SUPERIOR COURT OF THE STATE OF WASHINGTON FOR KING COUNTY

FOLWEILER CHIROPRACTIC, P.S., a Washington professional services corporation, Plaintiff, v. FAIR HEALTH, INC., a New York corporation, Defendant.	)	NO. 15-2-13107-9 SEA ORDER ON PARTIES' CROSS MOTIONS FOR SUMMARY JUDGMENT

This matter now comes before the Court on motions of both parties seeking summary judgment per CR 56 as well as various ancillary motions. First, as to those ancillary motions, the Court would ORDER as follows:

The motions (a) to file overlength brief and (b) for judicial notice are GRANTED;

The motions (a) to strike and (b) to continue are DENIED.

Both plaintiff and defendant have moved for orders on summary judgment – defendant seeking an order of dismissal and plaintiff seeking a declaration of the defendant's liability under Washington's Consumer Protection Act ("CPA"). The Court has considered all of the parties' submissions in connection with each motion. If there is a perceived need to more precisely catalogue those submissions, this may be accomplished by entry of an agreed order to supplement this order. The Court has also heard oral argument of counsel and reviewed their evidentiary submissions. Having considered all of the foregoing, the Court would now rule as follows.

Having presided over at least one of them, this Court is quite familiar with the cases concerning an insurance company's liability under the Consumer Protection Act for failing to fulfill its legal obligation to pay all reasonable costs under circumstances where it is required to do so. An insurance company may run afoul of the laws governing its conduct when it determines a PIP reimbursement through rigid adherence to computer driven models rather than by giving independent consideration to the reasonableness of a specific charge. The present case arises from such a scenario but it is decidedly not one of those cases.

The defendant FAIR Health is an entity created in 2009, with direction from the New York Attorney General and assistance of many academics and other professionals, with a mandate to maintain and distribute an impartial and accurate database of current healthcare costs. The product of this independent not-for-profit entity is intended to be relied upon by consumers, researchers,

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policy makers, government officials, and insurers. It has been relied upon by all of these - and justifiably so - for many good and worthwhile purposes.

One purpose for which it is not intended is to be blindly adhered to by insurance companies in establishing reimbursement rates for services that must be calculated in compliance with their own contractual terms and the laws of the fifty states. As declared by FAIR Health's Director of Data Management: "FAIR Health does not set UCR rates (usual and customary rates) or out-of-network reimbursement amounts; those determinations are made by licensees or their clients. FAIR Health data are intended to be used as a tool to help inform those decisions."

In licensing the use of their database for this purpose, FAIR Health's licensing agreement contains the following language:

> FAIR Health is not determining, developing or establishing an appropriate fee or reimbursement level for Licensee Customers or their businesses. Rather, the FAIR Health Products represent charge benchmarks for various geographic areas based on the claims data contributed to FAIR Health. The FAIR Health Products do not set forth a stated or implied "reasonable and customary" charge or allowed amount. Licensee's or Licensee Customers' determination or establishment of an appropriate level of reimbursement or fee is in their sole discretion, regardless of whether Licensee or Licensee Customers use the FAIR Health Products.

The Agreement further makes clear that the "Licensee" (e.g., Mitchell Medical) is required to inform any "Licensee Customer" (e.g., Progressive Insurance Co.) as to the above disclaimer. The evidence before the Court is that this has been done. It is consistent with these terms as well as sound public

policy to say that the insurance company's legal obligations remain the legal obligations of that insurance company.

In a related case and this one, the plaintiff healthcare provider has not only asserted that Progressive Insurance breached its legal duties to it (by shortchanging it on a PIP reimbursement) but further asserts that FAIR Health also violated the CPA in making available the data upon which Progressive relied in its claims review process.

To prevail on a claim under Washington's CPA, there are five clearly enumerated elements that must be proven. See, Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co., 105 Wn. 2d 778, 719 P. 2d 531 (1986). Among these elements, the major hurdles confronting this plaintiff are establishing that *this defendant* engaged in an "unfair or deceptive act" and that its act was the "proximate cause" of injury to the plaintiff.

A finding of an unfair act does not require there to be a direct consumer or business relationship between the plaintiff and the wrongdoer. Holiday Resort Cmty. Ass'n. v. Echo Lake Assocs., 134 Wn. App. 210, 135 P. 3d 499 (2006); Panag v. Farmers Insurance Co. of Wa., 166 Wn. 2d 27, 204 P. 3d 885 (2009). However, it remains true that "[w]hen established, the five *Hangman Ridge* elements of a CPA citizen suit assure that the plaintiff is a proper party to bring suit." Panag, 166 Wn. 2d at 44. It remains essential that each one of these elements be established.

On the face of things, there is no apparent basis for finding unfairness in FAIR Health's own acts. Plaintiff alleges injury resulting directly from actions of

Progressive Insurance. This defendant did not in any way direct or control the acts of Progressive. Plaintiff's argument that the defendant had some sort of duty to monitor and "enforce the limitations on use of its database" by others lacks support in the record or the law.

It is argued by plaintiff that the CPA's requirement of an unfair act may be met by application of a related Federal Trade Commission standard. Federal cases are cited for the proposition that "it is settled that [o]ne who places in the hands of another a means of consummating a fraud or competing unfairly in violation of the Federal Trade Commission Act is himself guilty of a violation of the Act." FTC v. Neovi, Inc., 604 F. 3d 1150 (9th Cir. 2010) (citing Regina Corp. v. FTC, 322 F. 2d 765 (3rd Cir. 1963).)

Of course, the reference to placing the potential tool for misconduct in the hands of another reminds one of Woody Guthrie's observation that "some will rob you with a six gun, some with a fountain pen." And yet neither gun nor pen manufacturers are deemed strictly liable for the ample damage caused by these instrumentalities. The pertinent question becomes under what circumstances the manufacturer of the fountain pen may be seen as complicit in its subsequent use as a means of violating the FTCA and/or the CPA.

This Court finds it unnecessary to reach the question of whether the FTC standard should be treated as incorporated into Washington's quite differently worded CPA. This is because under any standard, once an unfair act has been established, this act must be found to have been a *proximate* cause of injury. An

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alarm clock may strictly be the "but for" cause of all daily problems that ensue but CPA liability requires more.

In reversing a grant of summary judgment and remanding the case for trial, the Holiday Resort court stated the general rule that "[p]roximate causation is typically a question of fact for the jury." 134 Wn. App. At 227. From this statement plus the discussion of WPI 15.01 (the pattern jury instruction for factual determination of causation) in Indoor Billboard /Washington v. Integra, 162 Wn. 2d 59, 83, 170 P. 3d 10 (2007), the plaintiff argues that "but for" causation is the only pertinent inquiry in a CPA claim such as this. The Court disagrees.

In support of its stated proposition, the Holiday Resort court cited the familiar cases of Ayers v. Johnson & Johnson, 117 Wn. 2d 747, 818 P. 2d 1337 (1991) and Baughn v. Honda Motor Co., 107 Wn. 2d 127, 727 P. 2d 655 (1986). Each of these cases emphasizes that proximate cause always includes two elements: cause in fact and legal causation. As stated in Ayers, "Legal causation depends on considerations of 'logic, common sense, justice, policy, and precedent' [and] involves the 'determination of whether liability *should* attach as a matter of law given the existence of cause in fact.'" 117 Wn. 2d at 756. Nothing in Holiday Resort or Indoor Billboard rejects or supplants this traditional analysis; not every handing of a fountain pen to a fraudster should result in liability for the harm that might, *in fact*, wind up being caused with that pen.

In the present case, there is no evidence that FAIR Health had any contact with Progressive Insurance and no evidence that it played any role in Progressive's claims review process. The mere fact of the defendant's fulfilling

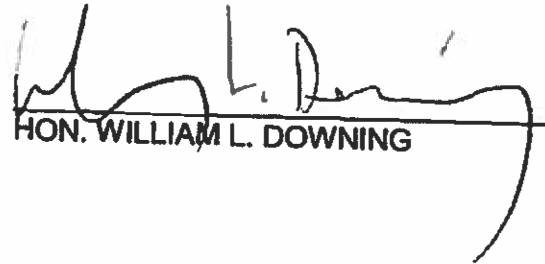
its mandate by providing a healthcare cost database – a tool that may have been misused by another – is insufficient to constitute commission of an unfair act and too remote and indirect to constitute a proximate cause of injury to the plaintiff. As a matter of law, the plaintiff is unable to establish this defendant's liability to it for a violation of Washington's Consumer Protection Act.

Based on the foregoing, it is HEREBY ORDERED:

The plaintiff's Motion for Summary Judgment is DENIED; and

The defendant's Motion for Summary Judgment is GRANTED and all plaintiff's claims shall be DISMISSED WITH PREJUDICE.

DATED this 20th day of July, 2016.



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