The Honorable Catherine Shaffer

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;

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

DEFENDANT'S SUBMISSIONS:

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

15. Errata to Declaration of Kim Grindrod;

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

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

ORDER AND DECISION

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

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

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

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

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

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

public knowledge.

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

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

9. There 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.

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

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

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

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

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

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

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

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

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

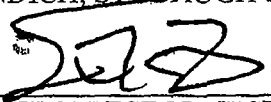
3. The hearing(s) regarding the determination of those persons who fall within the class definition and were eligible for benefits under all relevant rules and regulations should be held before the hearings on the other issues.

DATED this 5 day of November 2012.

HONORABLE CATHERINE SHAFFER

Presented by:

BENDICH, STOBAUGH & STRONG, P.C.



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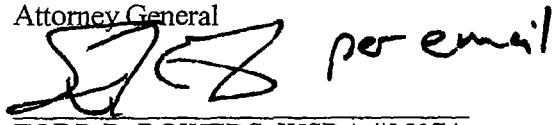

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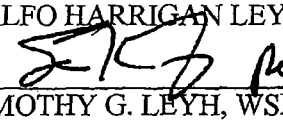

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SUPERIOR COURT OF THE STATE OF WASHINGTON

IN AND FOR THE COUNTY OF KING

DOUGLAS L. MOORE, MARY CAMP, GAYLORD CASE, and a class of similarly situated individuals, Plaintiffs, vs. HEALTH CARE AUTHORITY and STATE OF WASHINGTON Defendants.	VERBATIM REPORT OF THE PROCEEDINGS Cause No. 06-2-21115-4 SEA SUMMARY JUDGMENT

TRANSCRIPT

of the proceedings had in the above-entitled cause before the HONORABLE Catherine Shaffer, Superior Court Judge, on the 26th day of October, 2012, reported by Michelle Vitrano, Certified Court Reporter, License No. 0002937.

APPEARANCES:

FOR THE PLAINTIFFS: STEPHEN STRONG & STEVE FESTOR
Attorneys at Law

FOR THE DEFENDANTS: TIM LEYH, AARON WILLIAMS, and TODD BOWERS
Attorneys at Law

(Brief recess taken.)

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

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

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

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

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

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

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

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

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

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

I would suggest to the plaintiffs that there's a good case to be made that people who are working for a short period of time may not be interested in getting insurance and taking that deduction from their small paycheck, and there's also a good case to be made that people like that may not want the highest and best level of coverage either. So I think there are arguments to be made here on both sides, but 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 as a matter of common sense, public policy, and general knowledge.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Whereupon, the proceedings were concluded.)