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SUPREME COURT
OF THE STATE OF WASHINGTON

PREMERA, a Washington corporation; PREMERA BLUE CROSS, a Washington corporation; LIFEWISE HEALTH PLAN OF WASHINGTON, a Washington corporation; and WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST and its Trustee, F. BENTLEY LOVEJOY,

Defendants-Petitioners

v.

McCARTHY FINANCE, INC., a Washington corporation; McCARTHY RETAIL FINANCIAL SERVICES, LLC, a Washington limited liability company; HEMPHILL BROTHERS, INC., and its affiliates and subsidiaries; J.A. JACK & SONS, INC., a Washington corporation; LANE MT. SILICA CO., a Washington corporation; PUCKETT & REDFORD, PLLC, a Washington professional limited liability company; and ANNETTE STEINER, a single person,

Plaintiffs-Respondents

ON PETITION FOR REVIEW FROM
COURT OF APPEALS, DIVISION I

SUPPLEMENTAL BRIEF OF PETITIONERS

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TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION.....	1
II. STATEMENT OF THE ISSUES.....	2
III. STATEMENT OF THE CASE	3
A. Factual Background.....	3
B. Plaintiffs’ Allegations.	8
IV. SUPPLEMENTAL ARGUMENT.....	9
A. The Filed Rate Doctrine Should Bar Plaintiffs’ Claim.	9
1. The Filed Rate Doctrine Bars Plaintiffs’ CPA Claim Here Because They Seek a Refund of a Portion of Their Rate Approved by the OIC.	9
a. Courts Have Historically Applied the Filed Rate Doctrine to Health Insurance Rates and Consumer Protection Act Claims.	9
b. The Purpose of the Filed Rate Doctrine Is to Preserve Rational Rate Regulation and Preclude Rate Discrimination.....	12
c. The Filed Rate Doctrine Applies to Plaintiffs’ Allegations.	13
2. The OIC’s Rate Review Is Rigorous and Effective Even Though the Insurance Commissioner Cannot Force a Health Carrier to Use Its Surplus to Subsidize Its Rates.....	15
3. A Judicial Remedy Requiring Premera to Use Its Surplus to Subsidize Its Rates Would Violate Separation of Powers Principles.....	16
B. The Primary Jurisdiction and Failure to Exhaust Administrative Remedies Doctrines Also Bar Plaintiffs’ Claims.	18
V. CONCLUSION.....	20

TABLE OF AUTHORITIES

CASES	Page(s)
<i>Amundson & Assocs. Art Studio, Ltd. v. Nat’l Council on Comp. Ins., Inc.</i> , 988 P.2d 1208 (Kan. App. 1999)	10
<i>AT & T Corp. v. JMC Telecom, LLC</i> , 470 F.3d 525 (3d Cir. 2006).....	10
<i>Bauer v. Sw. Bell Tel. Co.</i> , 958 S.W.2d 568 (Mo. Ct. App. 1997)	10
<i>Ciamaichelo v. Independence Blue Cross</i> , 909 A.2d 1211 (Pa. 2006)	18
<i>Clark v. Prudential Ins. Co. of Am.</i> , 736 F. Supp. 2d 902 (D. N.J. 2010)	11
<i>Commonwealth ex rel. Chandler v. Anthem Ins. Cos.</i> , 8 S.W.3d 48 (Ky. Ct. App. 1999).....	10
<i>Crumley v. Time Warner Cable, Inc.</i> , 556 F.3d 879 (8th Cir. 2009).....	10
<i>Feiner v. Orange & Rockland Utils., Inc.</i> , 862 F. Supp. 1084 (S.D.N.Y. 1994).....	17
<i>Gallivan v. AT & T Corp.</i> , 21 Cal. Rptr. 3d 898 (2004)	10
<i>Guglielmo v. WorldCom, Inc.</i> , 808 A.2d 65 (N.H. 2002)	10
<i>H.J. Inc. v. Nw. Bell Tel. Co.</i> , 954 F.2d 485 (8th Cir. 1992)	13
<i>Hardy v. Claircom Commc’ns Group, Inc.</i> , 86 Wn. App. 488, 937 P.2d 1128 (1997)	11
<i>Hill v. BellSouth Telecomms., Inc.</i> , 364 F.3d 1308 (11th Cir. 2004)	10
<i>Horwitz v. Bankers Life & Cas. Co.</i> , 745 N.E.2d 591 (Ill. Ct. App. 2001).....	11

<i>In re Disciplinary Proceeding Against Petersen</i> , 180 Wn. 2d 768, 329 P.3d 853 (2014).....	16
<i>In re Empire Blue Cross & Blue Shield Customer Litig.</i> , 622 N.Y.S.2d 843 (N.Y. Sup. 1994).....	12
<i>In re Real Estate Brokerage Antitrust Litig.</i> , 95 Wn.2d 297, 622 P.2d 1185 (1980).....	18
<i>In re Wheat Rail Freight Rate Antitrust Litig.</i> , 759 F.2d 1305 (7th Cir. 1985)	15
<i>Keogh v. Chicago & N.W. Ry. Co.</i> , 260 U.S. 156 (1922).....	12, 17
<i>Marcus v. AT & T Corp.</i> , 138 F.3d 46 (2d Cir. 1998).....	12
<i>McCarthy Finance, Inc. v. Premera</i> , 182 Wn. App. 1 328 P.3d 940 (2014).....	passim
<i>McDuffie v. Stewart Title Guar. Co.</i> , 897 F. Supp. 2d 294 (E.D. Pa. 2009)	18
<i>MCI Telecomms. Corp. v. AT & T Co.</i> , 512 U.S. 218 (1994).....	17
<i>Miller v. Wells Fargo Bank, N.A.</i> , 994 F. Supp. 2d 542 (S.D.N.Y. 2014)	13, 14, 15
<i>Nader v. Allegheny Airlines, Inc.</i> , 426 U.S. 290 (1976).....	14
<i>Retail Store Employees Union v. Wash. Surveying & Ratings Bureau</i> , 87 Wn.2d 887, 558 P.2d 215 (1976).....	19, 20
<i>Simon v. KeySpan Corp.</i> , 694 F.3d 196 (2d Cir. 2012).....	12, 16
<i>Skagit Surveyors & Eng'rs, LLC v. Friends of Skagit Cnty.</i> , 135 Wn. 2d 542, P.2d 962 (1998)	16
<i>Tenore v. AT & T Wireless Servs.</i> , 136 Wn.2d 322, 962 P.2d 104 (1998).....	9, 10
<i>Transmission Agency of N. Cal. v. Sierra Pac. Power Co.</i> , 295 F.3d 918 (9th Cir. 2002)	10

<i>Wah Chang v. Duke Energy Trading & Mktg., LLC</i> , 507 F.3d 1222 (9th Cir. 2007)	10
<i>Wegoland Ltd. v. Nynex Corp.</i> , 27 F.3d 17 (2d Cir. 1994)	10
<i>Weinberg v. Sprint Corp.</i> , 801 A.2d 281 (N.J. 2002)	11

STATUTES

Patient Protection and Affordable Care Act, Public Law 111-148.....	6
RCW 48.04.010	19, 20
RCW 48.04.010(1)	20
RCW 48.43.005(30)	3
RCW 48.44.017	3
RCW 48.44.020	3, 4
RCW 48.44.020(2)	5
RCW 48.44.020(3)	5, 8
RCW 48.44.021	3
RCW 48.44.022	3
RCW 48.44.023	3
RCW 48.44.024	3
RCW 48.44.040	4
RCW 48.44.040	3
RCW 48.44.070	4

LEGISLATIVE REFERENCES

House Bill 1203 (2007 Regular Session)	2
House Bill 1858 (2009 Regular Session)	2
Senate Bill 5247 (2011 Regular Session).....	2

OTHER AUTHORITIES

45 C.F.R. Part 154(A).....6
1963 Op. Att’y Gen. No. 59, 1963 WL 6545619
WAC 284-43-9013, 4
WAC 284-43-9154, 8
WAC 284-43-915(2)4
WAC 284-43-9203
WAC 284-43-9253
WAC 284-43-9303
WAC 284-43-9503

I. INTRODUCTION

Plaintiffs allege that Defendants Premera, Premera Blue Cross, LifeWise Health Plan of Washington (collectively, “Premera”), and Washington Alliance for Healthcare Insurance Trust and its Trustee F. Bentley Lovejoy (collectively, “WAHIT”) charged them too much for their health insurance. Plaintiffs have pled only one cause of action, a claim under the Washington Consumer Protection Act (“CPA”) that Plaintiffs purchased Premera insurance based on misrepresentations to them. The only damages Plaintiffs seek in the case is reimbursement of some portion of their premiums that went into “surplus” held by Premera. However, the Office of Insurance Commissioner (“OIC”), using its expertise in this arena, rigorously reviewed and approved these premiums.

By seeking a refund of a portion of the approved rates as their sole measure of damages, Plaintiffs’ claims run squarely into the filed rate doctrine. To give Plaintiffs their requested relief, the fact finder would need to deconstruct the rate that the OIC previously approved, including rates approved many years in the past, and then determine what, if any, portion of those rates and the resulting surplus was excessive. To do that, the courts would have to substitute their judgment for that of the agency charged with responsibility in the highly technical and complex area of insurance rate setting.

The trial court dismissed Plaintiffs’ claims under the filed rate doctrine, failure to exhaust administrative remedies and primary jurisdiction. The Court of Appeals reversed on two grounds. First, it concluded that none of these doctrines apply to CPA claims alleging misrepresentation. This decision is unprecedented, and is contrary to well-established case law in Washington and throughout the country that applies these doctrines to consumer protection misrepresentation

claims in order to preserve the integrity of the regulatory rate making process.

The Court of Appeals also based its ruling on the fact that the Legislature has placed limits on the OIC's authority to require an insurer to use existing surplus to subsidize rates. The OIC has broad statutory power in Washington to approve or deny rates and rigorously exercises that power. As part of that review the OIC is required to and does consider surplus levels when denying or approving rate filings; however, the OIC does not have statutory authority to require Premera to use surplus to subsidize rates.¹ The Legislature has repeatedly rejected the proposed legislation that would expand the OIC's statutory authority to allow it to use surplus to subsidize premiums.² That there is some legislatively-imposed restriction on an agency's scope of authority does not preclude the filed rate doctrine. Were that so, the doctrine would never apply because there is always some statutory limitations on an agency's power. Thus, the Court of Appeals incorrectly determined that the legislatively imposed limitation on the OIC's rate review bars application of the filed rate doctrine and incorrectly found that the courts can grant the relief sought by Plaintiffs: the ability to recoup some portion of their premiums that contributed to surplus.

II. STATEMENT OF THE ISSUES

1. Does the fact that Plaintiffs allege a CPA misrepresentation claim preclude application of the filed rate doctrine where the OIC rigorously reviewed and approved the rate and Plaintiffs seek a refund of some of the rate as damages?

¹ "While the insurance commissioner cannot force a health carrier to use its surplus to lower its rates, he can and does consider the size of the surplus to reject the carriers' request to raise rates." See *McCarthy Finance, Inc. v. Premera*, 182 Wn. App. 1, 21 328 P.3d 940 (2014); see also CP 333 ("We do not have the authority to order a company to use surplus to subsidize or lower its rates.").

² See for example, House Bill 1203 (2007 Regular Session) (reintroduced in 2008 Regular Session); House Bill 1858 (2009 Regular Session), each titled "an Act relating to maximum capital and reserve accumulations by health care service contractors"; Senate Bill 5247 (2011 Regular Session). None of these bills passed in either a regular or special session. See CP 17.

2. Is the OIC's review of health insurance premiums rigorous where the OIC thoroughly analyzes Premera's surplus levels when approving or denying a rate, but the Legislature has denied the OIC authority to require Premera to use surplus to subsidize premiums?
3. Do separation of powers principles preclude a court from granting a remedy that requires Premera to use surplus to subsidize premiums, where the Legislature has denied that authority to the OIC, and Premera's rates were filed with and approved by the OIC pursuant to a rigorous regulatory scheme, which considered Premera's surplus levels?
4. Does the exhaustion of administrative remedies requirement apply where Plaintiffs demand a refund of their contribution to surplus as damages, and the OIC considers surplus in approving or disapproving the insurer's filed rates?
5. Should Washington courts defer to the OIC's primary jurisdiction with respect to a challenge to a health insurer's alleged improper accumulation of surplus, where the OIC considers surplus in approving or disapproving the insurer's filed rates?

III. STATEMENT OF THE CASE

A. Factual Background.

Overall Regulatory Process for Health Insurance Premium Rates. In Washington, the OIC reviews and approves health insurance rates. The OIC's review and approval process differs depending on whether the proposed rate applies to individual and small group plans, on one hand, or large group plans, on the other. With respect to individual and small group plans, state regulation requires Premera to pool the claim experience of everyone in the relevant individual or small group market – they are “community rated” – and then obtain regulatory approval of premium rates, as well as the contracts. *See generally* RCW 48.43.005(30), 48.44.017, 48.44.020, 48.44.021, 48.44.022, 48.44.023, 48.44.024, 48.44.040; WAC 284-43-901, 284-43-920, 284-43-925, 284-43-930, 284-43-950; CP 344-48. Large group plans are “group rated” based on the

particular group, and the rates vary depending on numerous factors, including but not limited to employee participation, prior claims experience, benefits, employee demographics, geographic issues and industry. *See generally* WAC 284-43-901 *et seq.*

When approving or denying any of Premera's rates, the OIC is required to consider Premera's surplus and investment earnings in that review. *See* WAC 284-43-915(2)(c) & (d); CP 323. The OIC has specifically enumerated criteria it must use to assess the reasonableness of Premera's rates, including accumulated surplus:

(2) Benefits will be found not to be unreasonable if the projected earned premium for the rate renewal period is equal to the following:

(a) An actuarially sound estimate of incurred claims associated with the filing for the rate renewal period, where the actuarial estimate of claims recognizes, as applicable, the savings and costs associated with managed care provisions of the plans included in the filing; plus

(b) An actuarially sound estimate of prudently incurred expenses associated with the plans included in the filing for the rate renewal period, where the estimate is based on an equitable and consistent expense allocation or assignment methodology; plus

(c) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges, where the justification recognizes the carrier's investment earnings on assets other than those related to claim reserves or other similar liabilities; minus

(d) An actuarially sound estimate of the forecasted investment earnings on assets related to claim reserves or other similar liabilities for the plans included in the filing for the rate renewal period.

(3) The contribution to surplus, contingency charges, or risk charges in subsection (2)(c) of this section, will not be required to be less than zero.

WAC 284-43-915 (emphasis added). Thus, in approving or denying any proposed rates, the OIC conducts a rigorous review with the assistance of a team of actuaries and other experts, and specifically considers surplus levels and investment earnings. *Id.*

Individual and Small Group Rates. Premera is required to file its individual and small group contracts and proposed premium rates with the OIC for review and approval. RCW 48.44.020, 48.44.040, 48.44.070. The OIC then has the power to approve or deny those rates and contracts. RCW 48.44.020(2) (“The commissioner may on examination, subject to the right of the health care service contractor to demand and receive a hearing under chapters 48.04 and 34.05 RCW, disapprove any individual or group contract form for any of the following grounds . . .”). The OIC reviews all proposed premium rates and must “disapprove any contract if the benefits provided therein are unreasonable in relation to the amount charged for the contract.” RCW 48.44.020(3).

A section on the OIC’s website entitled “[h]ow we review health rates” describes the agency’s rate-approval process for small group and individual plans in similar terms. CP 323. The OIC specifically states that it determines the “reasonableness” of proposed rates in light of, among many things, “the company’s current level of surplus”:

We also examine the following information to see if the rate is reasonable in relation to the plan’s benefits:

- That the premiums, claims and administrative costs are consistent with what the company reported in its financial statement.
- The actual vs. projected medical and prescription drug costs.
- The assumptions used to project the medical and prescription drug costs, including changes in these costs and in the benefit design.
- The actual vs. projected administrative costs, including expenses such as agent commissions, taxes, salaries, case management activities, claims and appeals processing costs, customer services, etc.
- **How much profit the company expects to make. This is generally called “contribution to surplus” or “projected profit.” Whether this amount is considered reasonable depends on the company’s current level of surplus, as well as the type of business.**

If we believe the rate request is justified, state law requires us to approve the increase.

If we don't believe the rate increase is justified we deny the increase. At this point, the insurer can revise its rate increase request or it can request a hearing.

Id. (emphasis added).

This examination process is rigorous and thorough; the record contains several "Rate Request Decisions" in which the OIC refused to approve Premera's proposed rate increases. CP 325-37. For example, in disapproving one proposed rate increase, the OIC explained as follows:

According to the company's financial statement, the company has \$879.4 million in surplus – which is enough to pay 5.29 months of claims. **Based on the company's significant profits on this block of business for the past few years**, we believe its level of risk is low and have **denied the 2.5% projected profit**. Reducing the projected profit from 2.5% to 0% will change the rate projection and lower it from 4.7% to 1.9%. **We do not have the authority to order a company to use surplus to subsidize or lower its rates. The approved 1.9% rate request will not require the company to use its surplus to lower rates, but will produce no projected profit for this block of business.**

CP 333 (emphasis added). Thus, the OIC cannot force health carriers to use surplus to subsidize rates, but it can and does consider surplus to reject carriers' requests to increase rates. And in fact, as demonstrated by the above quotation, the OIC exercises its authority even to limit a carrier to a rate that will produce no profit. Indeed, it works both ways; in another instance, the OIC noted concerns over LifeWise's decline in surplus. CP 304-07.

The recent federal health reform law, the Patient Protection and Affordable Care Act, Public Law 111-148, also requires effective and aggressive regulatory review of health insurance rates. 45 C.F.R. Part 154(A). In this context, the Federal government has affirmatively determined that Washington's regulatory rate review process is effective and robust. 45 C.F.R. §154.200 et seq.

Large Group Rates. Premera negotiates large group rates with each

customer because large groups have more bargaining power than individuals and small groups, and there is considerable competition among insurers for their business. CP 345–46 ¶¶ 6, 10. As a result, the OIC uses a different, but equally rigorous, procedure to regulate large group rates. The development of large group rates involves a complex process that requires a team of experienced underwriters, actuaries, brokers and other professionals, as well as the large groups themselves. CP 345 at ¶ 6. The starting point is the development and utilization of a Large Group Rating Model, which Premera is required to file, and does file with the OIC, for review and approval. *Id.* The OIC then reviews and either approves Premera’s filing or sends Premera “Objections” to the model. *Id.*; *see also, e.g.*, CP 357-59 (example of the OIC’s objection to Premera’s large group filing); CP 537-43 (same).

The model is a highly complex document of approximately 500 pages which weighs numerous factors, including each large group’s prior claims experience, its demographics, the benefits it wants to include, geographic issues, the provider network to be included, the group’s industry, tax issues, and changes in the law such as coverage mandates, as well as administrative expenses. CP 345-46 at ¶ 8, 9.

Under Washington law, the OIC can object to and require modifications to any large group contract, especially those that deviate substantially from the model, and must be supported by a long form filing. CP 347 at ¶ 11. Thus, once a large group’s rates are negotiated and agreed to, Premera files every large group contract and rate with the OIC. *Id.* These filings give the OIC the ability to “reverse engineer” any individual large group rate to see any deviations from the previously approved model. *Id.* As part of this process, the OIC also requires

Premera to file large associations' rates. For example, for one year alone, the filing for defendant WAHIT is 5,486 pages long, demonstrating the complexity and comprehensive review that the OIC requires. *Id.* at ¶ 13.

As with the individual and small group filings, Washington law requires the OIC to consider "contribution to surplus" and "investment earnings" when reviewing and approving large group rates. RCW 48.44.020(3); WAC 284-43-915 (the OIC must consider "contribution to surplus" as well as "forecasted investment earnings on assets related to claim reserves"). The model that Premera files expressly sets forth for OIC review and approval the precise contribution to surplus Premera proposes for each large group member. CP 496 (Table H-4).

B. Plaintiffs' Allegations.

The sole cause of action alleged in Plaintiffs' complaint is for violation of the CPA. CP 7-11, 14-16. However, the defendants fall into two groups – (1) Premera and its corporate affiliates, and (2) WAHIT and its trustee. The Complaint alleges that these two groups colluded in order to enable Premera to charge higher premiums and accumulate excessive surplus. Plaintiffs allege that due to Premera's "deceptive" conduct, "[t]he premiums charged by the defendants for the insurance coverage have resulted in profits of billions of dollars, profits in excess of the costs to the defendants in providing the coverage and unnecessary in view of their investment profits and surplus levels." CP 10-11 (¶22). Plaintiffs allege that as a result of these allegedly excessive rates, that Premera accumulated a "massive" surplus. *See* CP 4, 5, 10, 15, 17, 19-23 (¶¶ 12, 14, 22, 30(a) & (b), 34, 39, 40-47).

As to WAHIT, the Complaint also focuses exclusively on its allegation that

Premera has accumulated excessive surplus, alleging that WAHIT has been a means to that end. The Complaint alleges that WAHIT was “formed . . . by the PREMERA and LifeWise defendants for the purpose of marketing and selling health insurance policies,” and that WAHIT “is merely a conduit of the PREMERA defendants and the premiums paid to WAHIT for these coverages are not retained by WAHIT, but are funneled directly to the PREMERA companies.” CP 3, 10 (¶¶ 7, 21)

Plaintiffs allege their damages are the sum “of the excess premiums paid to the defendants,” and ask that “excess surplus . . . be refunded to the subscribers who have paid the high premiums causing the excess.” CP 15-16, 28 (¶¶ 30(d), 65-66).

IV. SUPPLEMENTAL ARGUMENT

A. The Filed Rate Doctrine Should Bar Plaintiffs’ Claim.

1. The Filed Rate Doctrine Bars Plaintiffs’ CPA Claim Here Because They Seek a Refund of a Portion of Their Rate Approved by the OIC.

a. **Courts Have Historically Applied the Filed Rate Doctrine to Health Insurance Rates and Consumer Protection Act Claims.** This Court should maintain and reinforce existing Washington law that the filed rate doctrine applies to a CPA claim that seeks to recover allegedly excessive rates that were approved by state regulators. The filed rate doctrine provides that “any ‘filed rate’—a rate filed with and approved by the governing regulatory agency—is per se reasonable and cannot be the subject of legal action against the private entity that filed it.” *Tenore v. AT & T Wireless Servs.*, 136 Wn.2d 322, 331, 962 P.2d 104 (1998) (citing *Wegoland Ltd. v. Nynex Corp.*, 27 F.3d 17 (2d

Cir. 1994)).³ The Court of Appeals agreed with Premera that the filed rate doctrine applies to health insurance rates. *McCarthy*, 182 Wn. App. at 13 (“Given the extensive legislative and regulatory framework applicable to health insurance rates, the filed rate doctrine applies to health insurance.”). However, the Court of Appeals then improperly concluded that the doctrine does not extend to misrepresentation claims under the CPA.

This conclusion goes against all the pre-existing authority in Washington and beyond, and the decision is counter to good public policy. Courts, including this Court and Washington appellate courts, have previously held or recognized that the filed rate doctrine precludes both direct and indirect challenges to the reasonableness of rates, including claims based on misrepresentation, fraud, deceptive acts and practices, false advertising, and other theories. *Tenore*, 136 Wn. 2d at 332-33 & n. 41 (citing numerous cases).⁴

³ As explained more fully in Premera’s Petition for Review, the Court of Appeals misread this Court’s decision in *Tenore* in two ways: First, contrary to the Court of Appeals’ characterization, this Court did not criticize the filed rate doctrine; rather, it recognized its breadth when contrasting the far more limited effect of preemption. *Tenore*, 136 Wn. 2d at 332. Second, in distinguishing filed rate doctrine cases in *Tenore*, this Court suggested that application of the filed rate doctrine may require a different result than preemption analysis. *Id.* at 341-42. If anything, then, *Tenore*’s analysis establishes that where, as here, the rates at issue are filed and approved by regulators, and where, as here, calculation of damages “implicate rate adjustment,” the claim is barred. *Id.* at 342.

⁴ See also, e.g., *Crumley v. Time Warner Cable, Inc.*, 556 F.3d 879, 880–81 (8th Cir. 2009) (filed rate doctrine barred claim alleging cable company fraudulently recovered double fees as part of rate filed with and approved by local regulating authority; noting that the filed rate doctrine applies regardless of the fact that the “claim involves allegations of fraud”); *Wah Chang v. Duke Energy Trading & Mktg., LLC*, 507 F.3d 1222, 1224–27 (9th Cir. 2007) (filed rate doctrine barred claim alleging rate approved by agency was too high because applicant fraudulently manipulated the market, skewing the rate approval process); *AT & T Corp. v. JMC Telecom, LLC*, 470 F.3d 525, 535 (3d Cir. 2006) (“[T]here is no fraud exception to the filed rate doctrine.”); *Hill v. BellSouth Telecomms., Inc.*, 364 F.3d 1308, 1311–13, 1315–17 (11th Cir. 2004) (filed rate doctrine barred state-law fraud claims that implicate approved rate); *Transmission Agency of N. Cal. v. Sierra Pac. Power Co.*, 295 F.3d 918, 932–33 (9th Cir. 2002) (filed rate doctrine precluded claims alleging fraud because “[t]he impact of any award of damages . . . would be to undermine [the regulatory agency’s] ability to regulate rates”); *Wegoland*, 27 F.3d at 18, 20–22 (“every court that has considered the [question] has rejected the notion that there is a fraud exception to the filed rate doctrine”); *Gallivan v. AT & T Corp.*, 21 Cal. Rptr. 3d 898, 905–06 (2004) (“filed rate” doctrine barred damages claim alleging fraud); *Amundson & Assocs. Art Studio, Ltd. v. Nat’l Council on Comp. Ins., Inc.*, 988 P.2d 1208, 1211–17 (Kan. App. 1999) (filed rate doctrine barred claims that workers’ compensation insurers conspired to control insurance rates); *Commonwealth ex rel.*

In *Hardy v. Claircom Commc'ns Group, Inc.*, 86 Wn. App. 488, 937 P.2d 1128 (1997), the plaintiff sued under the CPA and other theories based on the practice of “rounding up” telephone charges. 86 Wn. App. at 494–95. As the Court of Appeals correctly noted in *McCarthy*, “[c]oncluding that ‘any court-imposed award of damages would by definition result in [plaintiffs] paying something other than the filed rate,’ the *Hardy* court held that the claims were barred by the filed rate doctrine.” *McCarthy*, 182 Wn. App. at 12 (quoting *Hardy*, 86 Wn. App. at 494-95). In this case, the Court of Appeals attempted to distinguish *Hardy* by asserting that “*Hardy* focused on the importance of efficient nationwide telephone and radio service.” *Id.* But the Court of Appeals did not (and could not) address why the state regulation of health insurance premiums is less important and less deserving of the doctrine’s protection than federal regulation of cell phone rates. *See id.*

The Court of Appeals characterized Plaintiffs’ claims as allegations of marketing misrepresentations or false statements to the public. *See McCarthy*, 182 Wn. App. at 8, n.4. Such claims are nevertheless barred because of the relief that Plaintiffs seek here – a refund of a portion of the approved rate. *See also, Horwitz v. Bankers Life & Cas. Co.*, 745 N.E.2d 591, 605 (Ill. Ct. App. 2001) (“it is not the nature of the relief, nor the name of the cause of action, which triggers

Chandler v. Anthem Ins. Cos., 8 S.W.3d 48, 50, 53 (Ky. Ct. App. 1999) (there was no fraud exception to filed rate doctrine that would save claims that insurers “had engaged in a fraudulent scheme to charge Kentucky consumers of health insurance inflated premium rates”); *Bauer v. Sw. Bell Tel. Co.*, 958 S.W.2d 568, 570–71 (Mo. Ct. App. 1997) (filed rate doctrine barred claim alleging fraud; “[c]ourts that have considered the fraud issue almost unanimously have rejected the notion that there is a fraud exception to the filed rate doctrine”); *Guglielmo v. WorldCom, Inc.*, 808 A.2d 65, 67, 69–72 (N.H. 2002) (filed rate doctrine barred claims alleging telecommunications companies conspired with prisons to violate state antitrust and consumer protection laws to set excessive rates for collect calls to inmates); *Weinberg v. Sprint Corp.*, 801 A.2d 281, 283–84 (N.J. 2002) (filed rate doctrine barred claim for money damages premised on “consumer fraud [] or other bases on which plaintiffs seek to enforce a rate other than the filed rate”).

the doctrine,” but whether “the damages sought by plaintiff for consumer fraud would require the court to ascertain what would be a reasonable rate absent the fraud” (internal citation and quotation marks omitted)); *Clark v. Prudential Ins. Co. of Am.*, 736 F. Supp. 2d 902, 919-20 (D.N.J. 2010) (same); *In re Empire Blue Cross & Blue Shield Customer Litig.*, 622 N.Y.S.2d 843, 848 (N.Y. Sup., 1994) (same). The filed rate doctrine applies, even to CPA claims, where a plaintiff seeks damages that would require a court to reconsider and unravel a filed and approved premium rate.

b. The Purpose of the Filed Rate Doctrine Is to Preserve Rational Rate Regulation and Preclude Rate Discrimination. The seminal filed rate case is *Keogh v. Chicago & N.W. Ry. Co.*, 260 U.S. 156 (1922). Although the rates at issue were the product of price fixing and fraud, the Court held that because they were filed with and approved by the Interstate Commerce Commission, they could not be challenged in court. *Id.* at 160–65. The Court identified several rationales for the filed rate doctrine: (1) the fact that the regulatory process itself constitutes a remedy that must obviate any judicial remedies; (2) the fact that rates approved by a regulator are per se lawful; and (3) the difficulty of proving that an alternative lower rate would have been approved by the regulator. *Id.*; see generally *Simon v. KeySpan Corp.*, 694 F.3d 196, 205 (2d Cir. 2012) (summarizing and analyzing *Keogh*). The Court’s reasoning was that disparate litigation outcomes might result in non-uniform or discriminatory rates. *Id.* As courts have repeatedly recognized, “regulatory bodies have institutional competence to address rate-making issues; ... courts lack the competence to set ... rates; and ... the interference of courts in the rate-making process would subvert the authority of rate-setting bodies and undermine the

regulatory regime.” *Marcus v. AT & T Corp.*, 138 F.3d 46, 57-62 (2d Cir. 1998). Since *Keogh*, the filed rate doctrine has been extended across the spectrum of regulated entities. See *Simon*, 694 F.3d at 205. The courts have consistently recognized that “the rationale underlying the filed rate doctrine applies whether the rate in question is approved by a federal or state agency.” *H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485, 494 (8th Cir. 1992).

c. The Filed Rate Doctrine Applies to Plaintiffs’ Allegations. Plaintiffs’ core allegation is that Premera has “concealed the fact that their annual increases in premiums have been far in excess of those costs [for medical services], conduct that has had the capacity to deceive and did in fact deceive a substantial portion of the public and the class members who bring this lawsuit.” See CP 4, 5, 10, 15, 17, 19-23 (¶¶ 12, 14, 22, 30(a) & (b), 34, 39, 40-47). In the recent case of *Miller v. Wells Fargo Bank, N.A.*, 994 F. Supp. 2d 542 (S.D.N.Y. 2014), the court, applying New York law, reiterated that the filed rate doctrine “‘applies even when a claim is based on fraud or impropriety in the method by which the rate is determined.’” *Id.* at 553-54 (quoting *Simon*, 694 F.3d at 205). This applies to Plaintiffs’ allegation that Premera misled them about the OIC-approved rates they paid. In *Miller*, a homeowner alleged a putative class action against his mortgage lender and his homeowners’ hazard insurers, challenging the practice of force-placing hazard insurance on residential properties. The homeowner alleged violation of the Racketeer Influenced and Corrupt Organizations Act (RICO), and violation of the state consumer protection statute prohibiting deceptive acts or practices, among other claims. *Id.* at 547. He argued that he was “not challenging the insurance premium rates themselves, but rather ‘Defendants’ manipulation of the force-placed insurance market, and the

kickbacks that Defendants receive by virtue of their manipulations.” *Id.* at 554. The court held that the filed rate doctrine “squarely forecloses this argument” because “Plaintiff does not dispute that the force-placed insurance premiums he paid were calculated using rates filed by [the hazard insurers] and approved by [the regulators].” *Id.* at 553-54.

Likewise, here, the damages Plaintiffs seek would necessarily conflict with the OIC’s finding that Premera’s filed rates were reasonable and, worse yet, would require a court or jury to determine what a reasonable rate should have been each year going all the way back to 2009. This falls squarely within the rationale for the filed rate doctrine’s prohibition on claims like Plaintiffs’. Here, the OIC has determined that the rates paid by Plaintiffs were reasonable, in relation to the benefits. Further, the reasonableness of that rate is unchanged by any subsequent misrepresentation by the regulated company; and as such the rate determined by the regulator to be fair and reasonable must remain inviolate.⁵ The OIC has authority to determine health insurance rates, and the very same rates

⁵ The Court of Appeals relied upon *Nader v. Allegheny Airlines, Inc.*, 426 U.S. 290 (1976), claiming that the Supreme Court “determined there was no irreconcilable conflict between the regulation of airline carrier rates and the ‘persistence of common-law remedies’ because the claim it analyzed did not ‘turn on a determination of the reasonableness of a challenged practice’ but only on the issue of disclosure of that practice.” *McCarthy*, 182 Wn. App. at 14 (quoting *Nader*, 426 U.S. at 299). But *Nader* has no application here. *Nader* did not address the filed rate doctrine. The case addressed application of the primary jurisdiction doctrine, and “filed rate” does not appear in the opinion. In *Nader*, an airline passenger sued an airline that bumped him from an overbooked flight. The passenger alleged that the airline misrepresented its overbooking policy or practice. *Id.* at 298. The Supreme Court held that the tort action was not barred by the primary jurisdiction doctrine and could proceed concurrently with the Civil Aeronautics Board investigation under the Federal Aviation Act. *Id.* at 304-06. The Court’s reasoning was that since the passenger did not challenge the reasonableness of the regulated overbooking practice, but alleged only that the airline misrepresented the practice, the court action could proceed because the issues did not implicate agency expertise. *Id.* at 304-05. The remedy sought in that case stemmed from an allegation that the passenger was harmed by the misrepresentation that caused him to rely on the availability of the flight. *See id.* at 304-07. Here, the Plaintiffs are challenging the reasonableness of rates approved by the OIC because the remedy they seek is return of some portion of their premium that went into surplus.

Plaintiffs allege were excessive—see CP 3-5, 10-11, 15-17, 20 (¶¶ 8-15, 22, 30, 34 & 40)—were filed, reviewed, and approved by the OIC.⁶

2. The OIC’s Rate Review Is Rigorous and Effective Even Though the Insurance Commissioner Cannot Force a Health Carrier to Use Its Surplus to Subsidize Its Rates.

The OIC considers surplus in its review of rate filings. “While the insurance commissioner cannot force a health carrier to use its surplus to subsidize its rates, he can and does consider the size of the surplus to reject the carriers’ request to raise rates.” *McCarthy*, 182 Wn. App. at 21. The legislature always establishes the contours of rate regulation, but this does not mean that the rate review is not rigorous or effective. Were the Plaintiffs’ contention correct, the doctrine would never apply - there will always be some limitation on the agency’s power.

For example, in *In re Wheat Rail Freight Rate Antitrust Litig.*, 759 F.2d 1305 (7th Cir. 1985), legislation limited the regulatory agency’s review of the reasonableness of a railroad’s rates unless it first found the railroad at issue had market dominance. *Id.* at 1311. Given this limited review, the plaintiffs argued that the filed rate doctrine should not apply. *Id.* The court rejected this argument and held that the filed rate doctrine barred the antitrust damage claims in that case. *Id.* Thus, as long as the agency has the power to review and challenge a filed rate, it is unnecessary to consider the parameters of that power. *Id.*

Here, the OIC’s review of health insurance rates, including Premera’s, is

⁶ The Court of Appeals noted that Plaintiffs have alleged that Defendants misrepresented that WAHIT is an employer-governed trust. Plaintiffs’ allegations about WAHIT’s “false” representations nonetheless trigger the filed rate doctrine. To afford the relief which the Plaintiffs explicitly seek against WAHIT as well as Premera, *i.e.*, return of premiums remitted to and held by Premera, the Court would still have to second-guess the OIC-approved rates. See *Miller*, 994 F.Supp.2d at 554 (citing *Simon*, 694 F.3d at 205). (“The [filed rate] doctrine’s ‘twin principles of preventing carriers from engaging in price discrimination as between ratepayers and preserving the exclusive role of [] agencies in approving rates’ are no less implicated when a plaintiff brings claims against [a third party], which acquired policies with premiums based on [the regulated entity’s] filed rate, than when claims are asserted against the rate-filing entity itself.”).

comprehensive and robust. Plaintiffs cannot contest the OIC's own words about its review process: "We also examine the following information to see if the rate change is reasonable in relation to the plan's benefits: . . . How much profit the company expects to make. This is generally called 'contribution to surplus' or 'projected profit.' **Whether this amount is considered reasonable depends on the company's current level of surplus as well as the type of business.**" CP 323 (emphasis added). "[W]e scrutinize the company's projections and what they're based on, including the last three years' premiums, enrollment and claims," and also "examine [an extensive and detailed list of] information to see if the rate change is reasonable in relation to the plan's benefits. . . . If we don't believe the rate increase is justified, we deny the increase." CP 323; *see also* CP 325-37 (rate request decisions).

3. A Judicial Remedy Requiring Premera to Use Its Surplus to Subsidize Its Rates Would Violate Separation of Powers Principles.

"The power of an administrative tribunal to fashion a remedy is strictly limited by statute." *Skagit Surveyors & Eng'rs, LLC v. Friends of Skagit Cnty.*, 135 Wn. 2d 542, 558, 958 P.2d 962 (1998). Further, for a court to grant relief the legislature has denied to the OIC would violate separation of powers principles, where here the Legislature has considered whether the OIC should be able to grant Plaintiffs the remedy they seek, and declined. It would be a peculiar result for the courts to now obtain that power placed outside the scope of the OIC's otherwise comprehensive and rigorous review authority. The filed rate doctrine is a self-imposed judge made rule of self-restraint, *Simon*, 694 F.3d at 205, and therefore separation of powers considerations are inherent in any filed rate case.

"At its crux, the question to be asked is not whether two branches of

government engage in coinciding activities, but rather whether the activity of one branch threatens the independence or integrity or invades the prerogatives of another.” *In re Disciplinary Proceeding Against Petersen*, 180 Wn. 2d 768, 781, 329 P.3d 853 (2014) (citations and internal quotation marks omitted). “The theory of the *Keogh* case was that the filed rates determine the rights between the customer and the utility and the Interstate Commerce Act had provided a remedy for injured shippers and consignees, so that it was improbable Congress intended to afford another remedy under the Sherman Act.” *Feiner v. Orange & Rockland Utils., Inc.*, 862 F. Supp. 1084, 1088 (S.D.N.Y. 1994). Likewise, here, the Legislature determined that the appropriate remedy was to give the OIC authority to review surplus levels when approving proposed rates and to disapprove requested rate increases in light of accumulated surplus (a remedy OIC has exercised in *Premera’s* case); the Legislature did not give the OIC authority to require *Premera* to use surplus to subsidize rates, the sole remedy Plaintiffs seek in this case. Thus, a judicial remedy that requires *Premera* to use surplus to subsidize premiums violates separation of powers principles.

The United States Supreme Court articulated this important separation of powers concept in *MCI Telecomms. Corp. v. AT & T Co.*, 512 U.S. 218, 231 n.4 (1994), in which it refused to allow the Federal Communications Commission to exempt nondominant long distance carriers from tariff filing requirements, based upon the filed rate doctrine. 512 U.S. at 231. In doing so the Court articulated the truism that both the courts and government agencies “are bound, not only by the ultimate purposes Congress [*i.e.*, the Legislature] has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes.” *Id.* at 231 n.4. Assuming for purposes of argument that it is true that the Insurance

Commissioner's "public statements reveal that he is unable to effectively regulate the accumulation of surpluses," *McCarthy*, 182 Wn. App. at 18-20, this is because the Legislature has specifically withheld from the OIC the power to require insurers to use surpluses to subsidize rates, and neither the agency nor the courts should circumvent the Legislature's intent.⁷

B. The Primary Jurisdiction and Failure to Exhaust Administrative Remedies Doctrines Also Bar Plaintiffs' Claims.

The Court of Appeals reversed the Superior Court's dismissal based on the primary jurisdiction and failure to exhaust administrative remedies doctrines because it concluded that the Insurance Commissioner's "public statements reveal that he is unable to effectively regulate the accumulation of surpluses" and "the exhaustion of remedies would be futile." *McCarthy*, 182 Wn. App. at 20-22.

The OIC should have "primary jurisdiction" over Plaintiffs' claims. This Court has identified three factors that favor a finding of primary jurisdiction: (1) the agency has authority to solve the issue, (2) the agency has special competence over all or some part of the controversy, and (3) the issues before the court fall within the scope of a pervasive regulatory scheme so that a danger exists that

⁷ Plaintiffs' Answer to Premera's Petition for Review attempts to rely on a Pennsylvania state court case, *Ciamaichelo v. Independence Blue Cross*, 909 A.2d 1211 (Pa. 2006). Plaintiffs argue, absent page citation to *Ciamaichelo*, that the case says that "only issues or matters lying within the special competence of the regulator" are barred by the filed rate doctrine. *See* Answer to Petition for Review, 16. *Ciamaichelo* is inapposite. That case was based entirely on Pennsylvania's Nonprofit Corporation Law of 1988, not the filed rate doctrine. *See McDuffie v. Stewart Title Guar. Co.*, 897 F. Supp. 2d 294, 299 n.5 (E.D. Pa. 2009) (dismissing claim under the filed rate doctrine and noting, "Plaintiff cites inapposite authority in attempting to persuade us to reach the opposite conclusion [than dismissal based on the filed rate doctrine] . . ." (citing *Ciamaichelo*, 589 Pa. 415)). Here Washington's non-profit corporation statute (RCW 24.03) is entirely different from the Pennsylvania statute at issue in *Ciamaichelo*. As such, Plaintiffs have not, and could not, allege a cause of action under Washington's statute. Thus the Court of Appeals noted that Plaintiffs' complaint does not "state any claim that Premera's nonprofit status, in and of itself, or its statements to the public that it is a nonprofit provide a basis for any relief." *McCarthy*, 182 Wn. App. at 8, n.4.

judicial action would conflict with the regulatory scheme. *In re Real Estate Brokerage Antitrust Litig.*, 95 Wn.2d 297, 302-03, 622 P.2d 1185 (1980). All three factors are present here. For the same reasons discussed above, Plaintiffs' claims are an attack on OIC-approved rates; without those rates, there would be no allegedly excess surplus. The fact that there are legislatively-imposed restrictions on the regulator's authority does not change the analysis, as discussed above.

The Court of Appeals also incorrectly reversed the trial court's decision to bar the claims due to Plaintiff's failure to exhaust administrative remedies. The OIC does have authority to consider surplus in deciding whether to approve or disapprove an insurer's rates, and in fact it does.⁸ *See e.g.*, CP 333 (rejecting a proposed rate increase and holding that Premera cannot make any profit on the line of business due to surplus). The Complaint alleges that Premera's misrepresentations allowed it to charge premiums that were too high. An insured who objects to a proposed rate increase has several administrative avenues through which to challenge an insurer's rate filings. *See* RCW 48.04.010; Attorney General Opinion 63-64, No. 59, at 11-12.

Exhaustion of the various administrative remedies available under the Insurance Code is mandatory, and this Court has long-held that an insured seeking to challenge premium rates filed by an insurer must pursue those

⁸ When the OIC can redress a claim in the first instance, the administrative remedy must be exhausted before a plaintiff can bring suit; failure to exhaust requires dismissal. *See Retail Store Emps. Union v. Wash. Surveying & Ratings Bureau*, 87 Wn. 2d 887, 906-07, 558 P.2d 215 (1976). This remedy is mandatory. *Id.*; *see also* 1963 Op. Att'y Gen. No. 59, 1963 WL 65456, at *7 ("insured affected by an increase ... in his insurance rates may demand a full hearing before the [OIC] pursuant to RCW 48.04.010").

administrative remedies before filing a lawsuit against the insurer. *Retail Store Emp. Union v. Washington Surveying and Rating Bureau*, 87 Wn.2d 887, 906-07, 558 P.2d 215 (1976). In *Retail Store*, the plaintiffs (a union and its members) alleged, *inter alia*, that a group of insurers unlawfully controlled the operations of a rating agency that was responsible for filing the insurers' rates, and rate increases, with the Insurance Commissioner. *Id.* at 891, 906-07. The plaintiffs claimed that, as a result of the alleged control exerted by the insurers over the rating agency, the insurers were able to set improper rates and charge excessive premiums to their customers. *Id.* This Court held that the plaintiffs' must be dismissed, based on plaintiffs' failure to exhaust their administrative remedies under the Insurance Code (specifically RCW 48.04.010). *Id.* at 906-07. This Court found that, notwithstanding the plaintiffs' attempt to cast their allegations in terms of collusion among the insurers, in essence the plaintiffs were challenging the validity of the rate increases. *Id.* at 906-07.

Retail Stores is indistinguishable. Plaintiffs could and should have challenged the OIC's approval of those rates, and therefore Premera's regulation of accumulation of surplus, via the hearing procedure outlined in RCW 48.04.010(1). Plaintiffs in this case failed to pursue any of the administrative remedies provided under the Washington Insurance Code. The OIC approved Premera's proposed rates. Therefore, Plaintiffs' claims are barred.

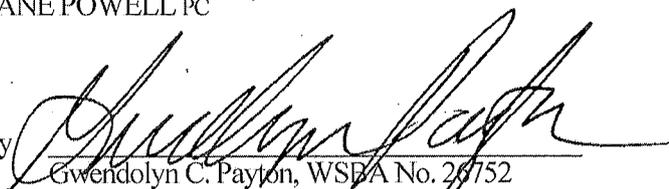
V. CONCLUSION

For the foregoing reasons, this Court should reverse the decision of the Court of Appeals and remand with instructions to reinstate the trial court's dismissal.

RESPECTFULLY SUBMITTED this 5th day of January, 2015.

LANE POWELL PC

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CERTIFICATE OF SERVICE

I certify, under penalty of perjury under the laws of the United States and the State of Washington, that on January 5, 2015, I served a copy of the foregoing document on all counsel of record as indicated below:

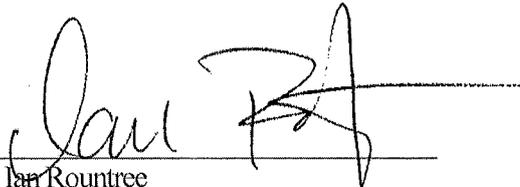
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Thank you for your assistance and feel free to contact me directly with any questions or concerns.

Best,

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