. As to those class members, any monetary recovery would be a windfall.

Second, the premiums-based measure of damage runs afoul of *Sitton* and violates the State's due process rights. The methodology presumes – again contrary to the parties' stipulation and the trial court's finding based on it – that all class members suffered monetary damages equal to the employer portion of the monthly premium. This presumption does away with Plaintiffs' obligation to prove both causation and the fact of damage for each class member and allows them to “skip over” these required elements of their case, contrary to settled class action law. It also precludes the State from defending the claims of the class by identifying those class members who, it is undisputed, suffered no monetary damages.

This Court should reverse the trial court's ruling on the measure of damages and remand the matter to the trial court to require Plaintiffs to establish both the fact of actual damage for each class member and the amount of that damage, caused by the State's denial of the opportunity to obtain health insurance. The trial court should establish a claims process where an individual class member may demonstrate his or her out-of-pocket costs during the periods that he or she was denied the opportunity to acquire benefits. An individualized claims process (or similar

approach) is the only method of determining damages under the unusual circumstances of this case that protects the State's due process rights.

II. ASSIGNMENTS OF ERROR

1. The trial court erred in ruling that the measure of damage for failure to offer class members the opportunity to enroll in employer-sponsored health care is not the actual monetary loss incurred by the employee in purchasing substitute health insurance or medical services during the time he or she was eligible for, but denied the opportunity to obtain employer-sponsored health care insurance.

2. The trial court erred in accepting the Plaintiffs' proposed measure of damages using as a proxy for actual monetary damages the amount of monthly premiums the State would have paid to third parties to provide health insurance to each class member for each month the class member was denied the opportunity to obtain coverage.

III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. Whether the proper measure of monetary damages for an employer's failure to provide an employee with the opportunity to enroll in employer-sponsored health care is the out-of-pocket expense, if any, the employee incurred because he or she was without insurance, such as the cost of purchasing substitute insurance or medical services.

2. Whether a “premiums-based” measure of damages is improper because it presumes the fact that each class member actually suffered monetary damage and allows the class to “skip over” individualized proof of the fact of damage, in a case where the parties have stipulated and the trial court has found that some class members suffered no monetary damages, thus violating due process and conflicting with the great weight of authority.

IV. STATEMENT OF THE CASE

Background. The State’s Health Care Authority (“HCA”), provides the opportunity for eligible employees of state agencies and higher-education institutions to obtain health care insurance through the Public Employees Benefit Board (“PEBB”).² State agencies screen employees for eligibility and, if eligible, employees have the right to enroll in one of the health care plans the HCA makes available through the PEBB. The employing agency pays most of the monthly premium for an enrolled employee, with the employee paying the remainder.

PEBB coverage is available not just to full-time state employees, but also to certain part-time employees who work sufficient hours to qualify for benefits. Plaintiffs are a class of these part-time employees

² The HCA contracts with various insurance carriers to offer insurance benefits to eligible employees. The HCA also contracts with third-party administrators to provide health care related administrative services under the State’s self-employed Uniform Medical Plan.

who were not offered the opportunity to enroll for PEBB health care benefits.

Summary Judgment Rulings. The trial court certified Plaintiffs' claims for injunctive and declaratory relief under CR 23(b)(1)(A) and (b)(2).³ Subsequently, in a series of summary judgment rulings not subject to this appeal, the trial court ruled that the State had incorrectly interpreted an eligibility rule for health insurance. Had the State properly interpreted and applied this rule, the State would have offered class members health insurance through one of the various plans offered by the PEBB. The class members would have received health insurance provided they did not waive coverage (as some employees do) and agreed to pay the employee share of the premium.⁴

The Legislature effectively codified the trial court's holdings in 2009. *See* Laws of 2009, ch. 537. As a result, Plaintiffs have received the equitable and declaratory relief they sought. The only claim remaining in the case is for monetary damages under CR 23(b)(3) for the State's failure to offer class members the opportunity to acquire PEBB health insurance.

The Parties' Stipulation and Trial Court's Finding. In September 2011, the parties entered into a stipulation stating that not all

³ CP 14-18.

⁴ The parties are working to identify eligible class members and the number of months each class member was not provided the opportunity to acquire PEBB health insurance.

class members suffered monetary damages as a result of the State's failure to properly interpret and apply the eligibility rules.⁵ Based on the parties' stipulation, the trial court expressly found that during the period the class members were eligible for but did not receive the opportunity to acquire health insurance, some class members did not purchase substitute insurance and some did not incur any medical expenses.⁶ The stipulation – a copy of which is attached as an Appendix – provides, in part:

2. During the month(s) each person meeting the class definition appears to have been eligible for PEBB health insurance, but did not receive that, each person did one of the following:

- a. Self-paid the entire premium to maintain PEBB benefits;
- b. Obtained health insurance through another source; or
- c. Did not have health insurance.

3. For those persons meeting the class definition who did not have any health insurance during a month(s) in which he or she appears to have been eligible for PEBB health insurance, the following are true:

⁵ CP 47-50 (attached as Appendix). The stipulation resolved a discovery dispute over whether the State could take the depositions of a sample of class members to learn about their health care expenditures, if any. See CP 48 ("The Defendants agree to forego a survey of persons meeting the class definition regarding their damages."). The stipulation established what the State sought to determine from the sample – that some class members had no actual monetary damages during the relevant time period.

⁶ CP 49-50.

- a. Some persons incurred no health care costs because those class members did not receive any health care services;
- b. Some persons incurred health care costs, but those costs would not have been covered by any PEBB health insurance plan.⁷

The record reflects that a substantial portion of the class was actually eligible for but denied the opportunity to obtain health insurance only for a short period (60 days or less) and those class members would not be expected to have incurred any health care costs during that time.⁸ Moreover, even for those class members who did incur health care expenses, some costs would not have been covered by PEBB insurance. In other instances, employees would have waived coverage to avoid paying the employee part of the premium or because they had coverage from some other source.

Certification for Damages. In late 2011, Plaintiffs moved to certify the issue of damages and expressed their intent to use a “proxy” instead of proving actual damages: the employer portion of the monthly insurance premium multiplied by the total number of months the class was without coverage. The trial court certified Plaintiffs’ damage claims under

⁷ CP 47-50.

⁸ *See, e.g.*, CP 489.

CR 23(b)(3) over the State's objection.⁹ The combination of the trial court's decision to certify the class for damages and the parties' stipulation and the trial court's finding that not all class members suffered any actual monetary damages, resulted in this anomalous fact: the CR 23(b)(3) class, which seeks only monetary damages, undeniably contains some members who have suffered no actual monetary loss. The parties do not know how large a portion of the class this group is, but because more than half of the class was without insurance for 60 days or less, the State believes the portion of the class who suffered no monetary damage is significant.¹⁰

Fact of Damage and Measure of Damages. In September 2012, the parties filed cross-motions regarding proof of the fact of damage and the proper measure of damages for Plaintiffs' claim.¹¹ In its motion, the State argued for a measure of damages focusing on the actual loss incurred by individual class members, if any, during the month(s) each was eligible for but not provided the opportunity to obtain PEBB insurance. Such loss could be the amount paid to purchase substitute insurance or the out-of-pocket cost of medical services.¹² In support of this measure of damages, the State relied on the only direct evidence in this case regarding class

⁹ CP 53-54.

¹⁰ CP 479, 489-91; RP (10/26/12) 23-24.

¹¹ *See, e.g.*, CP 58-124.

¹² CP 70-75.

members' monetary damages (or the lack thereof) – the court's finding, based on the parties' stipulation, that some portion of the class incurred no monetary loss.¹³

In addition to being consistent with the stipulation and the court's order based on the stipulation, the State noted that requiring Plaintiffs to prove out-of-pocket losses is required under *Sitton* and its due process rationale.¹⁴ The State also argued that an actual damages approach was consistent with the substantial majority of other jurisdictions which have adopted the out-of-pocket measure of damage for failure to provide employee benefits.¹⁵ The State also explained the approach was consistent with analogous Washington cases, including *Frank Coluccio Constr. Co., Inc. v. King County*, 136 Wn. App. 751, 150 P.3d 1147 (2007), in which this Court held that the measure of damage for the failure to procure insurance is the amount of any covered loss that occurs.¹⁶

Plaintiffs argued that the trial court should apply the premiums-based measure of damage because it would be administratively more convenient than requiring proof of actual damages.¹⁷ Under that

¹³ CP 478; RP (10/26/12) 22-25.

¹⁴ CP 66-70; 480; RP (10/26/12) 20-22.

¹⁵ CP 59, 70-72; RP (10/26/12) 27-28.

¹⁶ *See, e.g.*, CP 480; RP (10/26/12) 28.

¹⁷ CP 141-42.

methodology, Plaintiffs would multiply the monthly premium the State should have paid to a third party insurer to cover each class member by the number of months each class member was eligible for PEBB insurance but not provided the opportunity to enroll for that insurance.¹⁸

The trial court rejected the State's argument that presuming the fact of damage from class membership violates the State's due process rights as recognized by this Court in *Sitton*.¹⁹ The trial court apparently assumed that all class members must have suffered "impacts" in the form of "deferred health care."²⁰ The court did not address the fact that a presumption of damage by each class member runs directly contrary to the parties' stipulation and the trial court's order that some class members incurred no monetary loss.

In adopting Plaintiffs' proposed measure of damages and rejecting the State's position, the court relied on *Cockle v. Department of Labor & Indus.*, 142 Wn.2d 801, 16 P.3d 583 (2001), a case involving workers compensation in which, for the purpose of determining "time loss"

¹⁸ CP 134.

¹⁹ RP (10/26/12) 40.

²⁰ CP 590-91. Although the exact reasons for the trial court's decision are unstated, the court commented that class members may have deferred health care because persons without health insurance defer medical treatment, and that fact was commonly known through "the public and media discussion of the Affordable Care Act and studies that are public knowledge." CP 590-91.

benefits, the parties had stipulated that the value of the health insurance is the amount of the premium.²¹

On November 5, 2012, the trial court entered a written order on the fact of damage and the proper methodology for measuring damages.²² That order reflects the court's oral rulings, incorporating the hearing transcript.²³ The State timely filed and moved for discretionary review of the trial court's order.²⁴

Grant of Discretionary Review. On March 18, 2013, the Commissioner of this Court granted the State's motion for discretionary review.²⁵ The Commissioner ruled that the trial court's Order constituted probable error because it presumed the fact of damage for all class members, relieved Plaintiffs of the burden to show actual monetary damages for each class member, and precluded the State from defending on the basis that some class members had no actual monetary damage.²⁶

²¹ *See, e.g.*, RP (10/26/12) 43.

²² CP 588-93.

²³ CP 592.

²⁴ CP 598-606; Motion for Discretionary Review (filed December 20, 2012).

²⁵ Order Granting Discretionary Review of March 18, 2013 (contained in letter from Richard Johnson, Court Administrator of March 18, 2013).

²⁶ Order Granting Discretionary Review of March 18, 2013.

V. ARGUMENT²⁷

A. **The Proper Measure of Damages for an Employer's Failure to Provide an Eligible Employee the Opportunity to Enroll for Health Care Benefits is the Employee's Actual Out-of-Pocket Loss.**

Out-of-pocket loss is the only measure of damage in this case that can be squared with the parties' stipulation (and the trial court's finding) on the absence of actual monetary damage for some class members; the *Sitton* decision and its due process requirements; analogous cases from Washington; and on-point cases from other jurisdictions. The trial court's rejection of this measure of damages constitutes reversible error.

1. **An Out-of-Pocket Measure is Consistent With the Parties' Stipulation and Trial Court Order that Some Class Members Incurred No Monetary Damages.**

Based on the parties' stipulation, the trial court found and entered an order stating that some portion of the class did not incur monetary loss because these class members did not buy substitute insurance and/or did not pay for any medical services that would have been covered by a PEBB plan. The evidence is that the portion of the class who suffered no monetary damages is significant. Over fifty percent of the class was

²⁷ The appropriate methodology for measuring damages is a question of law that this Court reviews *de novo*. See *Shoemake v. Ferrer*, 168 Wn.2d 193, 198, 225 P.3d 990 (2010). Furthermore, Plaintiffs do not challenge (nor could they) the trial court's findings based on the parties' stipulation that some class members suffered no actual monetary damages during the relevant period. Such findings are considered verities on appeal. See *McCleary v. State*, 173 Wn.2d 477, 514, 269 P.3d 227 (2012).

ineligible for benefits for only one or two months.²⁸ The evidence was that it is less likely that this group needed PEBB-covered services than a group that was without benefits for a longer period.²⁹

This case therefore is unique in that the undeniable evidence is that the class contains members with no monetary damages. Only if an actual out-of-pocket measure of damages is adopted can the parties pay damages to those class members who actually suffered monetary damage, while allowing the State to defend against the claims of those who did not.

2. An Out-Of-Pocket Measure is Consistent With *Sitton* and Due Process.

Plaintiffs bear the burden of proving all of the elements of their claim, including causation and the fact of damages. This is just as true in a class action as in an individual claim. 1 JOSEPH M. McLAUGHLIN, McLAUGHLIN ON CLASS ACTIONS: LAW & PRACTICE § 5:23, at 1236-37 (9th ed. 2012). This due process requirement forms the basis of this Court's decision in *Sitton*. The premiums-based damages methodology accepted by the trial court bases damages solely on class membership and

²⁸ CP 489-91.

²⁹ CP 307, 491.

allows the Plaintiffs to “skip over” proving the fact of damages for each class member, contrary to *Sitton* and settled class action law.³⁰

The use of a class action cannot impair any of a defendant’s substantive rights, including the obligation for class members “to prove the same elements for each cause of action as they would in any individual trial.” 1 MCLAUGHLIN, *supra*, § 5:23, at 1236-37; *see Wal-Mart Stores, Inc. v. Dukes*, ___ U.S. ___, 131 S. Ct. 2541, 2561, 180 L. Ed. 2d 374 (2011) (Rule 23 not intended to ‘abridge, enlarge or modify any substantive right’ . . .”). Plaintiffs must prove both “the fact of injury and the amount of damages due to individual class members . . .” 1 MCLAUGHLIN, *supra*, § 4.19 at 731; *Lewis River Golf, Inc. v. O.M. Scott & Sons*, 120 Wn.2d 712, 717, 845 P.2d 987 (1993).

As a result, proving the fact of damage may require individualized treatment to protect a defendant’s due process rights in contrast to an approach that assumes the fact of damage:

After factoring out common elements of individual issues in a class action, irreducible separate questions may remain which must be adjudicated before the controversy is resolved in the absence of settlement. Class members may need to prove, on an individual basis, certain aspects of proximate cause or fact of damage and the amount of

³⁰ When, as here, the class already has received injunctive and declaratory relief, the class’s claims under CR 23(b)(3) are limited to seeking monetary damages. *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2558, 180 L. Ed. 2d 374 (2011) (“Given that structure, we think it clear that individualized monetary claims belong in Rule 23(b)(3).”).

individual losses or damages suffered, and the defendants may have unique defenses. . . .

3 ALBA CONTE & HERBERT NEWBERG, NEWBERG ON CLASS ACTIONS § 9:63 at 451-52 (4th ed. 2002) (emphasis added); *see also McLaughlin v. American Tobacco Co.*, 522 F.3d 215, 231 (2nd Cir. 2008) (“Roughly estimating the gross damages to the class as a whole and only subsequently allowing for the processing of individual claims would inevitably alter defendants’ substantive right to pay damages reflective of their actual liability.”).

These precepts that a class action does not alter the elements that a plaintiff must prove nor deprive the defendant of any substantive right form the foundation of this Court’s decision in *Sitton*. 116 Wn. App. 245. In *Sitton*, also a class action, this Court vacated a trial plan much like that adopted by the trial court here, in which Plaintiffs would rely on aggregate damages without proof of individual causation, and the State would be denied its due process right to defend on the absence of injury.

Sitton involved claims by insureds that State Farm engaged in bad faith by using a medical review program to improperly deny personal injury protection (“PIP”) benefits to insurance claimants. *Id.* at 249. The trial court adopted a trial plan bifurcating the proceedings into two phases. The first phase was to determine whether State Farm designed the medical

review program to deny or eliminate PIP claims; whether State Farm acted in bad faith; whether the medical review program caused harm to class members; and the amount of “aggregate class damages.” The second phase was to determine “the amount of each class member’s individual bad faith damages on an individually litigated basis depending on the amount of each class member’s asserted bad faith damages.” *Id.* at 257-58.

This Court vacated the trial plan because “it contemplates an award of damages without requiring plaintiffs to prove individual causation and without permitting State Farm to advance its defenses.” *Id.* at 258. The Court reasoned:

The central contention here is that State Farm acted in bad faith to deny PIP benefits to its insureds. The harm alleged is individual to each insured. Yet the trial plan contemplates class-wide damages (“aggregate damages”), which plaintiffs define as “the difference between PIP claims made and those paid by State Farm.” Plaintiffs contend such aggregate damages should be automatically awarded if the jury finds in Phase 1 that State Farm acted in bad faith. As Commissioner Verellen stated in granting discretionary review: “The plaintiffs’ faulty syllogism is that, because a bad faith program was intended to limit claims and resulted in the limitation of claims, the full amount of every claim made is valid.”

Id. Significantly, this Court in *Sitton* held that the main problem with the trial plan was that it permitted a damages award “without requiring individual claimants to establish causation and damages or providing State

Farm the opportunity to show it had a reasonable justification for denying individual claims.”³¹ *Id.* at 258 (emphasis added).

The lesson of *Sitton* is clear that a class action trial plan, including the measure of damage, must place the burden of proof as to all elements and as to all class members on the plaintiff. The plaintiff must prove causation and the fact of damage as to all class members. In addition, the defendant must be allowed to challenge any element, including causation and the fact of loss, as to any individual class member. Only by requiring plaintiffs to prove their actual out of pocket damages can these requirements be met.³²

³¹ This Court in *Sitton* stated that the trial court had a variety of tools to efficiently manage the class action, despite the need to prove damage and causation as to each class member:

As illustrative examples, the court can make use of special masters to preside over individual causation and damages proceedings. So long as State Farm retained the right to dispute the master's findings and request a jury determination, State Farm's right to a jury trial is not compromised. Or the court could certify subclasses in each county where class members reside, or even decertify the class altogether after the bad faith phase, and give notice to class members concerning how to proceed on individual damage claims.

Id. at 259-60.

³² In prior briefing, Plaintiffs relied upon *Moeller v. Farmers Ins. Co. of Wash.*, 173 Wn.2d 264, 267 P.3d 998 (2011). There, the Court rejected the defendant insurer's contention that class certification impaired the insurer's due process rights. But as the Court recognized in *Moeller*, that case was distinguishable from *Sitton* because the issue there was whether the trial court properly certified the class under CR 23(b)(3) and not, as in *Sitton*, whether the trial court's damage methodology relieved the plaintiffs of the burden to prove the fact of damage to each class member. Moreover, unlike *Sitton* (and this case) the defendant in *Moeller* was able to present its defenses to individual claims, and to defend the nature and extent of damages. *Moeller*, 173 Wn.2d at 280.

The United States Supreme Court recently confirmed the due process rights of a class action defendant in circumstances such as those presented here, in *Wal-Mart*, 131 S. Ct. at 2561. In *Wal-Mart*, a class of employees claimed gender discrimination and sought back pay under Title VII. The lower court approved a trial plan in which back pay would be determined by deriving an average damage award for a sample of the class and multiplying it by the total number of “(presumptively) valid claims” – similar to what Plaintiffs proposed and the trial court accepted here.

The Supreme Court rejected this “trial by formula” because it would have resulted in a denial of the employer’s right to litigate its defenses to individual claims. *Id.* at 2561. One of those defenses is the inability of some defendants to establish the fact of damage. This Court should reverse the “trial by formula” approach that the trial court adopted because it improperly allows Plaintiffs to avoid their obligation to show that the State’s failure to offer insurance to the class members caused monetary damage to every class member.

3. A Substantial Majority of Other Jurisdictions Have Concluded that the Proper Measure of Damage for Failure to Provide Health Insurance is Out-of-Pocket Expenses.

Although Washington courts have not addressed the issue of the appropriate measure of damages for an employer’s failure to provide

health insurance benefits, a substantial majority of other jurisdictions that have considered the issue have adopted an out-of-pocket measure of loss. The recent decision in *United States v. City of New York*, 847 F. Supp. 2d 395 (E.D.N.Y. 2012)³³, is illustrative of these cases.

In *City of New York*, a large Title VII employment discrimination class action, the District Court “sid[ed] with the weight of authority and h[eld] that the City’s liability for the loss of fringe benefits [including health insurance] should be valued by expenses that the claimants actually incurred.” *Id.* at 422.

[Plaintiffs] who did not purchase substitute health insurance, contribute to the interim employer’s health insurance costs, or pay for medical care directly, did not suffer an economic loss, and should not receive damages in the amount that the liable employer would have paid out in insurance premiums. Conversely, victims who were required to do any of those things may have suffered a larger loss than would be compensated by a judgment limited to the amount the liable employer would have paid in health insurance premiums.

Id. In that case, like here, plaintiffs’ main argument for an insurance premium rule was “the greater convenience of administering such a rule in a class context.” *Id.* But as the *City of New York* court correctly noted, administrative efficiency cannot trump the fundamental principle that class

³³ *Aff’d in part & rev’d in part on other grounds*, 717 F.3d 72 (2nd Cir. 2013). The Second Circuit vacated summary judgment on the issue of disparate treatment and intentional discrimination, and narrowed the injunction. The Second Circuit left undisturbed the District Court’s holding on the measure of damages for lost insurance benefits.

members are limited to a recovery that reasonably reflects their actual monetary damages:

The court acknowledges that estimating an aggregate loss based on the City's insurance costs, and then ordering a pro rata distribution of that loss, would be administratively the simplest method of proceeding. However, that simple method would create non-trivial opportunities for over- or under-compensation, both between the City and the claimants and among the claimants themselves.

Id.

The court in *City of New York* rejected a premiums measure of damage because of the windfall it would provide to those class members who suffered no loss. The same windfall would result under the trial court ruling here, as the parties agreed (and the trial court found) that not all class members suffered monetary damage. As the court in *City of New York* explained:

Victims of discrimination who did not purchase substitute health insurance, contribute to their . . . employer's health insurance costs, or pay for medical care directly, did not suffer an economic loss, and should not receive damages in the amount that the liable employer would have paid out in insurance premiums. Conversely, victims who were required to do any of those things may have suffered a larger loss than would be compensated by a judgment limited to the amount the liable employer would have paid in health insurance premiums. Moreover, while insurance premiums are priced in an attempt to predict the collective cost of medical care of the insured group ex ante, the court is now determining an award of damages ex post and therefore has no reason to close its eyes to the expenses individuals actually incurred.

Id. (citation omitted). The court thus concluded that the damage issue was “one that cannot be resolved on a class-wide basis and must be addressed in the individual claims process.” *Id.* at 423.

The *City of New York* approach – rejecting the use of premiums and requiring proof of actual monetary damages to recover for denial of employer-paid health insurance – has been followed in the Ninth Circuit, *see Galindo v. Stoodly Co.*, 793 F.2d 1502 (9th Cir. 1986), and the Western District of Washington, *see E.E.O.C. v. Northwest Airlines, Inc.*, 1989 U.S. Dist. LEXIS 16793, 51 Fair Empl. Prac. Cas. (BNA) 1316 (W.D. Wash., Aug. 7, 1989).

In *Galindo*, involving an alleged breach of a union’s duty of fair representation in connection with plaintiff’s layoff, the Ninth Circuit rejected an award based on the value of the medical and life insurance premiums, reasoning that premiums did not represent a monetary benefit owing to the plaintiff:

Where an employee’s fringe benefits include medical and life insurance, a plaintiff should be compensated for the loss of those benefits if the plaintiff has purchased substitute insurance coverage or has incurred uninsured, out-of-pocket medical expenses for which he or she would have been reimbursed under the employer’s insurance plan. [Citations in footnote omitted.] In this case, however, the district court awarded Galindo the value of the medical and life insurance premiums that [the employer] would have paid on his behalf had his employment not been interrupted

without a showing that Galindo would have received any payments thereunder, or that he actually incurred expenses for substitute medical or life insurance coverage. Such an award was improper because lost insurance coverage, unless replaced or unless actual expenses are incurred, is simply not a monetary benefit owing to the plaintiff. To include such an award, then, would make a plaintiff more than whole.

793 F.2d at 1517 (emphasis added).

In *E.E.O.C. v. Northwest Airlines, Inc.*, the District Court for the Western District of Washington considered the measure of damages for fringe benefits (life and health insurance) recoverable by airline pilots and others as back pay under the Age Discrimination in Employment Act. The court, relying on *Galindo* and the Seventh Circuit decision in *Kossman v. Calumet County*, 800 F.2d 697 (7th Cir. 1986), held that damages should include the “amounts actually expended by a claimant to replace the coverage he would otherwise have received” from the employer. *Id.* at *42 (emphasis added). It specifically rejected Northwest Airline’s position that damages should be “what it would have cost NWA” to cover claimants. *Id.* at *43.

Appellate and district court decisions in virtually all other federal circuits have adopted the same approach. These courts include those in the First Circuit, *McMillan v. Massachusetts Soc’y for the Prevention of Cruelty to Animals*, 140 F.3d 288 (1st Cir. 1998); the Third Circuit, *Taylor*

v. *Central Pa. Drug & Alcohol Servs. Corp.*, 890 F. Supp. 360 (M.D. Pa. 1995); the Fifth Circuit, *Pearce v. Carrier Corp.*, 966 F.2d 958 (5th Cir. 1992) and *Lubke v. City of Arlington*, 455 F.3d 489 (5th Cir. 2006); the Sixth Circuit, *Hance v. Norfolk S. Ry. Co.*, 571 F.3d 511 (6th Cir. 2009); the Seventh Circuit, *Kossmann v. Calumet County*, 800 F.2d 697 (7th Cir. 1986)³⁴; and the Eleventh Circuit, *Wilson v. S&L Acquisition Co., L.P.*, 940 F.2d 1429 (11th Cir. 1991), and *Pattee v. Georgia Ports Auth.*, 512 F. Supp. 2d 1372 (S.D. Ga. 2007).

In *Kossmann*, an action by discharged deputy sheriffs against their county employer challenging a mandatory retirement age, the Seventh Circuit held that plaintiffs

must establish that in fact they incurred expenses in securing alternative insurance coverage or incurred medical expenses that would have been covered under the County's insurance program had they not been terminated in order that they might recover the cost of the insurance benefits or be reimbursed for any proper medical expenses incurred The court should include those expenditures in the backpay award that [plaintiffs] incurred if in fact they did purchase alternative coverage or in lieu thereof incurred medical expenses ordinarily covered under the County's policy.

800 F.2d at 703-04 (emphasis added). The court reasoned that including the cost of insurance coverage in a damage award when plaintiff failed to obtain alternative coverage “allows a victim to recover an unwarranted

³⁴ *Overruled on other grounds, Coston v. Plitt Theatres*, 860 F.2d 834 (7th Cir. 1988).

windfall unless he or she can demonstrate that they were unable to secure coverage and had a medical expense.” *Id.* at 703.

The Sixth Circuit, in *Hance v. Norfolk S. Ry. Co.*, noted that “the more recent cases” have awarded damages “based on actual expenses incurred by a plaintiff in securing insurance or medical care,” and adopted that approach. 571 F.3d at 522 (citations omitted). Likewise, the Fifth Circuit in *Lubke*, brought under the Family and Medical Leave Act, held:

[T]he correct measure of damages for lost insurance benefits in FMLA cases is either actual replacement cost for the insurance, or expenses actually incurred that would have been covered under a former insurance plan. The lost “value” of benefits, absent actual costs to the plaintiff, is not recoverable.

455 F.3d at 499 (emphasis in original).

In *McMillan*, a pay discrimination case, the First Circuit held that “[l]ost benefits are recoverable only if the plaintiff has offered evidence of out-of-pocket expenses for the same benefits.” 140 F.3d at 305 (citations omitted); *see also Wilson*, 940 F.2d at 1438-39 (reinstating jury findings that plaintiff in age discrimination action was entitled to recover cost of insurance coverage she purchased after she was fired).

Plaintiffs relied upon *Fariss v. Lynchburg Foundry*, 769 F.2d 958 (4th Cir. 1985), and its progeny, involving life insurance, in support of a premiums-based measure of damage. But, in addition to being an example

of the minority rule on this issue, life insurance cases are also factually distinguishable.³⁵ In *Fariss*, the court acknowledged the unique characteristics of life insurance that made an award of the premium appropriate as opposed to other measures. *Fariss*, 769 F.2d at 965.

This Court should follow the well-reasoned approach taken by *Galindo, E.E.O.C. v. Northwest Airlines, Kossman, Hance, Lubke, Pattee*, and the many other cases that have measured plaintiffs' damages for loss of a health insurance policy by actual out-of-pocket monetary losses.

4. Out-of-Pocket Expenses as the Measure of Damages Also is Consistent With Analogous Washington Precedent.

While no Washington appellate case has ruled on the appropriate measure of damages for failure to offer an employee health insurance, Washington courts generally apply an "actual damage" standard in actions in which a defendant breaches its duty to procure insurance for another. In *Frank Coluccio Constr. Co., Inc., v. King County*, 136 Wn. App. 751, 150 P.3d 1147 (2007), this Court affirmed a judgment against the County for

³⁵ In *United States of Am. v. New York*, 847 F. Supp. 2d at 422 n.10, the district court explained the distinction between life and health insurance as follows:

There is at least one relevant difference between [health insurance and life insurance]: The loss caused by a lack of health insurance is felt by the victim, who must pay medical expenses directly or buy replacement insurance, while the loss caused by the lack of life insurance is felt by the victim's beneficiary. A premium or replacement measure of value lost may thus be more logical in the life insurance context than in the health insurance context.

breach of a contractual obligation to purchase an all-risk builder's risk insurance policy, and held that damages were the losses that would have been covered if insurance had been provided.

Damages recoverable for such a breach are the full amount that would have been covered by insurance, had the breaching party performed as specified. King County, therefore, was liable for the full amount of losses that would have been covered by the all risk builder's risk policy it was obligated to purchase To recover, [plaintiff] bore the burden of proving that the losses suffered would have been covered under an all-risk builder's risk policy

Id. at 766-67 (citation omitted). The holding in *Coluccio* is consistent with similar cases in Washington involving a defendant's failure to procure insurance on behalf of another. *See, e.g., Seabed Harvesting, Inc. v. Department of Natural Res.*, 114 Wn. App. 791, 798, 60 P.3d 658 (2002) (breach of agreement to procure insurance naming Department of Natural Resources as additional insured; damages awarded in the amount of the claim that would have been insured); *U.S. Oil & Ref. Co. v. Lee & Eastes*, 104 Wn. App. 823, 841, 16 P.3d 1278 (2001) (breach of agreement to procure insurance entitles plaintiff to recover amounts that otherwise would have been covered by insurance). Plaintiffs provided no basis to diverge from these line of cases.

B. The Premiums-Based Measure of Damage Adopted by the Trial Court Must Be Rejected.

1. The Premiums-Based Measure of Damage is Contrary to the Damage Evidence and the State's Due Process Rights.

The trial court's adoption of the premiums-based measure of damage is wrong for many of the reasons the out-of-pocket measure is correct. It is an unchallenged verity in this case that some portion of the class suffered no monetary loss. Yet the premiums-based measure of damages accepted by the trial court presumes that each class member suffered monetary damages. The unique facts in this case, that many class members suffered no monetary damage, cannot be squared with the proxy measure of damages Plaintiffs persuaded the trial court to accept.³⁶

Class members who had no need for health care during the months that the State did not offer them the opportunity to acquire health insurance, and who did not buy insurance on their own, suffered no monetary damage compensable in a CR 23(b)(3) class action for damages. Some class members were insured by spouses, and thus suffered no damages from the denial of the opportunity to enroll in PEBB. Others

³⁶ A premiums-based measure of damage also has no relationship to what class members lost. Class members lost the opportunity to acquire insurance through the PEBB, not the amount of the premium the employing agency paid to third-party insurers. The class members never would have been paid the premiums themselves.

would have chosen not to obtain coverage for a variety of reasons (such as not wanting to pay the employee contribution).

As a result, a premiums-based approach, with its assumption of actual monetary damage for every class member, would overcompensate and provide an undeserved windfall to those who suffered no damages. It also would undercompensate any class member who, for example, had to pay for medical services during the months in which he or she did not have insurance.

In addition, the use of the premium as the measure of damage runs directly contrary to due process and *Sitton*. While Plaintiffs need not prove the precise amount of damages with mathematical certainty, they nonetheless have the burden of establishing the fact of damage for each class member. *See Lewis River Gold*, 120 Wn.2d at 717. But as in *Sitton*, the trial court's approach here improperly presumes that each class member actually suffered monetary damage as a result of the State's failure to provide the opportunity to class members to acquire health insurance, when it is undisputed that not all class members suffered monetary damage (as the trial court has found). The trial court here would award aggregate damages "without requiring individual claimants to establish causation and damages" and "without permitting [the State] to

advance its defenses” with regard to individual class members’ lack of injury caused by the State. *Sitton*, 116 Wn. App. at 258.

These problems with using the premium as the measure of loss are discussed in the many cases that reject premiums in favor of actual loss as measured by out-of-pocket expenses. For example, as the district court in *Pattee* reasoned:

No rational person would pay today for health insurance covering yesterday, assuming a healthy yesterday. The present value of past health insurance, past, is zero. Therefore, when an employee is fired, remains healthy for two months, then gets more insurance, he is not entitled to any compensation for the health insurance coverage he would have had during the two months because it is valueless; the employer’s wrongful termination cost him nothing insofar as health benefits are concerned. To say that the employer must award him the premiums that the employer would have had to pay incorrectly focuses on what the employer would have spent rather than on the actual loss the plaintiff suffered.

512 F. Supp. 2d at 1381. Similarly, the trial court’s decision here to adopt the premiums-based measure of damages incorrectly focuses on what the employing agency would have spent, rather than the actual monetary damages class members may have suffered. This approach is the antithesis of due process.

2. The Trial Court’s Reliance on *Cockle* is Misplaced Because that Case did not Address the Valuation of Health Insurance and Thus is Distinguishable.

The trial court erroneously justified its premiums-based approach with a worker’s compensation case, *Cockle*, 142 Wn.2d 801.³⁷ However, there clearly was no such holding in *Cockle*, since the parties there stipulated that “the employer paid health care premiums fairly reflected the benefits’ value.” *Id.* at 821 n.10. In *Cockle*, the Court did not address the question presented in this case – how to value unprovided health insurance. No Washington case has decided the proper measure of damages for an employer’s failure to offer health insurance.

In *Cockle*, the Court construed the worker’s compensation statute provision, RCW 51.08.178(1), which defines “wages” for the purpose of calculating an injured employee’s “time loss” compensation, to include “the reasonable value of board, housing, fuel, or other consideration of like nature received from the employer as part of the contract of hire.” *Id.* at 805 (emphasis added). Relying on legislative history and applying canons of statutory construction,³⁸ the Court held that health care benefits were wages because they consisted of “other consideration of like nature”

³⁷ RP (10/26/12) 43.

³⁸ For example, the Court in *Cockle* noted that because the workers’ compensation statutory scheme was remedial in nature, the statute required the Court to liberally construe it in favor of injured workers. *Cockle*, 142 Wn.2d at 811, 822. There is no similar rule of construction that applies here.

to “board, housing, [and] fuel.” *Id.* at 807-11. In defining “wages” so broadly, the Court acknowledged the statute’s “definitional expansion clearly removes the term from its arguably more common usage . . .” *Id.* at 808; *see also Gallo v. Department of Labor & Indus.*, 155 Wn.2d 470, 484, 120 P.3d 564 (2005) (“As we noted in *Cockle*, the legislature expanded the ‘ordinary’ definition of ‘wages’ when it included ‘the reasonable value’ of *certain benefits*.”).

Thus, *Cockle* involved the question of what items of compensation to an employee are included in the term “wages”; it did not involve the question of how to value health insurance benefits that the employer failed to offer. Moreover, because *Cockle* was decided under a distinct and extremely broad statutory scheme, and the parties stipulated there that the employer’s premium was the value of the employee’s “wages,” the case has little or no relevance to this case.

3. The Trial Court’s Reliance On Restitution to Support a Premiums-Based Measure of Loss is Misplaced.

The trial court also justified its adoption of premiums-based methodology on a theory of restitution, agreeing with Plaintiffs that

to the extent that the State saved lots of money by not paying any premiums on behalf of class workers who should have been offered this benefit over the period of time at issue, arguably it owes some restitution . . .

I think the restitution argument is well taken³⁹

However, Plaintiffs did not plead any restitution or unjust enrichment claim, as required by Washington law. *Lewis v. Bell*, 45 Wn. App. 192, 197, 724 P.2d 425 (1986).⁴⁰ Even if they had, such relief is inappropriate here.

Restitution on a class-wide basis arguably would be appropriate only if Plaintiffs could establish that all class members suffered monetary damages. Here, as noted above, the parties stipulated and the trial court expressly found that some portion of the class suffered no such loss.

Moreover, restitution is a remedy for unjust enrichment. Unjust enrichment may apply where a person has acquired and keeps money or benefits which “in justice and equity belong to another.” *Bailie Commc’ns, Ltd. v. Trend Bus. Sys., Inc.*, 61 Wn. App. 151, 159, 810 P.2d 12 (1991). A claim of unjust enrichment requires that Plaintiffs show

- (1) a benefit conferred upon the defendant by the plaintiff;
- (2) an appreciation or knowledge by the defendant of the benefit; and (3) the acceptance or retention by the defendant of the benefit under such circumstances as to

³⁹ RP (10/26/12) 43-44.

⁴⁰ Plaintiffs’ Second Amended Complaint does not mention unjust enrichment or restitution. Although inexpert pleading has been allowed under the civil rule, insufficient pleading has not. A pleading is insufficient when it does not give the opposing party fair notice of what the claim is and the ground upon which it rests. *Lewis v. Bell*, 45 Wn. App. 192, 197, 724 P.2d 425 (1986); *Molloy v. City of Bellevue*, 71 Wn. App. 382, 385, 859 P.2d 613, 615 (1993) (complaint must apprise the defendant of the nature of the plaintiff’s claims and the legal grounds upon which the claims rest).

make it inequitable for the defendant to retain the benefit without the payment of its value.

Id. at 159-60.

Plaintiffs cannot establish the elements of unjust enrichment. No “benefit” was “retained” by the employers, because no legislative appropriations ever were made for the health insurance at issue. If an agency does not consider particular positions to be eligible for health-insurance, the Office of Financial Management does not request funding from the Legislature for insurance for those positions, and the Legislature does not appropriate funds for those costs.⁴¹

Because the agencies here did not interpret the relevant regulations to require that Plaintiffs be offered the opportunity to acquire employer-funded health insurance, funding for such benefits was never requested or appropriated, and cannot have been “retained” by the State. Application of the unjust enrichment doctrine under these circumstances was error.

C. There are Multiple Case Management Approaches Available to Determine the Fact of Damage, Consistent With the State’s Due Process Rights.

Plaintiffs persuaded the trial court that an individualized claims process would be unmanageable. But courts frequently use individualized processes in class actions to determine the fact of monetary damage,

⁴¹ CP 294.

and/or to permit defendant to litigate defenses to individual claims. These include:

(i) subject to Seventh Amendment limitations, bifurcation of the liability and damage phases with the same or different juries; (ii) appointment of magistrate judges or special masters to conduct individual damages proceedings; (iii) decertifying the class after the liability phase is complete and providing notice to class members about how they may proceed to prove damages; (iv) creating subclasses under Rule 23(c)(4); or (v) altering or amending the class at the damages phase.

MCLAUGHLIN, *supra*, § 4:19 at 665-66 (citations omitted).

At the trial court, the State proposed a simple claims process by which the court (or a claims administrator) would notify eligible class members of their potential right to obtain reimbursement of the cost of substitute insurance or uninsured health care costs upon submission of proof, such as invoices or receipts. One or more special masters would oversee this process, and also could resolve any defenses asserted by the State against individual class members.

With respect to class actions, when liability has been determined in favor of the class and a formula for individual proof of damages has been established that is capable of being uniformly applied, the courts have frequently referred the determination and distribution of damages claims to a special master.

3 NEWBERG, *supra*, § 9.55 (citing cases) (emphasis added). In response, Plaintiffs raised the specter of thousands of “mini-trials.” But courts

throughout the country frequently employ such procedures. *See, e.g.*, 3 NEWBERG, *supra*, § 9.55 (identifying various cases and approaches).

The State's proposed claims process is consistent with the approach suggested in *Sitton*,⁴² and would protect the State's due process rights by ensuring that Plaintiffs establish the fact of damage for every class member. The burden is on Plaintiffs to establish each element of their claims, and they have suggested no alternative that would meet their burden and also protect the State's constitutional right to litigate its defenses. An individualized proof-of-damages process also would ensure that class members who do establish any actual monetary damages will be fully compensated for their loss.

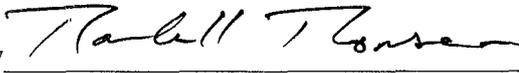
VI. CONCLUSION

For the reasons stated, the Court should reverse the trial court and remand with directions that that the court require proof of actual monetary damages sustained by all class members, ascertained through an individualized claims process.

⁴² *See Sitton*, 116 Wn. App. at 259-60 (court can make use of special masters to preside over individual causation and damages proceedings).

RESPECTFULLY SUBMITTED this 30th day of August, 2013.

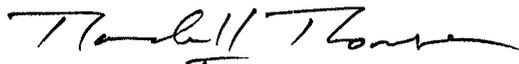
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For

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

APPENDIX

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JUDGE CATHERINE SHAFFER
DEPARTMENT 11

FILED
KING COUNTY, WASHINGTON
SEP 22 2011

KING COUNTY
SUPERIOR COURT

SUPERIOR COURT CLERK
BY Victor Higgins
DEPUTY

Honorable Catherine Shaffer

STATE OF WASHINGTON
KING COUNTY SUPERIOR COURT

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

NO. 06-2-21115-4 SEA

STIPULATION OF THE PARTIES
RE: SURVEY OF ABSENT CLASS
MEMBERS

Plaintiffs,

v.

and Order

HEALTH CARE AUTHORITY, STATE
OF WASHINGTON,

Defendants.

STIPULATION

The parties hereby stipulate to the following facts:

1. The term "class definition" as used in this stipulation means the class as defined on June 18, 2007, and as clarified on September 6, 2011.

2. During the month(s) each person meeting the class definition appears to have been eligible for PEBB health insurance, but did not receive that, each person did one of the following:

- a. Self-paid the entire premium to maintain PEBB benefits;
- b. Obtained health insurance through another source; or
- c. Did not have health insurance.

3. For those persons meeting the class definition who did not have any health insurance during a month(s) in which he or she appears to have been eligible for PEBB health insurance, the following are true:

- 1 a. Some persons incurred no health care costs because those class members did not
2 receive any health care services;
- 3 b. Some persons incurred health care costs, but those costs would not have been
4 covered by any PEBB health insurance plan;
- 5 c. Some persons would have incurred health care costs covered under a PEBB
6 health insurance plan. Those costs varied and were dependent upon the nature
7 of the health care services received and the provider of those services.

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

12 5. The Defendants agree to forego a survey of persons meeting the class definition
13 regarding their damages. The plaintiffs therefore withdraw their motion for protective order.

14 DATED this ____ day of September 2011.

15 BENDICH, STOBAUGH & STRONG, P.C.

15 ROBERT M. MCKENNA
16 Attorney General

17 *TWS #25274 for*
18 STEPHEN K. STRONG, WSBA #6299
19 STEPHEN K. FESTOR, WSBA #23147
20 Attorneys for Plaintiffs

TWR
20 TODD R. BOWERS, WSBA #25274
21 Senior Counsel for Defendants State of
22 Washington and Health Care Authority

21 *Approved via email*

22 DANIELSON HARRIGAN LEYH &
23 TOLLEFSON LLP

24
25 TIMOTHY G. LEYH, WSBA #14853
26 Special Assistant Attorney General
Attorney for Defendant State of Washington

1 ORDER

2 Based on the foregoing stipulation, the following facts are established for the purpose
3 of this action:

4 1. The term "class definition" as used in this order means the class as defined on June 18, 2007,
5 and as clarified on September 6, 2011.

6 2. During the month(s) each person meeting the class definition appears to have been eligible
7 for PEBB health insurance, but did not receive that, each person did one of the following:

- 8 a. Self-paid the entire premium to maintain PEBB benefits;
9 b. Obtained health insurance through another source; or
10 c. Did not have health insurance.

11 3. For those persons meeting the class definition who did not have any health insurance
12 during a month(s) in which he or she appears to have been eligible for PEBB health insurance,
13 the following are true:

- 14 a. Some persons incurred no health care costs because those class members did
15 not receive any health care services;
16 b. Some persons incurred health care costs, but those costs would not have been
17 covered by any PEBB health insurance plan;
18 c. Some persons would have incurred health care costs covered under a PEBB
19 health insurance plan. Those costs varied and were dependent upon the nature
20 of the health care services received and the provider of those services.

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

5 DATED this 21 day of September 2011

6 

7 **HONORABLE CATHERINE SHAFFER**
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