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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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**MOTION FOR DISCRETIONARY REVIEW**

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COURT OF APPEALS, DIVISION I  
STATE OF WASHINGTON

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## I. IDENTITY OF PETITIONERS

The moving parties herein are defendants Health Care Authority and the State of Washington (collectively, “the State”).

## II. DECISION BELOW AND INTRODUCTION

The State seeks discretionary review of the trial court’s written Order re Measure of Damages of Plaintiffs’ Statutory Claim, dated November 5, 2012, (“Order”), and the rulings by the trial court at the hearing on October 26, 2012, which are incorporated in and adopted by that Order.

This is a case in which plaintiffs have alleged damages of more than \$100 million for deprivation of state-funded health insurance. In its recent order, the court disregarded the fact that, as stipulated by the parties, some members of the 23(b)(3) class suffered no monetary damage as a result of the denial of insurance. The court adopted an aggregate “deferred health care” standard of damage, while at the same time rejecting any individualized claims process to determine which class members had such deferred health care. As a result, the State has been improperly deprived of its due process right to require plaintiffs to establish the fact of damage and causation as to each class member, and its right to defend on the basis of lack of damage to some class members.

Discretionary review is warranted here because the trial court has

made a probable legal error in disregarding the State's due process rights and departed from the accepted and usual course of judicial proceedings in rejecting the proper measure of damage. RAP 2.3(b)(2) and (3). The trial court's errors substantially limit the ability of the State to act. RAP 2.3(b)(2). Specifically, these errors make trial of this matter useless, and will make it impossible for the Health Care Authority to resolve the case through mediation. Discretionary review of the trial court rulings is also essential to ensure that the judicial and human resources to be consumed by trial--and the subsequent appeal as a matter of right of these erroneous legal determinations--are not wasted.

### III. ISSUES PRESENTED FOR REVIEW

Whether the State's due process rights are violated by the trial court's ruling that *all* persons who did not receive health insurance necessarily suffered damage from deferred health care is obvious or probable error warranting review under *Sitton v. State Farm Ins., Co.*, 116 Wn. App. 245, 63 P.3d 198 (2003)? RAP 2.3(b) (1) and (2).

Whether the trial court's conclusion, as a matter of first impression in this state, that the measure of damages for failure to provide health insurance is the amount of the monthly premium that should have been paid, is an error warranting review because the majority of other courts that have considered the issue have rejected such a premiums rule in favor

of out-of-pocket expenses incurred, and because a premiums approach would provide a windfall to a potentially large portion of the class that incurred no healthcare expenses during their time without insurance? RAP 2.3 (b) (3).

#### IV. STATEMENT OF THE CASE

Plaintiffs filed this class action in 2006, alleging that the State breached its statutory duty to provide health insurance to several categories of less-than-full-time state employees. In mid-2007, plaintiffs' statutory claim was certified for class treatment on the issue of liability under CR 23(b)(1)(A) and (b)(2) for equitable and declaratory relief.<sup>1</sup>

Thereafter, in a series of summary judgment orders, the court ruled that the State had not properly applied two of the many statutory eligibility rules for State employer-funded insurance. The court held that the State had (1) failed to average employees' time over the entire eligibility periods; and (2) failed to maintain benefits for employees who continued to work at least eight hours in each month after qualifying for benefits. These holdings were effectively codified by the Legislature in 2009 and, as a result, plaintiffs have received their equitable and declaratory relief. Engrossed Substitute House Bill 2245, 61st Leg., Reg. Session (Wash. 2009). Thus, the only claim remaining is for monetary damages.

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<sup>1</sup> See Order Certifying Class dated June 8, 2007, attached hereto as Ex. 1.

In December 2011, the court certified under CR 23(b)(3) the statutory claim on the issue of monetary damages. In advance of that hearing, the parties entered a stipulation providing that not all class members suffered monetary damages as a result of the failure to provide them with insurance.<sup>2</sup> Specifically, the parties agreed that during the month(s) the class members were eligible for but did not receive health insurance, “some incurred no health care costs because those class members did not receive any health care services” and others “incurred health care costs, but those costs would not have been covered by any PEBB [Public Employees Benefits Board] health insurance plan.”<sup>3</sup>

This Motion for Discretionary Review arises from the parties’ subsequent cross-motions regarding proof of the fact of damage and the proper measure of damages for plaintiffs’ statutory claim. The court considered these issues in a hearing held on October 26, 2012.

At the conclusion of the October 26th hearing, 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 v. State Farm Ins. Co.*, 116 Wn. App. 245, 63 P.3d 198 (2003). The *Sitton* court held that plaintiffs in a class action are required

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<sup>2</sup> Stipulation of the Parties Re: Survey of Absent Class Members (filed September 22, 2011) and attached hereto as Ex. 2.

<sup>3</sup> Ex. 2 at 3.

to prove causation and the fact of damage and that a trial plan which allows plaintiffs to sidestep this requirement through a presumption that damages were incurred violates due process.

The trial court, instead of following *Sitton*, concluded that *all* class members automatically suffered monetary damages as a result of the State's failure to provide them with insurance. This holding was based on the court's finding that persons without health insurance defer health care.<sup>4</sup> This conclusion, in turn, was based on the "public and media discussion of the Affordable Care Act" and various studies.<sup>5</sup> Neither the plaintiffs nor the court provided, nor cited to evidence that *all* class members in this case deferred health care.

The court found the State's out-of-pocket loss standard understated monetary damages because it disregarded deferred health care<sup>6</sup> In doing so, the court rejected an individualized claims process.<sup>7</sup> The court did not address the State's primary concern that the presumption of monetary loss as to all class members violates the State's due process right to require plaintiffs to prove all of the elements of their claim, including that each

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<sup>4</sup> The transcript of the October 26, 2012, hearing is attached hereto as Ex. 3. Citations are to the page and line number. (e.g., 1/1 – 2/2 is page 1, line 1 through page 2, line 2). The pinpoint citation for this cite is 40/23 – 41/19.

<sup>5</sup> Ex. 3 at 40/23 – 41/5.

<sup>6</sup> Ex. 3 at 40/23 – 41/19; 42/15 – 42/20.

<sup>7</sup> Ex. 3 at 42/15-20 ("I think that the defendants' argument that this should all get boiled down to individualized claims based on whether purchased substitute insurance or suffered medical damages is just wrong . . .").

class member in fact suffered damages, as well as the State's right to present evidence and challenge the losses claimed by particular class members.

In addition, the State noted two other problems with the presumption of damages. First, it runs directly contrary to the parties' stipulation that some class members suffered no monetary loss caused by the failure to provide insurance. Second, such a presumption is particularly problematic given the relatively short period of time most class members were eligible for, but improperly denied, health insurance. Specifically, more than half the class members were denied benefits for just one or two months.<sup>8</sup> It is unlikely that *all* such persons deferred health care; many likely suffered no loss for the simple reason they were not sick.

Regarding the measure of damages, the State noted that no Washington court has squarely addressed this important issue. The State cited to an analogous Washington case from this Court holding that the measure of damages for breach of a contractual duty to procure insurance is the amount of any covered loss that occurs. *Colucchio Constr. Co., Inc. v. King County*, 136 Wn. App. 751, 766-67, 150 P.3d 1147 (2007). In addition, the State cited multiple federal and state cases demonstrating that

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<sup>8</sup> Second Declaration of Steve Ross attached hereto as Ex. 4 at 6-7 (¶ 13).

the vast majority of the courts that have considered the issue have determined that the proper measure of damage for failure to provide a fringe benefit like health insurance is the out-of-pocket cost incurred by the employee to procure substitute insurance or to pay for medical care that would have been covered under the employer's health insurance.

The court appeared to agree there is no Washington authority on the measure-of-damage issue in the present context. But it rejected the cases cited by the State for a variety of reasons, relying instead on a few cases adopting a premiums approach and inaccurately concluding that the holdings of the cases cited by the State did not address the measure-of-damage issue in a class context.<sup>9</sup> In fact, the cases cited by the State did include class actions. *See, e.g., United States v. City of New York*, 847 F. Supp.2d 395 (E.D.N.Y. 2012).

Instead of following the majority of cases from other jurisdictions that have required proof of actual monetary damage to recover for wrongful denial of health benefits, the court adopted plaintiffs' proposed measure of damages – the employer portion of the monthly premiums that would have been paid. In doing so, the court found that benefits are part of an employee's wages, reasoning that the Supreme Court had concluded in *Cockle v. Dept. of Labor & Industries*, 142 Wn.2d 801, 16 P.3d 583

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<sup>9</sup> Ex. 3 at 40/12 – 40/22; 42/21 – 43/6.

(2001) that the value of the benefit portion of wages is the monthly premium.<sup>10</sup> The court did not address the State's argument that *Cockle* did not, in fact, decide that the monthly premium was the correct measure of damages because the parties in that case stipulated to the value of health insurance benefits. No Washington court has ever considered or decided the issue presented here.

On November 5, 2012, the court entered a written Order on the parties' fact and measure of damages motions.<sup>11</sup> That Order reflects the court's oral ruling and incorporates the hearing transcript.<sup>12</sup>

## V. ARGUMENT

### A. Discretionary Review is Required to Determine Whether the Trial Court's Rulings Violate the State's Due Process Rights as Recognized by This Court in *Sitton*.

The State's due process rights are violated by the trial court's ruling that the fact of damage is presumed for all class members; that plaintiffs need not prove each class member suffered an actual monetary loss; and that the State cannot challenge the presumption of damage as to particular class members at a trial. As this Court recognized in *Sitton*, a

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<sup>10</sup> Ex. 3 at 43/7 – 44/3.

<sup>11</sup> Order on re Measure of Damages on Plaintiffs' Statutory Claim attached hereto as Ex. 5.

<sup>12</sup> Ex. 5 at 5 (¶ 13). The trial court excised several paragraphs of the proposed findings and conclusions, but it is unclear why it did so. No conclusions, however, can be drawn from this since it did incorporate into the order the transcript of its oral ruling, which encompasses the stricken paragraphs.

class action defendant is entitled to have plaintiffs prove all elements of their cause of action, including causation and the fact of damage, as to each class member. Where, as here, a trial court's decision presumes the fact of damage as to all class members, not only has the trial court committed error, but, as this Court held in *Sitton*, such an error warrants discretionary review. *Sitton*, 116 Wn. App. at 257-58 (stating that the Court "granted discretionary review at this stage of the litigation in large part because of the trial plan adopted by the [trial] court," which "contemplates an award of damages without requiring plaintiffs to prove individual causation and without permitting State Farm to advance its defenses.").

*Sitton* was a class action by insureds who alleged 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 the medical review program was designed to deny PIP claims, and the amount of "aggregate class damages," among other issues. 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 granted discretionary review and vacated the trial plan because it “allow[ed] the jury to make a damages award without requiring individual claimants to establish causation and damages . . . .” and “without permitting State Farm to advance its defenses.” *Id.* at 258, 259.

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.*

The trial court’s decision on the fact of damage in this case is essentially the same as that rejected by this Court in *Sitton*. Both would permit classwide damages without requiring proof that each class member in fact suffered damages caused by the State, and the State would be denied its due process right to assert its defenses, including that no damages were incurred by some class members as a result of the State’s failure to provide insurance. *Id.* at 258.

The trial court’s “faulty syllogism” in this case is that because

liability has been determined against the State on plaintiffs' statutory claim, every class member necessarily suffered a monetary loss – either through actual out-of-pocket expenses or because they deferred care. The trial court's ruling ignores the fact that some members of the class (and perhaps many, given the short period of time the majority were without insurance for which they were eligible) may have suffered no loss because they were healthy and genuinely did not need health care. The court then compounded its error and the due process violation by precluding an individual claims process in which the State can challenge the fact of loss as to particular class members.

The holding in *Sitton* that such a ruling and trial plan is unconstitutional is consistent with the Supreme Court's recent decision in *Wal-Mart Stores, Inc., v. Dukes*, 131 S. Ct. 2541, \_\_\_ U.S. \_\_\_, 180 L.Ed2d 374 (2011). In that case, the Court confirmed that any "extrapolation" technique that denies a defendant the ability to litigate defenses to individual claims, including the absence of damages or loss, is improper.

*Wal-Mart* involved a class action in which employees claimed gender discrimination and sought back pay under Title VII. The lower court approved a trial plan in which back pay would have been determined by deriving an average damage award for a sample of the class and multiplying it by the total number of "(presumptively) valid claims" —

essentially what plaintiffs propose here.

The Supreme Court rejected this “trial by formula” plan because it would have resulted in a denial of the employer’s right to litigate its defenses to individual claims. *Id.* at 2561. The Court noted that use of the class action device must not impair any of a defendant’s substantive rights. *Id.* (“[T]he Rules Enabling Act forbids interpreting Rule 23 to ‘abridge, enlarge or modify any substantive right’ . . .”). One of those substantive rights is the requirement that plaintiffs must prove the fact of damage for each class member. Joseph M. McLaughlin, *McLaughlin on Class Actions* § 4.19 at 666-67 (8<sup>th</sup> ed. 2011) (no dispute that a class “must be able to prove the fact of injury and the amount of damages due to individual class members” to recover in a lawsuit).

A defendant also has the due process right to assert and litigate any defenses it may have to claims made by individual class members, including that the class members suffered no monetary loss or damages:

After factoring out common elements of individual issues in a class action, irreducible separate questions which 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 individual losses or damages suffered, and the defendants may have unique defenses. These defenses can be that particular class members do not fall within the definition of the affected class; . . . and mitigation . . . . To resolve irreducible individual questions, the court must turn its

attention to appropriate procedures and forums to be used for this purpose.

*Newberg* § 9:63 at 451-52 (emphasis added); *see also* § 9:57 at 446 (“Most class actions involve individual issues as well as the required common questions. Individual issues may arise in connection with any phase of a class controversy, including ... causation or fact of damage, relief entitlement, ... unique defenses, and other issues.”).

The trial court’s rulings that the fact of damage can be presumed as to all class members because of “deferred care,” that plaintiffs need not prove that each class member suffered a monetary loss, and, in effect, that the State cannot assert its defenses regarding the absence of injury, violate due process and this Court’s decision in *Sitton*. This Court should therefore accept discretionary review as it did in *Sitton*, and reverse the trial court’s decision.

**B. The Trial Court’s Rejection of an Actual Monetary Damages Standard and an Individualized Claims Process Requires Discretionary Review under RAP 2.3(b)(3).**

The second error committed by the trial court that merits discretionary review involves the measure-of-damages standard the court adopted: the employer portion of the monthly premiums. The trial court’s error in this regard is obvious and probable, and merits review at this time for two reasons. First, it is based on the unsupported assumption that *all*

class members who did not pay out-of-pocket during the time without insurance – even the majority that were without insurance for just one or two months – necessarily incurred damages because they deferred health care that would have been covered under a State plan. There is no evidence in the record to support this conclusion. Second, in adopting this measure, the court, acting in the absence of any controlling Washington authority, rejected the rule adopted by the vast majority of other courts, *i.e.* that the measure of damages for failure to provide health insurance is not the monthly premiums, but the out-of-pocket loss, if any, incurred by the employee (either the cost of procuring substitute insurance or the amount paid for medical care that would have been covered under the employer’s plan).

It is undisputed in this CR 23(b)(3) action that some class members incurred no out-of-pocket monetary loss. Plaintiffs have stipulated to this. Nevertheless, the trial court found that the class suffered damage through deferral of health care. There is no factual basis for the court’s conclusion. Indeed, it is axiomatic at least some members of the class had no out-of-pocket expenses in the time without insurance not because they deferred health care, but because they were healthy and did not need such care. This is particularly true where, as here, the majority of the class was without insurance for just one or two months. And, again, the trial court’s

error here is compounded because the presumption of loss that the court has attached to mere membership in the class precludes the State from challenging the fact of damage as to individual class members at a trial.

No Washington appellate opinion has decided the proper measure of damages for denial of employer-paid health insurance benefits.<sup>13</sup> One analogous case, however, is *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 breach of a contractual duty to procure all-risk insurance is the amount of any covered loss that occurs.

This is consistent with the majority of other courts that have considered the question in the context of failure to provide health insurance or other fringe benefits. The recent decision in *United States v. City of New York*, 847 F. Supp.2d 395 (E.D.N.Y. 2012), a Title VII discrimination class action, exemplifies that approach. The court there determined liability, and then addressed damages from loss of benefits, including the key question of “how to value some of those benefits, such as employer-provided health insurance.” *Id.* at 409.

Some courts have held that an employer is liable for the amount it would have paid in premiums for an employee’s health insurance. [Citations omitted.] However, the weight of authority appears to be in favor of a contrary rule—that

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<sup>13</sup> Plaintiffs argue to the contrary under *Cockle v. DLI*, 142 Wn.2d 801, 16 P.3d 583 (2001), a worker’s compensation case, but there the parties stipulated to the benefit’s value. *Id.* at 821.

an employer is liable for an employee's out-of-pocket expenses that would have been covered under the employer's health plan. See, e.g., *Galindo v. Stoodly Co.*, 793 F.2d 1502, 1517 (9<sup>th</sup> Cir. 1986) (interpreting backpay provisions of the National Labor Relations Act and holding that “plaintiff should be compensated for the loss of [health] benefits if the plaintiff has purchased substitute insurance coverage or has incurred uninsured, out-of-pocket expenses for which he or she would have been reimbursed”); . . . .

*Id.* (emphasis added).

In *City of New York*, like here, plaintiffs' main argument for an insurance premium rule was “the greater convenience of administering such a rule in a class context.” *Id.* at 422. However, a premium rule “would create non-trivial opportunities for over- or under-compensation, both between the City and the claimants and among the claimants themselves.” *Id.*

Furthermore, determining damages on a classwide basis would not advance the purpose of making plaintiffs “whole.”

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.

*Id.* Therefore, the court 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 same approach – and rejection of a premium rule - was taken by the Ninth Circuit in *Galindo*, 793 F.2d 1502 (“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”) and by the federal district court in Seattle in *E.E.O.C. v. Northwest Airlines, Inc.*, 1989 WL 168009, \*16 (W.D. Wash. 1989) (damages for fringe benefits payable in action under the Age Discrimination in Employment Act should be “amounts actually expended by a claimant to replace the coverage he would otherwise have received” from the employer.). *See also Hance v. Norfolk Southern RR Co.*, 571 F.3d 511, 522 (6th Cir. 2009) (stating that “the more recent cases” have awarded damages “based on actual expenses incurred by a plaintiff in securing insurance or medical care,” and adopting that approach); *Kossman v. Calumet County*, 800 F.2d 697, 703-04 (7th Cir. 1986)<sup>14</sup>;

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<sup>14</sup> *O’ruled on o’tr grds, Coston v. Pitt Theatres*, 860 F.2d 834 (7th Cir. 1988). The District Court held in *Kossman* 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

*Pearce v. Carrier Corp.*, 966 F.2d 958 (5th Cir. 1993); *Lubke v. City of Arlington*, 455 F.3d 489 (5th Cir. 2006); *McMillan v. Mass. Soc. for the Prevention of Cruelty to Animals*, 140 F.3d 288 (1st Cir. 1998); *Pattee v. Georgia Ports Authority*, 512 F. Supp. 2d 1372 (S.D. Ga. 2007); *Wilson v. S&L Acquisition Co.*, 940 F.2d 1429, 1438-39 (11th Cir. 1991); *Ginn v. Kelley Pontiac-Mazda, Inc.*, 841 A.2d 785, 787-88 (Maine S.Ct. 2004).

While the trial court stated that “[t]here are numerous federal cases holding that it is appropriate in a class action seeking money damages to assess the measure of damages on a classwide aggregate basis rather than individually,” neither the court nor plaintiffs cited to any case (and the State is unaware of any) adopting an aggregate approach where, as here, some members of a CR 23(b)(3) class undisputedly suffered no monetary damage. The main case cited by plaintiffs for a “premium” approach to damages for denial of insurance benefits was the worker’s compensation case, *Cockle*. But as noted above, that case provides no guidance on the central issue here, which is how to value the deprivation of health insurance benefits, because the parties there stipulated to the benefit’s value. *Id.* at 821. Plaintiffs also cited to *Farris v. Lynchburg Foundry*, 769 F.2d 958 (4th Cir. 1984) and its progeny, involving life insurance, for

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not been terminated in order that they might recover the cost of the insurance benefits or be reimbursed for any proper medical expenses incurred . . . .”

a premium measure of damages. But as the Court noted in *City of New York*, 847 F. Supp.2d at 422, n. 10, “a premium measure of value lost may . . . be more logical in the life insurance context than in the health insurance context.”

The trial court’s statement that “there’s a split in authority” and “plenty of federal cases” supporting an aggregate premium measure of damage<sup>15</sup> is a significant overstatement, particularly in a case like this one. None of the cases that plaintiffs relied on involved CR 23(b)(3) classes for monetary damages where it was undisputed — indeed, stipulated — that some class members cannot establish any actual monetary damage.

## VI. CONCLUSION

This Court in *Sitton* recognized that due process is violated where the trial court permits an entire class to recover without proving causation and the fact of damage as to each individual class member and where the defendant is precluded from asserting its defenses, including that individual class members suffered no loss. This Court in *Sitton* also recognized that this constitutional error requires discretionary review.

The trial court in this case committed such an error. Its recent decision presuming that *all* class members suffered a monetary loss is the same error identified in *Sitton*.

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<sup>15</sup> Ex. 3 at 40/12-17.

The need for review is underscored by the trial court's additional error regarding the measure of damages. There is no Washington authority on this issue in this context, and the trial court ignored the rule adopted by the majority of other courts that have considered the issue (including the Ninth Circuit). A premiums measure of damage will grossly overcompensate and provide a windfall to those class members who suffered no loss because they were healthy and did not need care during the time they were without benefits.

RESPECTFULLY SUBMITTED this 20th day of December, 2012.

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Senior Counsel

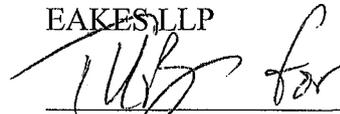
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# EXHIBIT 1

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Honorable Catherine Shaffer

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

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

Plaintiff,

v.

HEALTH CARE AUTHORITY and  
STATE OF WASHINGTON,

Defendants.

NO. 06-2-21115-4 SEA

ORDER CERTIFYING CLASS

This matter came before the Court on plaintiffs' motion for class certification. Having considered the materials submitted, the arguments of counsel, and the record in the case, the Court hereby finds and orders as follows:

1. Plaintiffs assert that the defendants breached their duty to provide health insurance to employees who work on nonstandard work schedules when their hours average half-time or more for six or more months and, after they become eligible for health insurance, when they work eight or more hours in a month. Plaintiffs seek declaratory relief concerning the minimum hours a state employee must work to receive health insurance, an injunction requiring defendants to provide plaintiffs and the class health insurance under these rules, and monetary relief to compensate for the denial of health insurance.

2. The first prerequisite for a class action is that "the class is so numerous that joinder of all members is impracticable." CR 23(a)(1). Here, joinder is impracticable because

1 the class includes at least 800 persons. Joinder is also impracticable because many class  
2 members' claims are relatively small and it would be cost-prohibitive to pursue individual  
3 lawsuits.

4 3. The second prerequisite for a class action is that "there are questions of law or  
5 fact common to the class." CR 23(a)(2). This prerequisite is satisfied when there is at least  
6 one question common to the class. Here, there are at least two overriding questions of law  
7 common to the class, with a number of sub-issues. The first common question is the mini-  
8 mum number of hours state employees must work to receive health insurance. Another com-  
9 mon question is the validity and/or effect of HCA's June 2006 amendments to the eligibility  
10 rules. Common sub-issues include how the eligibility rules for health insurance are affected  
11 by the Supreme Court's decision in *Mader v. HCA*, 149 Wn.2d 458 (2003) and RCW  
12 41.05.065(2)(g), which states "[t]o maintain the comprehensive nature of employee health  
13 benefits, employee eligibility criteria related to the number of hours worked . . . shall be sub-  
14 stantially equivalent to the . . . eligibility criteria in effect on January 1, 1993." If plaintiffs'  
15 claim is successful, the appropriate declaratory and/or injunctive relief is also an issue of law  
16 common to the class. There are common questions here as required by CR 23(a)(2).

17 4. The third prerequisite for a class action is that "the claims or defenses of the  
18 representative parties are typical of the claims or defenses of the class." CR 23(a)(3). This  
19 does not require that the representative plaintiffs share "identical" facts with the class mem-  
20 bers. Here, plaintiffs allege the State failed to provide health insurance to employees on non-  
21 standard work schedules after the employees averaged half-time or more for longer than six  
22 months and/or when they worked eight hours in a month after they became eligible. Plaintiff  
23 Mary Camp works on a fluctuating work schedule as a part-time community college instructor  
24 and the State requires her to sign a new contract each quarter, plaintiff Doug Moore works at  
25 the Washington Horse Racing Commission on a seasonal basis, and plaintiff Gaylord Case  
worked at the Department of Transportation with "on-call" status. The representative plain-

1 tiffs thus represent state employees on nonstandard work schedules, and their claims for  
2 health insurance are "typical" of the class claims as required by CR 23(a)(3).

3 5. The fourth prerequisite for a class action is that "the representative parties will  
4 fairly and adequately protect the interests of the class." The class here is represented by ex-  
5 perience class counsel. Plaintiffs also have no conflict of interest with the class, and the  
6 lawsuit is not collusive. The requirements of CR 23(a)(4) are therefore met.

7 6. Accordingly, the class claim here satisfies the requirements for a class action in  
8 CR 23(a). For purposes of class certification, a class action must also satisfy one or more  
9 provisions in CR 23(b).

10 7. A class action is appropriate under CR 23(b)(1)(A) if individual actions by  
11 class members "would create a risk" of "inconsistent or varying adjudications with respect to  
12 individual members of the class which would establish incompatible standards of conduct for  
13 the party opposing the class." Here, individual actions by class members would create a risk  
14 of inconsistent obligations for the defendants. For example, if in this action the defendants  
15 are required to provide health insurance to employees whose work hours average half-time or  
16 more for six months or longer, and at the same time other cases were brought that result in a  
17 different requirement, the defendants would be placed in a position where they have conflict-  
18 ing obligations. To avoid this, certification under CR 23(b)(1)(A) is appropriate.

19 8. A class action is appropriate under CR 23(b)(2) if the "party opposing the class  
20 has acted or refused to act on grounds generally inapplicable to the class, thereby making ap-  
21 propriate final injunctive relief or corresponding declaratory relief with respect to the class as  
22 a whole." Here, plaintiffs allege that defendants failed to perform a legal duty on grounds ap-  
23 plicable to the class, *i.e.*, defendants failed to provide employees health insurance when their  
24 work hours qualified them for that insurance. And plaintiffs seek declaratory relief concern-  
25 ing the defendants' duties to the class. Injunctive relief may also be appropriate to ensure that  
defendants comply with those duties in the future. Class certification is also appropriate un-

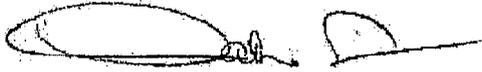
1 der CR 23(b)(2).

2 9. Accordingly, class certification is appropriate under CR 23(b)(1)(A) and (b)(2)  
 3 for the purpose of equitable and declaratory relief. The Court has some questions, however,  
 4 as to the application of the double damages statute, RCW 49.52.070, to this action, and how  
 5 this statute and other issues relating to damages may affect class certification. Rather than  
 6 address these issues at this time, the Court will bifurcate this case and certify the class under  
 7 CR 23(b)(1) and (b)(2) for the purpose of determining liability and, if appropriate, declaratory  
 8 and injunctive relief. If the class prevails in the liability phase of this action, and after addi-  
 9 tional briefing by the parties, the Court will address the issue of whether the class should re-  
 10 main certified under CR 23(b)(1) and (b)(1) or whether certification under CR 23(b)(3) is ap-  
 11 propriate for the damages phase of this action. The current case schedule is stricken, and a  
 12 new one will be established.

13 10. The class is defined as:

14 all state employees who worked half-time or more on average for six months,  
 15 and who were denied health insurance (a) commencing in the seventh month  
 16 of employment, and/or (b) at any time in the nine or more months or in the  
 17 corresponding off-season for those employees who work half-time or more on  
 18 a nine-month (or more) seasonal basis, and/or (c) in any month after the em-  
 19 ployees became eligible in which the employees received pay for eight or  
 20 more hours of work in the same position. The class is limited in time to em-  
 21 ployees within the applicable statute of limitations and, for employees who re-  
 22 leased claims as part of the class action settlement in *Mader v. HCA, King Co.*  
 23 No. (King County No. 98-2-30850-8), the employees' claims are limited to  
 24 the time after the effective date in that settlement agreement.

20 DATED this 8 day of June, 2007.



JUDGE CATHERINE SHAFFER

1 Presented by:

2 BENDICH, STOBAUGH & STRONG, P.C.

3 

4 STEPHEN K. STRONG, WSBA #6299

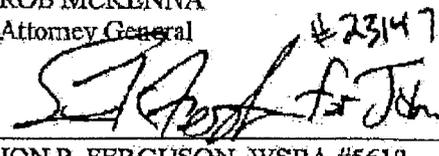
5 STEPHEN K. FOSTER, WSBA #23147

6 Attorneys for Plaintiffs and the Class

7 Copy Received; Notice of Presentation waived:

8 ROB MCKENNA

9 Attorney General

10  #23147

11 JON P. FERGUSON, WSBA #5619

12 Assistant Attorney General

13 Attorneys for Defendants

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# EXHIBIT 2

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JUDGE CATHERINE SHAFFER  
DEPARTMENT 11

**FILED**

KING COUNTY  
SUPERIOR COURT

KING COUNTY, WASHINGTON

SEP 22 2011

SUPERIOR COURT CLERK  
BY Victor Bigornia  
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. ROBERT M. MCKENNA  
16 Attorney General

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

20 *Approved via email*

*TWB*  
TODD R. BOWERS, WSBA #25274  
Senior Counsel for Defendants State of  
Washington and Health Care Authority

DANIELSON HARRIGAN LEYH &  
TOLLEFSON LLP

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

26

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.

21 ///

22 ///

23 ///

24 ///

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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# EXHIBIT 3



## 1 PROCEEDINGS

2 October 26, 2012

3 THE COURT: Welcome back, everyone. Okay.

4 A few preliminary things. First of all, let me  
5 tell everybody how extremely irritated I was to  
6 read the squabbling about the order the Court  
7 signed, what was it, last September, a year ago, in  
8 this case, and let me walk you through why I find  
9 it irritating. First of all, if the plaintiffs did  
10 agree to withdraw a pending motion, it would be  
11 nice to let the Court know about it, other than by  
12 way of submitting a stipulation between the  
13 parties. The Court does not review stipulations  
14 between the parties the way I review motions  
15 because I generally am not going to object to your  
16 agreements to do anything except move the trial  
17 date. That's about the only thing I insist on  
18 maintaining control over.

19 Secondly, I'm not even sure that we had the  
20 stipulation in hand at the time that I had the  
21 motion. So just as a courtesy to the Court, really  
22 if somebody doesn't want to pursue a motion, you  
23 should tell me. Secondly, to the extent that a  
24 party thinks that the Court signed an order that it  
25 shouldn't have signed because the motion was

1        withdrawn, it should take less than a year to tell  
2        the Court that, and it shouldn't be brought up in  
3        the heat of pleadings over a different dispositive  
4        motion in the case.

5                I'm not ruling on the motion to strike. It's  
6        not calendared until today. I don't rule on  
7        motions until the day after they're calendared,  
8        which will be Monday, but I will tell everybody  
9        that I read this and I thought, oh, my goodness,  
10       how could these parties have had such poor  
11       communication with the Court. And I hope it  
12       doesn't happen again because by and large I think  
13       we've all worked together pretty well in terms of  
14       staying in contact and knowing what's going on in  
15       the case.

16               Having said that, okay, I want to tell  
17       everybody that I think I've been able to read all  
18       of the materials that you submitted for this  
19       motion, except the motion to strike, which was  
20       referred to in the materials I read for this  
21       motion, and I think that we're ready to go. I  
22       think given the significance of the issues we're  
23       dealing with today that it's probably appropriate  
24       that we take argument with 20 minutes per side, so  
25       each side will have 20 minutes to address their

1 motion and their opposition to the other side's  
2 motions. That's a total of 20 minutes, not 40  
3 minutes per side.

4 And in terms of how we divide the time, who  
5 brought the first motion? Was it plaintiffs or the  
6 State?

7 MR. LEYH: I think it was simultaneous,  
8 your Honor, but I'm happy to have the plaintiffs  
9 start.

10 THE COURT: Since the plaintiffs brought  
11 the case then, we'll give you the tie breaker. The  
12 plaintiffs will start arguing, and you can tell me  
13 how much time you're reserving for rebuttal. Then  
14 I'll hear defendants argue, and you'll tell me how  
15 much time you're reserving for rebuttal. Then the  
16 plaintiffs will argue for their rebuttal time, and  
17 defendants will argue for rebuttal time, and then  
18 hopefully I'll be able to give you a ruling.

19 Go right ahead, Mr. Strong. How much time of  
20 your 20 minutes do you want to reserve?

21 MR. STRONG: I'll save five minutes, your  
22 Honor.

23 THE COURT: Go right ahead.

24 MR. STRONG: I'm Steve Strong representing  
25 the plaintiffs. I'm sorry if we had any

1 communication mistake.

2 THE COURT: No. This is just an  
3 irritation for the Court reviewing the materials.

4 MR. STRONG: This case is -- this motion  
5 is about the measure of damages, and it's basically  
6 based on the inherent authority of the Court to  
7 decide issues of law, not just on rule 56, but rule  
8 23(d) provides for the Court's authority to decide  
9 how to handle class action efficiently, and the  
10 rules of evidence provide you can decide how to  
11 simplify, organize evidence, and you have great  
12 discretion in organizing evidence. So anyway, this  
13 motion is based on the inherent authority of the  
14 Court to decide issues of, law and the measure of  
15 damages is an issue of law.

16 And the plaintiffs have three proposed  
17 measures of damages. The first one is wages, the  
18 second one restitution, and the third one is the  
19 aggregate actuarial method. The State wishes to  
20 bring up basically a side issue involving causation  
21 or what they call the fact of damages, which is  
22 really a repeat of the class certification, the  
23 individualized assessment based on paper records  
24 that we heard last year, and the upshot really is  
25 that they can do it but they want to wait to do

1 that after the liability issues that remain are  
2 resolved, and there are a few of them, the  
3 definition of termination, and a few other things,  
4 that we put in the list earlier.

5 The first measure of damages is the most  
6 simple one and relies on the Supreme Court of  
7 Cockle case. It says that health insurance  
8 premiums are wages and the value of those wages is  
9 defined based on the employer contribution to the  
10 health insurance. The wage statutes are also  
11 brought. It is not just the Cockle case or the  
12 worker compensation case; it relied on the  
13 dictionary. They broadly include any kind of  
14 compensation from an employer.

15 The State cites the Minimum Wage Act as an  
16 exception, which it is, because minimum wage is  
17 different from wages generally because it's only  
18 cash, because you only buy groceries and pay rent  
19 with cash, and health benefits or other types of  
20 retirement benefits, or whatever, are not  
21 considered as part of a minimum wage.

22 The best way of looking at this wage issue is  
23 to look at the way it's considered in the federal  
24 tax law. The Internal Revenue Code, all  
25 compensation, all remuneration, including noncash

1 benefits, are paid from employer for -- by an  
2 employer for services rendered are wages.

3 The health benefits in an approved plan are  
4 excludable from taxes, but they're still wages.  
5 And in this particular situation, because the  
6 defendant has failed to pay the health benefits in  
7 accordance with an approved plan, any payments that  
8 the defendant ultimately pays to the plaintiffs are  
9 going to be taxable W-2 wages. While I have  
10 quarrelled with that with IRS a number of times,  
11 that has never succeeded that if it would have been  
12 nontaxable in the approved benefit plan but it's  
13 paid in lieu of those benefits, it's taxable W-2  
14 wages when the time comes.

15 The next most straightforward one I'm going to  
16 talk about is restitution. Restitution is a remedy  
17 here. Restitution can be either a remedy or a  
18 substantive claim. It's available as a remedy  
19 where the calculation of damages is too difficult  
20 by other methods. The State has only two responses  
21 to restitution in their briefs. One is that it's  
22 not in the complaint, but that's implying that it's  
23 a substantive claim. Restitution is not a  
24 substantive claim for unjust enrichment where there  
25 are -- I should say it's only a substantiative

1 claim for unjust enrichment where there are no  
2 substantive claims in tort contract or statute.  
3 Here we have those substantive claims, and it is  
4 simply a remedy that we've pointed out that it was  
5 a remedy that we were seeking a long time ago.

6 Since the unification of law and equity,  
7 restitution has been available in cases at law.  
8 Now, the only other defense the State refers to in  
9 terms of restitution is that they didn't retain the  
10 money; they spent it on other things. I don't  
11 really think that that qualifies as a defense.  
12 Restitution is plainly available because the  
13 wrongdoer may not profit from the wrong. In this  
14 particular case it withheld the premiums that it  
15 should have paid. Restitution was based on the  
16 amount of the premiums that should have been paid.  
17 And that would prevent unjust enrichment of the  
18 State.

19 This is an appropriate remedy here if there  
20 are no other reasonably easy methods of calculating  
21 damages. We think that there are. So the  
22 actuarial method is an available method. The facts  
23 of the actuarial method are not disputed. They're  
24 supported by an actuary who's very experienced and  
25 has formerly been the lead actuary for the State

1 plans in New Jersey and California. The State  
2 itself has actuaries, but it has not submitted any  
3 actuary testimony at all, nor has it submitted any  
4 statistical evidence. Mr. Boedecker was proposed  
5 as an expert but then dropped.

6 The point sometimes the State wants to make is  
7 that there's some people that may not have had a  
8 loss. The stipulation that they cite does not say  
9 that there is no loss for anybody. It said, in any  
10 given month, there may be no cost in the month, and  
11 some months have potentially higher costs.

12 The study that was submitted here without  
13 controversy, it was first brought up by Professor  
14 Feldman, who's the expert that the State has, a  
15 health policy professor. He submitted or cited a  
16 book about the cost of uninsurance, and we quoted  
17 that in our motion. One of the things that's most  
18 important there is that in 2003, when that book was  
19 written, it was calculated that for every year of  
20 uninsurance, every year of not having insurance,  
21 you have the economic value of diminished health  
22 and longevity equal to in that time \$1645 to \$3280  
23 per year, according to our motion at page 18.

24 So that's purely a matter of economic value of  
25 diminished health and longevity. There's also, of

1 course, when you're uninsured, potential for  
2 deterred cost because you put off things, and then  
3 there are people that have to pay out of pocket.  
4 There's various things, but anyway, based on that  
5 study, which is not disputed, everybody has an  
6 economic loss due to the fact of being uninsured  
7 because they don't get this type of treatment that  
8 they -- or preventive care that they should have  
9 had. And the value is calculated in economic  
10 terms.

11 The next point about the actuarial method is  
12 the law pertaining to this situation. The State  
13 generally tries to argue that if there is an  
14 aggregate method, it must reflect the actual amount  
15 of the loss of each individual in the class, but  
16 that is not what authorities say, including the  
17 authorities the State refers to. In the State's  
18 reply, it says, quote, Newberg states that any  
19 aggregate damages must fairly represent the  
20 collective value of claims of individual class  
21 members. The ultimate aggregate liability of  
22 defendant can be no larger than the liability of  
23 all class members that individually asserted their  
24 claims.

25 It does not have to be representation that

1 each person's individual claim added up; it's the  
2 collective value of all the claims. That's what  
3 we've been trying to explain here with the proposal  
4 and the evidence of Mr. Wilson.

5 Then there's cases cited at the end of  
6 defendants' response to our motion, it's called  
7 Hickory, Second Circuit case, it's unpublished, and  
8 I normally wouldn't talk about it, but --

9 THE COURT: Well, you aren't in federal  
10 court so I won't ding you. Go ahead.

11 MR. STRONG: But I'm talking about it here  
12 not only because they cited it but because they  
13 quote a published case from the First Circuit on  
14 this very point, so I'm quoting the quote. But  
15 anyway, they said that the use of aggregate damage  
16 calculations is well established in federal court  
17 and implied by the very existence of the class  
18 action mechanism itself. A district court must  
19 ensure that the damage awards roughly reflect the  
20 aggregate amount owed the class members.

21 It's not the individual amount owed the class  
22 members. It's the aggregate amount owed to all  
23 class members. So our actuarial method here is  
24 based on using the comparable group of State  
25 employees who are in the same plan at the same

1 time. We have 20,000 people in the class perhaps.  
2 It's a little hard to tell because the State often  
3 talks about people that aren't really in the class,  
4 like the waivers and all that, like several  
5 thousand people with waivers and other odd ball  
6 things, but --

7 THE COURT: That's somewhere between 4,000  
8 and 20?

9 MR. STRONG: It appears to me there's  
10 probably 20 to 25,000 class members. That's way  
11 more than I thought when we first brought the case.  
12 You may recall, I recall anyway, saying that at the  
13 time that we brought the case that we didn't really  
14 add them all up or anything, because we had limited  
15 data, but we thought there were at least 800  
16 people, and over the years, actually it's been  
17 several years since then, it's been growing all the  
18 time. Even now probably 40 percent of the people  
19 that should be getting health insurance in this  
20 group are not.

21 There's -- the -- after the statute was passed  
22 and after your rulings, the number of people being  
23 omitted took a decline but perhaps only by 60  
24 percent, and it's a problem with computer  
25 programming basically, I think, but so we have

1 several more years, so the number of class members  
2 has grown, plus there were more identified.

3 The employee number then and the number of  
4 months, which is around 200,000 months of omitted  
5 health insurance for those 20,000 people, is very  
6 large, large enough to be statistically similar to  
7 the group of class members, group of State  
8 employees as a whole, and so therefore one can  
9 calculate for this 20,000 people as a whole that  
10 they would have the same average expenses as the  
11 other people who are comparables who are in the  
12 plans at the same time.

13 The only exception might be that the defendant  
14 has pointed out is the possibility of demographic  
15 differences, which are basically age and sex, but  
16 their arguments on the demographic differences here  
17 are all based on the so-called notice class, which  
18 is they say vastly overstated, includes all those  
19 people with waivers that should be taken out of the  
20 class, and so forth.

21 So we don't actually have an accurate list  
22 yet. While Mr. Ross says an accurate list is  
23 possible, he says we have to look at more paper  
24 records to get that all nailed down. I think it's  
25 simpler than that. But we don't actually have an

1 accurate class list yet. The accurate class list  
2 will take care of the fact of damages, causation,  
3 that is the accurate class list will show these are  
4 the class members during this time period, these --  
5 each individual has eight, nine, twelve months,  
6 whatever, that are omitted. That's the causation  
7 factor. Those are the people who have been  
8 affected by the violation.

9 THE COURT: You're getting toward your  
10 five minutes. You're within a minute or two of  
11 your five minutes reserve period.

12 MR. STRONG: I have a minute or two left  
13 before my five minutes. Okay. The facts about the  
14 actuarial method are undisputed, and nobody has  
15 quarrelled with it, the details, except to make a  
16 suggestion that we should look at some things  
17 differently. They have the subscriber versus  
18 employees issue that I think is senseless. The  
19 class's employees, employees should get the same  
20 benefits that other employees get, and that  
21 includes dependent coverage. We don't have a class  
22 of, nor do we have to have a class of employees and  
23 each person is a dependent of theirs. So that's  
24 silly I think. The other issue is profit they say.

25 THE COURT: You would agree, wouldn't you,

1 Mr. Strong, that sometimes people have dependents  
2 that they choose not to get coverage for?

3 MR. STRONG: Yes.

4 THE COURT: That not everybody obtains  
5 every level of coverage that's available to them?

6 MR. STRONG: The people vary, but the  
7 group here is large enough to be statistically the  
8 same as everybody else.

9 THE COURT: If I accepted your wages  
10 argument, how would you handle the fact that often  
11 sometimes people don't pick up all the coverage  
12 that they could under a State offered plan?

13 MR. STRONG: Certainly people do waive  
14 coverage who are offered the coverage.

15 THE COURT: Or don't accept the highest  
16 level of coverage because it's a higher premium to  
17 them.

18 MR. STRONG: There is a little bit higher  
19 premiums for the employees. It's a very good plan  
20 though. You might analogize it to a bus pass or  
21 something where there's a noncash wage item. If  
22 they don't pay you, give you your bus pass, you  
23 don't have to prove that you walked to work.

24 THE COURT: No, no, no. I guess I'm  
25 getting at something else, which is even if I

1 accept the wage plan, it seems to me there's still  
2 some lurking issues of fact here in developing what  
3 are those damages that aren't just solved by  
4 saying, what did the State pay in premiums for the  
5 people that it did cover. You'd have to look at it  
6 at least in the actuarial way, if not individually,  
7 the behavior of the class members to determine  
8 whether any of them did waive coverage, whether as  
9 a general rule people don't always take the highest  
10 level of coverage, particularly when they're not  
11 being paid a lot of money, and they don't want to  
12 deduct more from their paycheck, in other words,  
13 that it's not, it seems to me, cut and dried, even  
14 if we accept your wage claim what the damages  
15 figure would be. Do you follow me?

16 MR. STRONG: I think that what your  
17 reference to actuarially is correct, that the  
18 actuarial method can account for all of those  
19 issues because it assumes correctly, based on the  
20 size of this group, that their behavior on average  
21 would be the same as the average behavior of the  
22 other people in the plan at the same time, and only  
23 if the State were actually able to show that there  
24 was a demographic difference, like these people  
25 were ten years younger or something, would that

1 average method not work, and that could be easily  
2 accounted for. The actuarials have a simple system  
3 with hundreds of millions of people in their  
4 database to know very well how much difference five  
5 years makes.

6 THE COURT: Okay. Thanks, Mr. Strong.  
7 Let's stop you there, because you're down to about  
8 three minutes to respond.

9 MR. LEYH: Good morning, your Honor.

10 THE COURT: Good morning. Good to see you  
11 again.

12 MR. LEYH: I'm Tim Leyh, and I'm from  
13 Calfo Harrigan Leyh & Eakes, which you have to say  
14 slowly because it's a new firm name for me.

15 THE COURT: It's great that your name is  
16 in it though.

17 MR. LEYH: Pardon me?

18 THE COURT: It's great that your name is  
19 in it.

20 MR. LEYH: I've handed up a packet of  
21 materials. I'm going to be referring to these.  
22 They're duplicative of the charts that I'm going to  
23 be showing you. Whichever is more convenient for  
24 your Honor.

25 A few comments on the procedural posture that

1 we're in, first of all, your Honor. Now, first I'd  
2 like to reserve about two minutes, if I may.

3 THE COURT: Okay.

4 MR. LEYH: There are two motions for  
5 summary judgment here. There's the State's motion  
6 that as a matter of law the plaintiffs have to  
7 prove both the fact that each class member actually  
8 suffered damage and that the -- and second, that  
9 the measure of damages that are actual out-of-  
10 pocket losses. Then there was the plaintiffs'  
11 motion that as a matter of law their actuarial or  
12 their premiums-based approach to damages is a  
13 reasonable proxy to actual damages.

14 We've objected to the proxy approach both  
15 because the plaintiffs are ignoring the requirement  
16 that they prove the fact of damage for each class  
17 member and also because it involves a host of  
18 disputed fact issues relating to how it would  
19 actually be implemented and the reasonableness of  
20 the result.

21 THE COURT: Let's stop right there with  
22 the fact of damage and the citation argument and  
23 let me ask you some questions about that. So are  
24 you saying that if somebody was definitely a member  
25 of the class, they were entitled to healthcare

1 benefits, and they weren't paid that nonetheless  
2 you can dispute whether they were damaged?

3 MR. LEYH: Yeah. And here's why, your  
4 Honor. I will answer the question. Can I do it in  
5 a slightly elliptical manner?

6 THE COURT: Sure.

7 MR. LEYH: We've cited -- first of all,  
8 this is a B3 class, so we're talking at this point  
9 only about monetary damages. It's black letter law  
10 that a plaintiff, in order to recover monetary  
11 damages, has to show the fact of damage.

12 THE COURT: Yup.

13 MR. LEYH: And that requirement is the  
14 same for a plaintiff in a class action as it is an  
15 individual plaintiff, and that's just a corollary  
16 of the rule that the class action device is a  
17 procedural device. It's not to change anybody's  
18 substantive rights, and the Walmart case recently  
19 affirmed that principle.

20 THE COURT: Those were cases that turned  
21 on individual treatment within Walmart and whether  
22 a class should have been certified at all. I have  
23 a class here. I know there were people who went  
24 uncovered. I'm looking for something analogous  
25 that says that people who aren't covered at all by

1 health insurance that they were entitled to aren't  
2 damaged.

3 MR. LEYH: Yeah. Two points. First, we  
4 know from the Sitton case that we need to look at  
5 individual damages. So in Sitton, the Court was --  
6 the Court rejected the plaintiff's trial plan,  
7 because it essentially skipped over the requirement  
8 of individual causation. What the plaintiffs  
9 propose to do --

10 THE COURT: But that again was a question  
11 of individual treatment by, as I recall, a lot of  
12 the doctors, right? They were claiming that they  
13 weren't reimbursed appropriately?

14 MR. LEYH: No. It had to do with the  
15 rejection of PIP claims by State Farm.

16 THE COURT: Right. But nonetheless, the  
17 question was as to each PIP claim as to whether or  
18 not it was properly rejected. Again it turned on  
19 individualized issues with the class.

20 MR. LEYH: Causation and damages. Excuse  
21 me for interrupting you, your Honor.

22 THE COURT: I know, but that's my point is  
23 that it was a liability issue, not just a damages  
24 issue. Had there been a class that was limited to  
25 only the people whose PIP claims had actually been

1       wrongly denied, then I would have trouble seeing  
2       why there wouldn't be damages flowing from that.

3               MR. LEYH: In Sitton the class had been  
4       certified.

5               THE COURT: I know.

6               MR. LEYH: And the plaintiffs alleged that  
7       there was a bad faith policy of rejecting these  
8       claims.

9               THE COURT: I know.

10              MR. LEYH: And then they said, the next  
11       thing, once we establish that, we're then going to  
12       turn to the question of was the class as a whole  
13       damaged. And then we're going to turn to the next  
14       phase was going to be what's the amount of the  
15       aggregate damages.

16              THE COURT: But wasn't the problem that  
17       the Court pointed out that there was just a  
18       skipping over of whether or not there had been a  
19       bad faith denial of any of the individual class  
20       members' claims?

21              MR. LEYH: Right, exactly.

22              THE COURT: But we haven't skipped over  
23       anything. We know that some of the members of the  
24       class in fact didn't get their benefits.

25              MR. LEYH: Right. That is the same as

1 having the thing denied for bad faith, having the  
2 thing denied. What the Sitton Court said is you  
3 can do a bifurcated approach, a phased approach, so  
4 long as it requires individual claimants to  
5 demonstrate causation and damages. And so then  
6 we've cited numerous cases to this effect in our  
7 briefing, your Honor.

8 THE COURT: Right, but I'm asking you to  
9 go back to the question I'm asking you, which is if  
10 I know somebody had their PIP claim denied in bad  
11 faith, if I know somebody was not paid their  
12 healthcare benefits, then why isn't causation  
13 established?

14 MR. LEYH: Because of this, your Honor.  
15 We know, this stipulation makes this case  
16 completely unique in my experience, your Honor, and  
17 I have done a few of these cases. This is -- this  
18 is the second tab there. I have the full one in  
19 your materials, but this is an excerpt of it. The  
20 parties stipulate that three, for those persons  
21 meeting the class definition, who did not have an  
22 any health insurance during months that they were  
23 eligible, so they're in the class and properly  
24 within the class, A, some persons incurred no  
25 healthcare costs because those class members did

1 not receive any healthcare services and, B, some  
2 persons incurred healthcare costs but those costs  
3 would not have been covered by any PEBB insurance  
4 plan.

5 So this stipulation applies to people who are  
6 correctly within the class. They were denied  
7 coverage and they were eligible for it. And within  
8 that group, some persons incurred no healthcare  
9 costs because they didn't go to the doctor and, B,  
10 some persons incurred healthcare costs, but they  
11 were for, you know, orthodontics and that wasn't  
12 covered under the plan. Those persons suffered no  
13 damage that would be recoverable in this case, and  
14 so we note, that's a matter of fact in this case.  
15 It's signed and entered by the Court. What we  
16 don't know is whether it applies to one person or a  
17 majority of the class.

18 We suspect that it applies to a substantial  
19 portion of the class for this reason, your Honor.  
20 The class notice group, and I'm going to talk about  
21 that in a minute, we know that more than half of  
22 that group, 51 percent, was without coverage for 60  
23 days or less, one or two months. It's fairly  
24 intuitive and I think reasonable to assume that  
25 persons who are without coverage for a relatively

1 short period of time probably wouldn't have gone to  
2 the doctor during that period of time and would not  
3 have incurred any out-of-pocket healthcare costs,  
4 and so that -- that's a fact in this case. It's an  
5 undisputed fact, and it completely changes the  
6 nature of this case from frankly any other case  
7 that I've ever been in where we have members of the  
8 class who admittedly suffered no damage.

9 This is not like a case where there's some  
10 hidden fee in your phone bill, and so merely by  
11 virtue of the fact that you're in the class, you've  
12 suffered the damage. That definitional approach to  
13 damages doesn't work here, because of this  
14 stipulation, and because of all the other problems  
15 we've identified. We know some of the class  
16 members didn't suffer any out-of-pocket damages.  
17 We know that suffering out-of-pocket damages is an  
18 essential element of your case. We know from the  
19 Sitton case that a trial plan, a damages approach  
20 that does not require individual claimants to  
21 demonstrate causation and damages will be rejected  
22 by Division I, and so that's the situation we're in  
23 here. We have a class that, you know, correctly or  
24 not, includes people who suffered no damage, and  
25 there's no dispute from the plaintiffs about that.

1           So let me turn to the next topic that I want  
2 to get to, because it will actually blend back into  
3 this. And that's the measure of damages. The  
4 question is what have other courts done in the  
5 context of measuring damages for unpaid health  
6 insurance? Cuz that's the issue we have here, and  
7 the question is not do we label it wages or do we  
8 label it restitution or do we label it something  
9 else. It's how do you measure it. Cuz that's what  
10 these motions are about.

11           We've cited a number of cases, key among them,  
12 I think, or most significant among them is the City  
13 of New York case, and I'll test your patience, your  
14 Honor, and I'm just going to read some of these  
15 quotes.

16           THE COURT: I've already read the New York  
17 case. You've all cited it to me and I've read it.

18           MR. LEYH: Okay. That case clearly says  
19 that the measure of damages for a victim of  
20 discrimination is the actual out of pockets. If  
21 you didn't suffer an economic loss, if you didn't  
22 purchase substitute insurance or pay for medical  
23 care directly, you didn't suffer an economic loss  
24 and you shouldn't receive damages. It goes into  
25 the rationale for that. Premiums are purely

1 looking forward. They're a predictive feature of  
2 insurance. Premium is set at the beginning of the  
3 year as a guess for what will happen during the  
4 year. Damages are to look back at what happened.

5 Liability is based on the actual loss to the  
6 plaintiff, not a projection of what the loss is.  
7 And mind you, your Honor, this was in a very large  
8 discrimination class action involving firefighters  
9 in the city of New York. The Court there addressed  
10 and rejected the very same argument the plaintiffs  
11 are making here is really their only argument in  
12 favor of this actuarial approach, which is  
13 convenience. The Court in New York said, the main  
14 argument is the greater convenience of  
15 administering such a rule in the class context.

16 And as the Court said, I understand that. We  
17 agree. I agree today that adopting some kind of,  
18 you know, actuarial approach would be more simple,  
19 but it would be wrong. That simple method would  
20 create nontrivial opportunities for over or under-  
21 compensation, both between the City and the  
22 claimants and among the claimants themselves.

23 One way to look at this, your Honor, is  
24 imagine you had two identically situated  
25 plaintiffs, members of our class who were denied

1 coverage for three months. One of them is  
2 perfectly healthy. The other gets hit by a bus in  
3 the middle of that period. The plaintiffs' plan  
4 would give them each \$500 a month because that's  
5 the premium. So the guy who was healthy gets a  
6 windfall of \$1500. The guy who got hit by the bus  
7 and incurred a hundred thousand dollars in medical  
8 costs suffers an uncompensated loss. That's the  
9 problem with this approach. It's one of the  
10 problems with this approach.

11 The Galindo case -- there's no Washington case  
12 that's spot on directly on point here, your Honor.  
13 The Galindo case is from the Ninth Circuit, and it  
14 holds, where an employee's fringe benefits include  
15 medical and life insurance, a plaintiff should be  
16 compensated for the loss of those benefits if the  
17 plaintiff has purchased substitute insurance or has  
18 incurred uninsured out-of-pocket medical expenses.  
19 The Court goes on to say that the district court  
20 gave -- went with the premiums approach and the  
21 Ninth Circuit rejected that and said such an award  
22 was improper because lost insurance coverage,  
23 unless replaced or unless actual expenses are  
24 incurred, is simply not a monetary benefit owing to  
25 the plaintiff.

1           We have Judge Weinberg's decision in the EEOC  
2 vs. Northwest Airlines case where he rejected the  
3 EEOC's position that it should be premiums.

4           The Frank Coluccio case we cited, your Honor,  
5 is kind of the closest that Washington courts have  
6 gotten, and that was a contract case. The issue  
7 was a breach of an obligation to provide a  
8 builder's risk policy to King County. Division I  
9 said the measure of damages is the amount that  
10 would have been covered by insurance that was not  
11 in place, not the premiums. That is precisely the  
12 issue. It was a contract claim. It wasn't a class  
13 action, but it's pretty darn close.

14           So the cases that the plaintiffs rely on don't  
15 suggest otherwise. The only case -- or their main  
16 case is Cockle. Cockle is not on point and here's  
17 why, your Honor. Cockle involved the question of  
18 whether health insurance fell within the definition  
19 of wages for the purposes of the workers  
20 compensation statutes. The Court held that it did,  
21 but the question of how do you value health  
22 insurance was never even raised in Cockle because  
23 the parties stipulated to the value of the health  
24 insurance benefit. That appears on the very first  
25 page of the opinion, where the Court says, the

1 parties stipulated that the coverage was worth  
2 approximately 20 percent of her monetary  
3 compensation.

4 So the question that is at issue on this  
5 motion, how do you value health insurance, was  
6 never even presented in Cockle. There's language  
7 about it that the plaintiffs have taken out of  
8 context, but it's pure dicta, and it wasn't even at  
9 issue.

10 Fariss, the other case they rely on, Fariss  
11 vs. Lynchburg Foundry, that involved life  
12 insurance, and in life insurance the benefits never  
13 go to the injured employee who was deprived of the  
14 benefit. They go to the beneficiaries or, you  
15 know, the survivors of that person.

16 So the cases that have specifically addressed  
17 this issue have nearly all found that the measure  
18 of damages for a failure to provide health  
19 insurance is the plaintiff's out of pocket losses.

20 And obviously if you-- if the Court adopts  
21 that approach, you solve the problem of conflict  
22 with Sitton, the fact of damage problem with  
23 Sitton, because no plaintiff will recover without  
24 establishing that they in fact suffered damage. So  
25 the problem that is created by our stipulation goes

1 away if the measure of damages is appropriately  
2 addressed.

3 Now, let me deal with some of the problems  
4 with their actuarial approach. Their plan, I mean  
5 they don't even pretend to be proving actual  
6 damages. They are proving -- they are supplying a  
7 proxy which they say will get you reasonably close  
8 and should be adopted for purposes of  
9 administrative convenience. It basically consists  
10 of taking X, which is the eligible without  
11 receiving months, times Y, which is the premiums,  
12 and multiplying them together to get damages. The  
13 problem is that both variables in that are  
14 overstated and wrong.

15 The X value, which is the number of eligible  
16 without receiving months, is overstated now for all  
17 of the reasons that we go into in the briefs about  
18 why the class notice group is so overbroad at this  
19 point. We've gone into some great detail about  
20 that because there's a dispute about whose fault it  
21 is that the class notice has gone out to a broad  
22 group. But the fact of the matter is the State has  
23 spent hundreds of hours and thousands of dollars  
24 trying to get this right, and we can't get, and  
25 that is because of the difficulties of using

1 computers to try to apply this class definition to  
2 the database that we have, and what's going to be  
3 necessary is an individual document review to get  
4 to an actual accurate class group.

5 But X here is overstated for an even more  
6 fundamental reason, and that's the stipulation. We  
7 know, because the plaintiffs have agreed, that  
8 whatever we come up with with X includes people who  
9 in fact suffered no damage. And so X is overstated  
10 throughout. Then the Y, the question, the  
11 premiums, well, the premiums don't work as the --  
12 here because they don't in any way match the actual  
13 damages suffered by the plaintiffs.

14 Premiums necessarily include all of the  
15 insurers overhead and its costs and its profits,  
16 and they don't reflect the actual -- even if they  
17 were not forward looking, they don't reflect the  
18 actual costs incurred by the plaintiffs.

19 Secondly -- well, Dr. Feldman, one of the  
20 State's experts, has said that those -- that the  
21 insurer profit and overhead portion of the premiums  
22 can be as much as 40 percent of the premium. The  
23 plaintiffs say, well, we're going to take that out,  
24 but they don't tell us how, they don't tell us  
25 when, anything about how they're going to do that.

1 Worst, the premiums that they're trying to use here  
2 are for a demographically different group.

3 Mr. Strong said just a moment ago that their  
4 calculation assumes that the demographics of the  
5 class match the demographics of the group. We put  
6 in evidence that that's not so. The class is in  
7 fact materially younger, which ends up being  
8 materially cheaper in the insurance world than the  
9 State employee population as a whole, which kind of  
10 makes intuitive sense, because they're part-time  
11 workers, by and large, or a lot of them are. So  
12 the evidence that we've put in front of the Court,  
13 your Honor, is that that will substantially and  
14 materially affect the cost to insure this group,  
15 and it makes the use of premiums inappropriate.  
16 There's at least a factual issue about that  
17 dispute, about that issue, your Honor.

18 Finally, as your Honor has noted, the premiums  
19 vary according to the company. There's several  
20 different insurers that you can choose from within  
21 the State plan, the tier of coverage, whether  
22 you're going with just the individual or the  
23 individual plus spouse or individual plus two kids  
24 or three kids. Those all change the premiums and,  
25 you know, you can elect what kind of deductible you

1 want and copay; that all changes the premiums. So,  
2 you know, we're operating in a vacuum here as to  
3 what premium they're actually going to even use.

4 This actuarial proposal in fact, your Honor,  
5 is a black box proposal, and there is -- there are  
6 way too many factual issues for the Court to impose  
7 it at this point as a matter of law.

8 It's the product of the multiplication of two  
9 overstated values to get an overstated damages  
10 number. You heard Mr. Strong make reference to  
11 200,000 months without coverage and \$500 per month.  
12 That's a hundred million dollars that the  
13 plaintiffs are trying to get here using this  
14 calculation, your Honor.

15 In conclusion, your Honor, a damages  
16 methodology has to pass the test of reasonableness,  
17 both in the methodology and in the results that it  
18 derives. Their actuarial proposal doesn't even  
19 come close to meeting that standard and certainly  
20 not as a matter of law. The Court should follow  
21 the rule of the Sitton case -- I got 30 seconds.

22 THE COURT: You don't. But go ahead.

23 MR. LEYH: -- and require the plaintiffs  
24 to show that each class member suffered individual  
25 damage. It should require that the plaintiff show

1 their actual out-of-pocket damages to recover any  
2 monetary relief. These are just the normal  
3 requirements for plaintiffs' case. The goal of  
4 damages is to make the plaintiffs whole, put the  
5 plaintiff where she would have been but for the  
6 breach of duty. These plaintiffs were never  
7 entitled, pardon me, were never entitled to get the  
8 premiums. They were entitled to have their out-of-  
9 pocket medical expenses paid for, and that should  
10 be the measure of their damages. Thank you, your  
11 Honor.

12 THE COURT: All right. You're out of  
13 time. The plaintiff has three minutes left. Let  
14 me hear from you on the Galindo case, which I don't  
15 think you discussed in any of the memoranda that  
16 I'm looking at here. You talked plenty about the  
17 U.S. --

18 MR. STRONG: All I know about the cases,  
19 your Honor, those were all different kinds of  
20 discrimination cases.

21 THE COURT: I just want you to talk about  
22 Galindo.

23 MR. STRONG: What?

24 THE COURT: Galindo, I want you to just  
25 talk about Galindo and address whatever you like,

1 the Ninth Circuit case.

2 MR. STRONG: I don't have a copy of  
3 Galindo here, your Honor.

4 MR. LEYH: I can get you one.

5 THE COURT: Okay.

6 MR. STRONG: It's a fair representation  
7 case, your Honor. It doesn't say that the class  
8 action can do one way or another actually.

9 THE COURT: It's a calculation of what  
10 fringe benefits are worth, and what the Court says  
11 there is that the plaintiffs should be compensated  
12 only if the plaintiff has bought substitute  
13 coverage or has uninsured out-of-pocket medical  
14 expenses. Do you want to talk about that at all?

15 MR. STRONG: Sure. This case, like all  
16 the other discrimination cases, involves people who  
17 are not employees of the employer, because they  
18 were fired or never hired. There's always the  
19 issue about what they received somewhere else. And  
20 it is a proper way of calculating sometimes. I  
21 mean that's not really an issue. It's not however  
22 in any case required by -- by any court.

23 The situation with the class action is  
24 extremely different, and the reason why it's  
25 different, and one of the important things here, is

1 that we have submitted a lot of facts to explain  
2 why it's different, and the other side has a lot of  
3 arguments, and they cite the New York case and this  
4 case as though they were facts, but the important  
5 thing here, and in response to your question now  
6 and your question earlier about wages, is that the  
7 premiums were not just forward looking. They are  
8 based on the actual experience of that year.

9 In this particular case, we're looking  
10 backward. We can look at the composite funding  
11 rate for each year, and it contains all the things  
12 that deal with the actual losses of employees on  
13 average. The composite funding rate includes the  
14 average of how many dependents they have, of what  
15 plan they chose. All those issues you brought up  
16 earlier are all built into the composite funding  
17 rate by the actuaries the State has.

18 So when you take the composite funding rate  
19 and multiply it by the number of employees, you end  
20 up with a very precise number for the total loss of  
21 the class. That's not at all disputed that that's  
22 an accurate statistical actuarial method of  
23 determining a precise method of the loss for the  
24 class.

25 Now, the other side here wants to talk about

1 the New York case and these other cases, mostly for  
2 the purpose of complaining about that issue of  
3 overcompensation or undercompensation, because they  
4 say, well, one person might not have had any -- a  
5 loss in a month and they say, one or two months.  
6 Well, first of all, one to two months, those people  
7 are all the people that aren't in the class at all  
8 with the waivers and so forth, and take out all the  
9 people with one or two months, according to Mr.  
10 Ross, you take out 20,000 months, that is a lot of  
11 people, but not very many of the months. We still  
12 have 90 percent of the months, and those people who  
13 were left have average of ten months or twelve  
14 months, or something like that. It's really hard  
15 to say they don't have any loss, and the evidence  
16 shows that they have some loss just because they  
17 don't have insurance. That's an undisputed fact  
18 here too.

19 THE COURT: Lastly, talk very briefly  
20 about your stipulation.

21 MR. STRONG: Yes. The stipulation says  
22 that people don't have -- the stipulation is not a  
23 stipulation about causation. The causation is the  
24 question of which people had loss which months.  
25 The stipulation pertains to this question of the

1 actuarial method, whereas does the actuarial method  
2 include some people in it that have no loss. Yes,  
3 we've always said it does. The actuarial method  
4 has 200,000 months. We know from the actuarial  
5 method and the way the State sets up the premium  
6 funding rate what the total loss on average is for  
7 most people.

8 THE COURT: You're saying the stipulation  
9 is about using the actuarial method, not about  
10 causation.

11 All right. Folks, thank you. I'm going to  
12 step off the bench and I'll come back with my  
13 ruling.

14 (Brief recess taken.)

15 THE COURT: Thank you everyone for as  
16 usual a truly impressive level of briefing and  
17 argument on this case. Let me walk through the  
18 Court's thinking here. There are a number of  
19 factual issues remaining in this case that prevent  
20 the Court from ruling entirely in the plaintiffs'  
21 or the defendants' favor on the issues presented  
22 here. The first issue is the one well known to the  
23 parties, and that is that the class is still not  
24 defined, and that bears directly on the question  
25 that the plaintiffs have asked me to rule on.

1           We have enough problems with how the class is  
2           defined that I just denied a motion by the  
3           plaintiffs to reissue the notification to potential  
4           class members of the class action. And I did that  
5           because I can't really tell if the notice is  
6           overbroad. It appears to be, but the ways in which  
7           it's overbroad still seem to be under discussion  
8           between the parties. As I understand where the  
9           parties are right now, they have deferred some of  
10          the hard decisions about who is in and out of the  
11          class and have simply been overinclusive.

12           That's going to greatly affect the measure of  
13          damages here for reasons that I'm going to get to.

14           A second question, which we haven't talked  
15          about as much because we're only now reaching the  
16          issue of damages, is deciding the behavior of  
17          people who should have received health insurance as  
18          a benefit and weren't given that option. I don't  
19          agree with the plaintiffs that it's an appropriate  
20          proxy to say that that group would have behaved  
21          like the people who did receive insurance coverage.  
22          And therein I think lies the best of the  
23          defendants' argument about the need to prove  
24          causation, that and the problem with the definition  
25          of the class.

1           Let me walk you more clearly through my  
2           thinking here. Let me first of all say something  
3           rather strong about the appropriate measure of  
4           damages here that I am now convinced of having read  
5           your case law. I don't agree with the defendants  
6           that there's a strong, consistent rule that when  
7           healthcare benefits aren't paid that the  
8           appropriate approach is an individualized one of  
9           assessing whether somebody got their own  
10          replacement health insurance and whether they had  
11          actual healthcare costs.

12          The best I can say about the federal case law  
13          that's been provided to me is there's a split in  
14          authority. There's plenty of federal cases  
15          indicating that it's perfectly appropriate in this  
16          kind of class action to look at the plaintiffs in  
17          aggregate, not individually. And there are a lot  
18          of things wrong with the assumption that one should  
19          look at the plaintiffs individually, which don't  
20          exist and didn't exist in cases like Sitton and  
21          Walmart, and for that matter some of the other  
22          cases cited to me today.

23          First of all, the fact that people don't have  
24          health insurance, as we all know now I think from  
25          the endless public and media discussion of the

1 Affordable Healthcare Act, does not mean that they  
2 didn't have impacts on their healthcare choices.  
3 The studies that have come out indicate that people  
4 who don't have health insurance put off necessary  
5 healthcare. They don't get routine care and  
6 check-ups, which results in the deferred problems  
7 that the plaintiff has talked about in their  
8 briefing. They don't go in for pressing medical  
9 needs either, according to the studies that I think  
10 are public knowledge at this point. People even  
11 put off necessary care for urgent medical issues  
12 like potentially fatal diseases, so to say that the  
13 measure of loss for somebody who didn't get health  
14 insurance coverage that they should have been  
15 offered and were entitled to is nothing, unless  
16 they bought replacement care or had actual medical  
17 costs, is a great understatement, according to  
18 everything we know about this field, of what actual  
19 damage was.

20 But I will also say, because I don't think  
21 this is a mystery either, that as the State handles  
22 insurance, and as I think almost everybody does,  
23 health insurance is a benefit that employees are  
24 offered but that not every employee takes. That's  
25 clearly true in the experience the parties have had

1 here, because there's lots of people who currently  
2 waived their right to coverage. Also lots of times  
3 people will be offered very generous benefits that  
4 would cover dependents they have, and they don't  
5 take those benefits because they have to pay a  
6 higher amount out of their paycheck.

7 I would suggest to the plaintiffs that there's  
8 a good case to be made that people who are working  
9 for a short period of time may not be interested in  
10 getting insurance and taking that deduction from  
11 their small paycheck, and there's also a good case  
12 to be made that people like that may not want the  
13 highest and best level of coverage either. So I  
14 think there are arguments to be made here on both  
15 sides, but I think that the defendants' argument  
16 that this should all get boiled down to  
17 individualized claims based on whether purchased  
18 substitute insurance or suffered medical damages is  
19 just wrong as a matter of common sense, public  
20 policy, and general knowledge. "

21 And the fact that a case like Galindo  
22 calculates otherwise as to an individual doesn't  
23 really change my mind about that. Galindo was  
24 looking specifically at somebody who had been  
25 damaged in that particular case, not at how to look

1 at a class of people who hadn't received healthcare  
2 benefits they were entitled to. So this problem of  
3 aggregate impacts on failure to provide healthcare  
4 benefits that should have been offered isn't  
5 informed by the assessment of how a Court treats an  
6 individual plaintiff in a labor case.

7 I also want to tell the parties that it is  
8 very clear to me that in Washington, if not in  
9 other places, that we view the right to healthcare  
10 benefits as a form of wages. I agree that Cockle  
11 is a workers compensation case, but I do not agree  
12 that Cockle is limited to wages in the workers  
13 compensation context. The Cockle Court looked very  
14 broadly at what wages are under Washington law, and  
15 the Court expressly rejected any method that  
16 required a hypothetical calculation of market  
17 value. The Court in Cockle indicated that premiums  
18 actually paid by the employer to secure the benefit  
19 are going to be the best measurement for wages  
20 lost.

21 It's very difficult to think about the health  
22 benefit that should have been offered to the class  
23 in this case as anything but a wage benefit.

24 And to the extent that the State saved lots of  
25 money by not paying any premiums on behalf of class

1 workers who should have been offered this benefit  
2 over the period of time at issue, arguably it owes  
3 some restitution.

4 Now, having said that I accept the broad idea  
5 that the failure to pay wages, the failure to  
6 provide healthcare benefits is a form of wages, and  
7 that this is a failure to pay wages claim by the  
8 class, and having said as well that I think the  
9 restitution argument is well taken, I don't think  
10 that ends our inquiry.

11 Because the employer's obligation to pay  
12 premiums and what the employer would have paid in  
13 premiums will depend a great deal on the factual  
14 questions that still haven't been answered here.  
15 Let me come back to this one more time with the  
16 parties. Not everybody is going to opt for a  
17 deduction from their paycheck for healthcare, and  
18 we don't know how that would have impacted this  
19 class. That's part of the damages causation  
20 inquiry that I think we still have alive in this  
21 case.

22 Not everybody that should have been offered  
23 healthcare benefits would have opted for top level  
24 care or top tier care. In fact, it's quite likely  
25 that a good deal of them would have opted for cheap

1 healthcare and lower tier, but we don't know how  
2 many, and that too goes to some degree damages  
3 causation.

4 Not everybody that's putatively before me  
5 today is really a member of this class. And that's  
6 going to go to the overall calculation of damages  
7 as well as to the subinquiries about how the actual  
8 class would have behaved.

9 So we still have issues of fact in this case.  
10 What I can tell you clearly, what's obvious to the  
11 Court, is that the failure to provide healthcare  
12 benefits was a denial of wages for actual class  
13 members, and it's also clear to me that the  
14 plaintiffs' restitution theory makes sense.

15 A third thing that I think is true but that  
16 I'm not willing to rule on at this moment, it seems  
17 self-evident but we will see, is that it's  
18 extraordinarily unlikely that there's a lower  
19 measure of what the plaintiff class should have  
20 received than the premiums that the employer would  
21 have had to pay had they offered these healthcare  
22 benefits to the class.

23 I say that because I suspect there's no better  
24 price out there for the healthcare benefits that  
25 weren't offered than what the State as an employer

1 could receive in the market. It's pretty unheard  
2 of for individuals to be able to get better premium  
3 rates than the State, but I'll let the parties  
4 fight about that.

5 So what the Court is saying again is not  
6 exactly what the parties are arguing to me. I  
7 agree with the plaintiffs that the failure to pay  
8 benefits is a failure to pay wages, and I agree  
9 with the plaintiffs that the State received a  
10 windfall here as a whole, that it shouldn't have  
11 received, by not paying for the folks that are in  
12 the class, but I think there are huge factual  
13 issues that the parties are going to have to tackle  
14 and solve first about who's in the class.

15 Second, for those who were in the class, about  
16 what the behavior would have been in terms of  
17 actually opting for coverage and, thirdly, what  
18 their behavior would have been with regard to what  
19 level and quality of coverage.

20 The State would not have had to pay as much in  
21 premiums I think as the plaintiffs are calculating,  
22 not even close for the members of this class,  
23 because my bet is that once we have some actuarial  
24 evidence from the State that we're going to find  
25 that the number of people who would have opted for

1 coverage or would have opted for it in as rich  
2 amounts as the full-time employees who received  
3 coverage is a good deal less.

4 I think this case has been in some ways a  
5 moving target. Each time we look more closely at a  
6 facet of this case, we discover complexity that we  
7 didn't see coming, and this is not another example  
8 of it. So I have done my best for you on the  
9 measure of damages ruling. I do reject the  
10 defendants' argument that this is an individualized  
11 inquiry for the reasons I've stated, but I do agree  
12 with them that there are issues of fact here on the  
13 topics that I've outlined.

14 Give me an order that reflects my ruling, if  
15 you would, everybody. Thank you.

16 (Whereupon, the proceedings were  
17 concluded.)

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C E R T I F I C A T E

STATE OF WASHINGTON)

) SS.

COUNTY OF KING )

I, Michelle Vitrano, Certified Court Reporter,  
in and for the State of Washington, do hereby  
certify:

That to the best of my ability, the foregoing  
is a true and correct transcription of my shorthand  
notes as taken in the cause of DOUGLAS L. MOORE, et  
al., vs. HEALTH CARE AUTHORITY, et al., on the date  
and at the time and place as shown on page one  
hereto;

That I am not a relative or employee or  
attorney or counsel of any of the parties to said  
action, or a relative or employee of any such  
attorney of counsel, and that I am not financially  
interested in said action or the outcome thereof;

Dated this 31st day of October, 2012.

\_\_\_\_\_

Michelle Vitrano

Certified Court Reporter

# EXHIBIT 4

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The Honorable Catherine Shaffer  
Friday, October 26, 2012  
With Oral Argument at 10:00 a.m.

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

SECOND DECLARATION OF  
STEPHEN C. ROSS RE: MEASURE OF  
DAMAGES

I, STEPHEN C. ROSS, am over the age of 18, base this declaration on  
personal knowledge, and am competent to make this declaration.

Introduction

1. I have been designated by the Defendants as a testifying expert in this litigation  
("Moore"). I have personal knowledge of the facts set forth herein and have been asked by  
the State of Washington to offer my opinions with respect to the matters discussed in this  
declaration.



1 2011 Declaration. The statement is misleading and relates to a class list  
2 that is materially different from the current *Moore* notice class list.  
3 Moreover, Mr. Festor further testified in that same paragraph: "*The*  
4 *State says the lists are 'over-inclusive.'* *We agree with the State that the*  
5 *lists are over-inclusive in the sense that they include some employees*  
6 *that should not be included. The lists also appear to be under-inclusive*  
7 *in some respects.*"<sup>5</sup>)

8 (c) "*the State's violation of the health benefits statute actually denied*  
9 *benefits to 20,000-plus class members in specific discrete months.*"<sup>6</sup>

10 (d) "*Plaintiffs are seeking, and have proved through the State's records and*  
11 *through expert testimony, the aggregate loss for the class as a whole.*"<sup>7</sup>

12 (e) "*...the parties have identified both the class members and the specific*  
13 *months for which they were wrongly denied health benefits that were*  
14 *owed as part of their employment with the State.*"<sup>8</sup>

15 6. Despite the State's lengthy and diligent efforts, it has not yet been possible to  
16 accurately identify the actual *Moore* class members and the number of months during which  
17 they were wrongly denied health benefits. The current notice class list is significantly  
18 overbroad. As further described in this declaration, difficulties arise from the fact that  
19 notwithstanding the clarified class definition, numerous issues regarding health benefits  
20 eligibility still exist. Furthermore, the actual class members cannot be identified reliably and  
21 accurately solely from a computer query of the State's electronic payroll and health benefits  
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23  
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25 <sup>5</sup> Declaration of Stephen Festor, November 10, 2011, pg 2, lines 16-19.

26 <sup>6</sup> "Plaintiffs' Response to State's Motion for Individual Bill Submissions," pg. 15, lines 16-17.

<sup>7</sup> "Plaintiffs' Response to State's Motion for Individual Bill Submissions," pg. 20, lines 7-9.

<sup>8</sup> "Plaintiffs' Response to State's Motion for Individual Bill Submissions," pg. 21, lines 9-11.

1 data. This work is ongoing and depends in part on further rulings from the Court on  
2 important eligibility issues.<sup>9</sup>

3  
4 **Plaintiffs' Assertion That the State's Liability Defenses "Apply to a Very Small**  
5 **Fraction of the Class"**

6 7. Plaintiffs also incorrectly assert that "*The State retains a few defenses to*  
7 *liability that apply to a very small fraction of the class...*"<sup>10</sup> The State's liability defenses are  
8 broad and potentially apply to a large percentage of the class.

9 8. By definition, the State can only be liable for improperly denying health  
10 benefits (and the resulting damages, if any) if an employee actually was eligible for health  
11 benefits. The mere inclusion of an individual on the *Moore* notice class list does not  
12 establish eligibility. Moreover, the *Moore* notice class list substantially overstates both the  
13 individuals and the months for which they were actually eligible for, and wrongly denied,  
14 health benefits.<sup>11</sup> This primarily results from the following issues:

- 15 (a) The State's electronic payroll and health benefits data contains  
16 significant data gaps or otherwise does not provide the information  
17 necessary to establish whether an individual was actually eligible for and  
18 improperly denied health benefits. For example, there is no hire or  
19 termination date data for six of the seven educational employers. 76%  
20 (154,389 months) of the total months of "apparent" eligibility for the  
21 *Moore* notice class relates to these six employers. The questions of  
22  
23

24 <sup>9</sup> The impediments and complexities involved in identifying the actual *Moore* class are discussed in detail in  
25 my September 28, 2012 declaration.

26 <sup>10</sup> "Plaintiffs' Response to State's Motion for Individual Bill Submissions," pg. 11, footnote 2.

<sup>11</sup> The reasons why the *Moore* notice class list is overstated are discussed in further detail in my September 28,  
2012 declaration.

1                   whether an employee was terminated and, if so, under what  
2                   circumstances are important to determining potential eligibility.

3                   (b) The electronic payroll data includes some form of job title or position  
4                   data for only four of the seven educational employers.<sup>12</sup> However, even  
5                   when this information is included in the electronic data, it is not always  
6                   determinative. For example, the SBCTC data includes thousands of  
7                   entries which indicate little more than the nature of employment (i.e.,  
8                   part-time, exempt, hourly, classified, student) as opposed to the job  
9                   position. Of the approximately 80,000 months of "apparent" eligibility  
10                  attributed to employment at SBCTC, at least 34,000 months include no  
11                  (or no meaningful) job position information.<sup>13</sup>

12                 9. To the extent that establishing and/or maintaining eligibility for employer-  
13                 provided PEBB health benefits requires an employee to work in the same job position during  
14                 those months (a question relevant to the State's potential liability for health benefits), the  
15                 absence of hire and termination dates in the electronic payroll data will necessitate the review  
16                 of extrinsic data, as will the absence of useful or any job title or position data. Clearly, this is  
17                 not a limited occurrence that may "*apply to a very small fraction of the class.*"

18                 10. In addition, there are numerous unresolved eligibility questions which have yet  
19                 to be decided by the Court. Once these issues have been decided by the Court, or otherwise  
20                 resolved, it will be necessary to incorporate any resulting modifications to the class definition

21 <sup>12</sup> Because the meaning and applicability of work in the "same position" is not agreed by the parties, the job title  
22 or position data was not utilized in any way in the query criteria utilized to identify "apparent" eligibility for  
the notice class.

23 <sup>13</sup> Based upon the non-faculty, non-permanent employee query results where "apparent" eligibility is indicated  
24 and the SBCTC job class title is either blank or contains one of the following: "Class B Hourly," "Class  
25 Exempt PT," "Class Hourly," "Classified Hour," "Exempt-Hourly," "H Nonstudent," "Hourly," "Hourly -  
26 Studen," "Hourly Other," "Hourly-Nonstude," "Hrly Exmpt 1-4," "Hrly Exmpt II-5," "Hrly Exmpt V-3,"  
"Hrly Exmpt V-5," "Hrly Exmt III-5," "Hrly Exmt III-7," "Misc Hourly," "Other Hourly," "P.T. Hourly,"  
"P/T Hourly," "Part Time Hourl," "Parttime Hourly," "PT-Hourly Assgn," "PT-Other," "Student," "Student  
Emp," "Student Help," "Student Hourly," "Students," "Students Hourly," "Temp Hourly," "Temp. Part-  
Time," or "Temporary Non S."

1 so that revised analyses of potential class eligibility can be performed. Resolution in the  
2 State's favor will reduce (and could substantially reduce) the *Moore* notice class. Once the  
3 computer queries are rerun to generate a revised potential class list, it will be necessary to  
4 undertake individualized assessments of extrinsic data to determine which potential class  
5 members are actual class members and the respective periods for which health benefits were  
6 improperly denied.

7 11. Furthermore, based on the work that I have performed, it is apparent that there  
8 are other data gaps such as unrecorded waivers, and other information maintained by the  
9 respective employers demonstrating that putative class members identified by computer  
10 queries of the State's electronic payroll and benefits data were not, in fact, eligible for health  
11 benefits.<sup>14</sup>

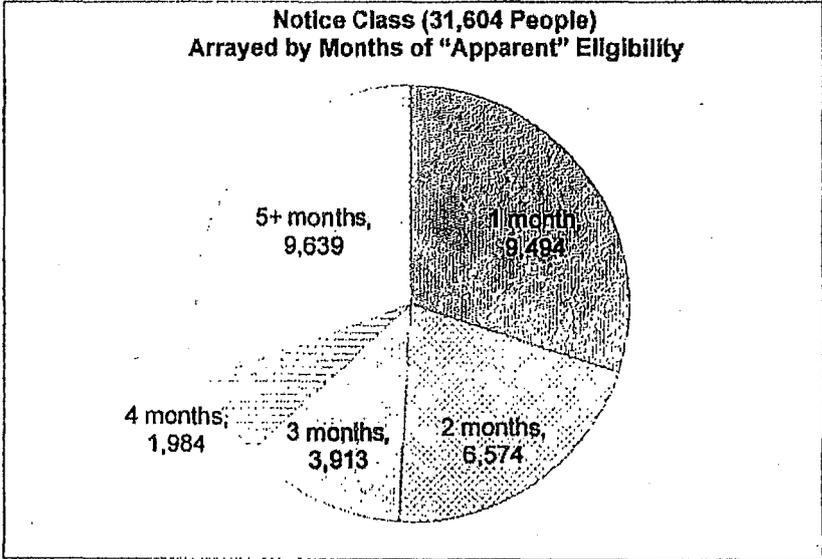
12 12. In my opinion, there is no credible basis to conclude that the State's liability  
13 defenses (e.g., whether an employee was in fact eligible for and improperly denied health  
14 benefits) "*apply to a very small fraction of the class.*" Rather, data gaps and other issues  
15 central to the question of eligibility apply to a significant majority of the current *Moore*  
16 notice class. Whether an employee actually was eligible for health benefits can only be  
17 determined once these issues are investigated and resolved. It cannot be accomplished solely  
18 by computer queries.

19  
20 **The "One Month of Apparent Eligibility" Issue**

21 13. A large proportion of the individuals in the *Moore* notice class have very few  
22 months of "apparent" eligibility. As set out in the following chart, 9,494 people, or 30% of  
23 the individuals, have one month of "apparent" eligibility, while 16,068, or 51%, have two  
24 months or less of "apparent" eligibility.

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26 <sup>14</sup> These circumstances are discussed in my November 10, 2011 declaration.

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14. Of the 9,494 people with one month of "apparent" eligibility, the data reflects that for 2,912 people (31%), the single month of "apparent" eligibility was either 1) the final month of that person's employment with the State in any position, or 2) followed by a break in service of at least one calendar month after which the person eventually returned to work (months or years later, in a position which may or may not have been the same as he/she previously held).

15. Even assuming that the extrinsic data demonstrates these people actually were eligible for health benefits, it still would be necessary to conduct individualized assessments to determine whether or not the State notified these employees of their eligibility for health benefits, and, if so, whether the employee responded prior to the break in service.

16. An additional 4,057 people (43%) either received or waived PEBB health benefits the month following the single month of "apparent" eligibility.

17. Clearly, the State offered these employees health benefits. However, absent individualized assessments, the extent to which the timing of the receipt of health benefits or waiver was influenced by the timing of the State's actions (i.e., when did the State notify

1 the employee) as opposed to the employee's actions (i.e., when did the employee respond)  
2 cannot be determined. Again, given the number of individuals involved, the issue does not  
3 "apply to a very small fraction of the class."

4 19. The fact that more than half of the *Moore* notice class has "apparent" eligibility  
5 for two months of benefits or less (further analysis of extrinsic data is required to establish  
6 actual eligibility) strongly suggests that the lack of benefits was not a result of the State's  
7 failure to properly apply averaging, or to otherwise intentionally deny benefits. It also  
8 raises issues with respect to potential damages. It is reasonable to assume that individuals  
9 without health insurance for one or at most two months would be less likely to procure  
10 alternative insurance or incur health care expenses in that period compared to individuals  
11 who were without health insurance for considerably more extended periods. In any event,  
12 individualized assessment is necessary to determine whether and in what amount damages  
13 may have been incurred.

14  
15 DATED this 5th day of October 2012 in Seattle, WA.

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20 STEPHEN C. ROSS  
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**PROOF OF SERVICE**

I hereby declare that on this 5<sup>th</sup> day of October 2012, I caused to be electronically filed the foregoing document with the Clerk of the Court using the King County E-filing system and/or E-Service which will send notification of such filing and that I also served a copy of this document on all parties or their counsel of record on the date below as follows:

Hand Delivery *and email*

Stephen K. Strong  
Stephen K. Festor  
Bendich, Stobaugh & Strong, P.C.  
701 Fifth Avenue, Suite 6550  
Seattle, WA 98104

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

DATED this 5<sup>th</sup> day of October 2012, at Seattle, Washington.



LINDA BLEDSOE

# EXHIBIT 5

The Honorable Catherine Shaffer

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ATTORNEY GENERAL'S OFFICE  
TORTS DIVISION  
SEATTLE

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

ORDER RE MEASURE OF  
DAMAGES ON PLAINTIFFS'  
STATUTORY CLAIM

This matter came before the Court on October 26, 2012, on cross-motions: Plaintiffs' Motion on Measure of Damages and Defendants' Motion for Partial Summary Judgment re Fact and Measure of Damages. The Court has considered the pleadings filed in this case, including, but not limited to the following:

**PLAINTIFFS' SUBMISSIONS:**

1. Motion on Measure of Damages;
2. Response to State's Motion for Individual Bill Submission;
3. Reply on Measure of Damages;
4. Errata, 10/12/12;
5. Corrected Response to State's Motion for Individual Bill Submissions, 10/12/12;
6. Declaration of David Wilson, October 5, 2012;

- 1 7. Declaration of David Stobaugh, October 5, 2012;
- 2 8. Declaration of David Wilson, September 14, 2012;
- 3 9. Declaration of Stephen Festor, November 23, 2011;
- 4 10. Declaration of Stephen Festor, November 10, 2011;
- 5 11. Declaration of David Wilson, September 15, 2011;
- 6 12. Declaration of Susan Long, September 15, 2011;
- 7 13. Declaration of Stefan Boedeker, August 24, 2011;
- 8 14. Declaration of Susan Long, August 23, 2011;
- 9 15. Declaration of Stefan Boedeker, August 17, 2011;
- 10 16. Declaration of Stephen Festor, June 17, 2011.

11 **DEFENDANT'S SUBMISSIONS:**

- 12 1. Motion for Partial Summary Judgment re Fact and Measure of Damages;
- 13 2. Response to Plaintiffs' Motion on Measure of Damages;
- 14 3. Reply in Support of Motion for Partial Summary Judgment;
- 15 4. Declaration of Stephen Ross, October 21, 2012;
- 16 5. Declaration of Tim Leyh, October 5, 2012;
- 17 6. Second Declaration of Stephen Ross, October 5, 2012;
- 18 7. Declaration of Stephen Ross re Measure of Damages, September 28, 2012;
- 19 8. Declaration of Pam Davidson, September 28, 2012;
- 20 9. Errata to Declaration of Pam Davidson.
- 21 10. Declaration of Jay Jenkins, September 28, 2012;
- 22 11. Errata to Declaration of Jay Jenkins;
- 23 12. Declaration of Robert Hyde, September 28, 2012;
- 24 13. Second Declaration of Roger Feldman, September 28, 2012;
- 25 14. Declaration of Kim Grindrod, September 28, 2012;
- 26

1 15. Errata to Declaration of Kim Grindrod;

2 16. Declaration of Robert Hyde, September 14, 2012.

3 BASED ON the foregoing, the Court hereby enters the following:

4 **ORDER AND DECISION**

5 1. The current class is overly inclusive and includes state employees who were not  
6 eligible for employer healthcare benefits through the Public Employee Benefits Board of the  
7 Health Care Authority (hereafter, benefits) under all relevant rules, regulations and policies  
8 (hereafter, eligibility rules).

9 2. The parties have deferred the resolution of issues relating to the interpretation and/or  
10 application of various eligibility rules.

11 3. There is an outstanding issue as to whether the class of persons who were eligible for  
12 benefits but were not notified of that eligibility would have behaved like the group of persons  
13 who did receive such notice relative to decisions such as whether to enroll for such benefits (or  
14 to waive them), the specific plan chosen, or the specific coverage tier chosen.

15 4. Not all employees who are offered insurance decide to accept that benefit, but some  
16 instead waive coverage for themselves as well as their dependents.

17 5. An employee's decision whether to waive coverage for themselves and their  
18 dependents is likely affected by their ability to pay their portion of the premium for such  
19 coverage. This is particularly true where an employee has been working for a short period of  
20 time. It is quite likely that a number of those class members who were working for a short  
21 period of time would have opted for less expensive insurance plans and less expensive tiers of  
22 coverage.

23 6. A lack of health insurance impacts an individual's healthcare choices by causing them  
24 to defer necessary healthcare and to not get routine care and checkups. This conclusion is  
25 supported by the public and media discussion of the Affordable Care Act and studies that are  
26

1 public knowledge.

2 7. A measure of damage for the failure to provide healthcare benefits that consists of the  
3 cost of substitute coverage or out-of-pocket payments for medical services that would have  
4 been covered under the employer's insurance plan understates the actual damages suffered. It  
5 is wrong as a matter of common sense, public policy and general knowledge.

6 8. There are various factual issues in this case that remain to be determined. These  
7 include: a) A determination of those persons falling within the current class definition who  
8 were eligible for benefits under all relevant rules and regulations; b) A determination of which  
9 plan, if any, those class members eligible for benefits would have selected; and c) A  
10 determination of what coverage tier those class members eligible for benefits who would not  
11 have waived the same would have selected.

12 9. There are numerous federal cases holding that it is appropriate in a class action seeking  
13 money damages to assess the measure of damages on a classwide aggregate basis rather than  
14 individually.

15 10. The defendants' proposed measure of damages for the failure to offer insurance to  
16 eligible employees and to provide that for those who do not waive such insurance – the cost  
17 incurred in procuring substitute insurance or the out-of-pocket cost to the employee of medical  
18 services that would have been covered under the employer's plan – and that the damages under  
19 this measure must be established through an individual claim process is wrong as a matter of  
20 fact and law.

21 11. Healthcare benefits are part of an employee's wages. *Cockle v. Dept. of Labor and*  
22 *Industries*, 16 P.3d 583 (2001). Although *Cockle* addressed whether health benefits are wages  
23 in the context of workers' compensation, the *Cockle* Court looked very broadly at what wages  
24 are under Washington law. Therefore, a failure to pay benefits is a failure to pay wages.

25 12. The *Cockle* court held that the best measure of the value of the healthcare benefits  
26

1 portion of an employee's wages is the premium paid by the employer to secure the benefits.

2 13. The defendants owe restitution to the class because the State saved lots of money by  
3 not paying the premiums it should have paid to provide healthcare benefits to the class. The  
4 State received a windfall here by not paying the premiums for those in the class who were  
5 wrongly omitted from the health benefits. The plaintiffs have not proven that the defendants  
6 caused damage to all of the persons who fall within the current class definition because of the  
7 factual issues remaining.

8 13. The Court incorporates and adopts as part of this decision its oral ruling on these issues  
9 announced on October 26, 2012.

10 BASED ON the foregoing, **IT IS HEREBY ORDERED, ADJUDGED AND**  
11 **DECREED:**

12 1. Both parties' motions are DENIED, consistent with this order.

13 2. The parties shall note for hearings pursuant to an agreed scheduling order the following  
14 three issues: a) A determination of those persons falling within the current class definition  
15 who were eligible for benefits under all relevant rules and regulations; b) A determination of  
16 which plan, if any, those class members eligible for benefits would have selected; and c) A  
17 determination of what coverage tier those class members eligible for benefits who would not  
18 have waived would have selected.

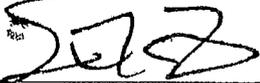
19 3. The hearing(s) regarding the determination of those persons who fall within the class  
20 definition and were eligible for benefits under all relevant rules and regulations should be held  
21 before the hearings on the other issues.

22 DATED this 5 day of November 2012.

23   
24 **HONORABLE CATHERINE SHAFFER**

1 Presented by:

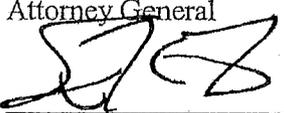
2 BENDICH, STOBAUGH & STRONG, P.C.

3 

4 STEPHEN FESTOR, WSBA #23147  
5 STEPHEN K. STRONG, WSBA #6299  
6 DAVID F. STOBAUGH, WSBA #6376  
Attorneys for Plaintiffs

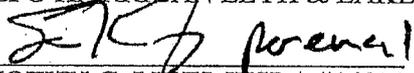
7 Approved as to Form:

8 ROBERT M. MCKENNA  
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10  per email

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