

DIC ✓ 36

SMALL BUSINESS ECONOMIC IMPACT STATEMENT
LONG-TERM CARE RULES
INSURANCE COMMISSIONER MATTER NO. R 95-5

(a) Are the rules required by federal law or federal regulation?
No.

(b) What industries are affected by the proposed rules?
Accident and Health Insurance Companies (#6321)
Hospital and Medical Service Plans (#6324)
Insurance agents, brokers, and service (#6411)

(c) List the specific parts of the proposed rules, based on the underlying statutory authority (RCW section), which may impose a cost to businesses.

-Standardization of triggers: Benefit triggers (or gatekeepers) to benefits are standardized to include physician certification, Activities of Daily Living (ADLs), or cognitive impairment, and minimum standards for defining these terms are included. Most insurers already employ one or some combination of these as triggers for benefits. The definitions of ADLs generally follow the NAIC model regulation.

-Alternate care standards: Sets standards for alternatives to institutional care (as a minimum standard for the "institutional care" benefit). If a person is eligible for nursing home coverage, but could stay at home if changes were made to the home, insurers would be required to pay for changes to the home in lieu of paying for nursing home coverage. This minimum standard is included as a hedge against the future. It is likely that in WA nursing home beds will become less available as alternatives to nursing home confinement will proliferate. It is desirable that insurance contracts include flexible benefits so that future delivery systems can be accommodated without requiring insureds to buy new policies.

-Prevention of unintended lapse: This section permits an applicant or insured to name a person to whom notice of

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lapse will be sent if the premium remains unpaid. This rule is designed to prevent unintended lapses by insureds who are infirm or ill when the premium is due and who forget to pay the premium.

-Standard LTC disclosure form: The rules set forth a new uniform format for disclosure. There currently is a standard Washington LTC disclosure form; this is an update based on changes in the design of LTC insurance products since the adoption of the first disclosure form in 1987. The new form better communicates the information about available LTC insurance so consumers can make better choices among plans.

(d) **What will be the compliance costs for industries affected?**
The following are likely:

- amendment of marketing and advertising materials
- amendment of insurance forms (and filing their new forms for prior approval by the insurance commissioner)
- retraining of agents

The policy forms of many insurers already meet or exceed most (if not all) of the standards of the proposed rules. The cost of compliance company-by-company will vary, not based on the size of the insurer, but based on the extent to which the company already meets the new standards.

(e) **What percentage of the industries in the four-digit standard industrial classification will be affected by the rule?**
100% of those insurers that choose to offer long-term care insurance contracts for sale in this state will be affected.

(f) **Will the rules impose a proportionately higher economic burden on small businesses within the four-digit classification?**

No. The cost of compliance company-by-company will vary, not based on the size of the insurer, but based on the

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extent to which the company already meets the new standards.

- (g) Can mitigation be used to reduce the economic impact of the rule on small businesses and still meet the stated objective of the statutes which are the basis of the proposed rule? No. The goals of the proposed rules are: standardization of disclosure materials and benefit triggers, to provide a right to policy "down-grades," modification of benefits in case of state or federal health care reform that duplicates contract benefits, acceptable alternatives to nursing home benefits in certain cases, and to protect against unintended lapse. The intent of all of these goals is increased: (a) fairness to policyholders, (b) usefulness of policies when the way care is delivered changes over time, and (c) understanding of policies and disclosure materials.

These proposed rules are specifically designed to establish uniform minimum standards for all long-term care insurance contracts, marketing materials, and advertising. Long-term care policies are guaranteed renewable contracts which are purchased many years before they are used -- maybe even as many as 20 years. The proposed rules help keep an insured's policy from becoming outmoded as changes occur in the way long-term health care is delivered in the future.

Many companies will have to make only a few changes to their forms and the way they do LTC business in order to comply with these new standards. Some companies will have to redesign their contracts. All insurers will have to retrain their agents -- some more than others. It is important for the commissioner to assure residents of this state that the policies they purchase today include meaningful benefits both when purchased and in the future.

The standard Washington LTC disclosure form has not been amended since 1987 and much has changed in the long-term

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care insurance market since then. The insurance companies will need to amend their current forms (the questions are not very different from the current form). Most companies provide the proposed information now; this is a new format.

(h) **What steps will the commissioner take to reduce the costs of the rule on small businesses**

It is important that all insurers in WA the long-term care insurance market play by the same rules in order to be sure that no one company has a competitive advantage. The consumer protection purpose of the statute will be thwarted if small insurers are permitted to escape regulation. Standardization cannot be achieved if some insurers are not required to comply with the minimum standards. Policyholders should not be protected differently if their policy is with a small or large insurer.

Some ideas for rules were discarded due to projections of the high costs of compliance, including rules for mandatory non-forfeiture values, rate stabilization, new standards for group contracts, policy "up-grades," and limitations on agent compensation.

(i) **Which mitigation techniques have been considered and incorporated into the proposed rule?**

Similar rules were proposed in 1994 and withdrawn for further consideration of content and design. This rule making is the end-product of considerable discussion and recognizes many of the concerns raised during the 1994 rule making.

(j) **Which mitigation techniques were considered for incorporation into the proposed rule but were rejected, and why?**

The following mitigation techniques were considered and

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rejected¹:

- differing compliance or reporting requirements or timetables for small businesses
- exemption of small businesses from any or all requirements of the rule

- (k) Briefly describe the reporting, recordkeeping, and other compliance requirements of the proposed rule. Keeping records of persons to be designated to receive notice of unpaid premium is the only reporting, recordkeeping, or other compliance requirement required by the rule which insurers do not already employ. Many insurers are already offering insureds the opportunity to name a friend or relative to receive notice of unpaid premium; this is part of the NAIC model long-term care regulation and has been adopted by other states. Although the Washington version of the NAIC model rule was re-written for clarity, there is nothing in the proposed rule that is different than the comparable section of NAIC model regulation. No other section of the proposed rules requires additional reporting or record keeping.
- (l) List the kinds of professional services that a small business is likely to need in order to comply with the reporting, recordkeeping, and other compliance requirements of the proposed rule.
None that it does not already have.
- (m) Analyze the cost of compliance including, specifically:
-Cost of equipment: no new equipment will be required
-Cost of supplies: no new supplies will be required for compliance; however, insurers may have to develop new disclosure forms and destroy an existing supply of out-dated

¹also see (h) above

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forms

-Cost of labor: employees of the insurer will be required to modify the insurer's marketing and advertising materials; policy forms of some insurers may need to be amended; some insurers may wish to refile rates; the associated costs are incurred as a regular business expense of insurers on a more-or-less continuing basis as they revise contract forms

-Increased administrative costs: none are anticipated except costs that may be associated with implementing the rule on "unintended lapse"

(n) Compare the cost of compliance for small business with the cost of compliance for the 10% of businesses that are the largest businesses in the four-digit classification using one or more of the following (as specifically required by RCW 19.86.040(1)(a), (b), and (c): Cost per employee, Cost per hour of labor, or Cost per \$100 of sales
The costs of compliance for a small insurer should be no greater than the costs of compliance for a large insurer. The cost of compliance company-by-company will vary, not based on the size of the insurer, the cost per employee, the cost per hour of labor, or the cost per \$100 of sales; any cost differences will be based on the extent to which the company already meets the new standards.

(o) **Have businesses that will be affected been asked what the economic impact of the rule will be?**
Yes. On July 3, 1995, a representative of the association that represents most of the insurers writing long-term care insurance in this state was asked to provide help to determine the economic impact of the rules. In addition, the preproposal statement of intent to adopt long-term care rules was sent to all insurers authorized to write disability insurance in this state. Only two insurers have submitted comments to date.

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- (p) How did the commissioner involve small businesses in the development of the proposed rule?
The commissioner appointed a committee to assist in the development of the rules, the accurate assessment of the costs of the proposed rule, and the means to reduce the costs imposed on small insurers and agents. Members of the committee included senior citizens, AARP, DSHS Aging and Adult Services, and insurance agents.

This committee met several times, both in full task force and in small working groups, between April and September of 1994. All meetings were open to the public and in at least two cases, arrangements were made for persons who could not attend in person to participate by telephone conference call. In addition, during 1994 and 1995, there have been several telephone conversations between members of the commissioner's staff and representatives of a number of insurance companies, many of whom are members of the NAIC LTC Working Group or are known to be active in the marketing of long-term care insurance policies.

- (q) How and when were affected small businesses advised of the proposed rule?
-Direct notification of known interested small businesses or trade organizations affected by the proposed rule in the general mailing in 1994 and 1995 following publication of the preproposal statements of intent.
-Publication of the subject matter of the proposed rule making in the "Washington State Register" (WSR 94-09-048 - filed 4/20/94 and WSR 95-13-101 - filed 6/21/95).

OIC 137

CONCISE EXPLANATORY STATEMENT
Long-Term Care Insurance
R 95-5

Pursuant to RCW 35.05.325(6) - ESHB1010(304(6))

1. What are the Commissioner's reasons for adopting the rule:

These rules clarify and set standards for long-term care benefits and disclosure requirements. The goals of the rule are: to provide minimum standards for benefits and disclosure requirements; to make it easier for applicants to compare policy forms and to make an informed choice among several alternatives; to provide standards to be certain that policies sold today will provide coverage to insureds in the future even though delivery systems of health care may change during the term of the policies; to provide an automatic change in benefits if future federal or state programs provide benefits that duplicate insurance coverage; and to provide for flexibility in delivering and covering a range of health care services.

2. Describe the differences between the text of the proposed rule as published in the Washington State Register and the text of the rule as adopted (other than editing changes) and state the reason:

In response to public comment several changes were made that are primarily editing. The most extensive difference between the rule as proposed and the rule as adopted is in WAC 284-54-040; this section was amended to track with the NAIC long-term care model section on Activities of Daily Living WAC 284-54-170 was withdrawn for the time being; the issue of alternate plans of care is so important that it will be reconsidered at a later date. WAC 284-54-253 was changed to follow the NAIC LTC model section on unintended lapses.

3. Attached is a summary of all comments received regarding the proposed rule listed by category or subject matter, and an indication of how the final rule as adopted reflects the Commissioner's consideration of the comments, or why the final rule failed to reflect the comments.

NOTE: All of the comments received were exceptionally helpful. Each letter was carefully considered and provided useful and informative suggestions for improving these rules.

CONCISE SUMMARY OF COMMENTS

Long-Term Care Insurance -- R 95-5

General Comments

Policy stability is particularly important in this marketplace and the Commissioner should be conscious of rate impacts when proposing new rules. Insurers cannot achieve rate stability until there is regulatory stability.

Response: Rate stability is important and the interests of policyholders must be protected. These rules are adopted to protect consumer interests; at the same time, the insurers in the marketplace can be assured of a "level playing field" which helps rate stability.

It is important to continue to provide a choice for consumers between institutional and community-based and home-care benefits. As the way we delivery care changes, and with technological improvements, more and more people can be cared for at home or in a home-like setting. We appreciate the leadership of Commissioner Seann to encourage this flexibility.

Response: Health care delivery is rapidly changing and evolving; insurance policies must be designed to be flexible enough to reflect these changes. These rules try to strike the balance between certainty (which both policyholders and insurers need -- to be sure each knows what benefit is expected) and flexibility (which both policyholders and insurers need -- to be certain that a policy can provide benefits in the future when it will be needed).

Definitions

(10). You need to include a definition of "hospice" and "home health care"; see RCW 70.127.010(9),

Response: These definitions may be incorporated in a later rulemaking. While long-term care insurance policies provide significantly more than hospice and home health care benefits, LTC policies are fundamentally disability insurance policies issued by insurers and health care service contractors. Standards for "hospice" and "home health care" are provided by statute at RCW 48.21.200 and 48.44.320; such standards apply to LTC policies as well.

"Physician" is not defined; you should allow both allopathic and osteopathic physicians.

Response: A definition of "Physician" will be considered at a later rule-making; right now it does not appear to be a significant problem which needs to be addressed.

WAC 284-54-020(1) "Community-based care"

Community-based care is not the same as home-based care; they are two separate concepts; home-based care is but one part of community-based care. The amendment to the definition appears to make the terms interchangeable. This definition should make the distinction between facilities that provide overnight care. It's not the setting that distinguishes institutional care from community-based care -- it's the inclusion of overnight care.

Response: Thank you for the comments; the amendment was edited to clarify that the terms "community-based care" and "home-based care" are not the same and to clearly indicate that the distinguishing characteristic between "community-based care" and "institutional care" is whether or not overnight care is provided.

WAC 284-54-030 (9) "Home care services" and (10) "Home health care"

(10) "Home health care"

You need to delete home care agencies in the definition because home care agencies are not allowed to deliver home health services by law.

Response: Thank you for the information; the amendment was edited to make this more clear.

(9) and (10)

What do you mean by "regulated"? Do you mean regulated by the state of Washington, licensed, Medicare certified, JCAHO accredited, or something else? There is an alarming trend to require nursing homes to be Medicare certified; this is different from regulated by the state.

Response: It is the intent of the amendment to refer to some sort of licensure or certification by the state of Washington; in particular, this amendment does not refer to accreditation by JCAHO or Medicare certification. The amendment was edited to make this more clear.

WAC 284-54-040 -- Benefit Triggers and Activities of Daily Living

You should not adopt benefit triggers or definitions of Activities of Daily Living (ADLs) until both the NAIC and Congress complete their work.

Response: We need not wait for Congress to complete the LTC tax proposal; it may take a long time. The NAIC model has now been completed and it is appropriate to proceed to adopt its standards at this time.

The definitions do not follow the NAIC model. The NAIC model will be amendment at its September meeting to include benefit triggers and definitions of Activities of Daily Living (ADLs) which are the result of more than a year of deliberations on a nation-wide basis. If the definitions of ADLs are common throughout the nation there will be less consumer confusion as policyholders move from state to

state and premiums will be reduced. The NAIC based the model ADLs on the work of Dr. Sidney Katz. There is a tremendous difference in pricing depending on which ADLs are chosen.

Federal standards for tax benefits will likely be based on the Katz six ADLs with no more than three to trigger benefits. The House-passed bill uses the six NAIC-Katz ADLs with three to trigger; the Senate is considering similar requirements; state triggers should not conflict with what Congress does.

The average current nursing home resident is deficient in at least 2.5 out of the Katz ADLs. If the 3-ADL-trigger is used, claim costs will be about 30% less.

Use the NAIC ADLs and allow an insurer to use a minimum of 5 of the 6; require a trigger of no more than 3 of 6. The industry standard is 2 of 5 ADLs based on the Katz standard, which translates to 3 of 6; at least one company uses the more liberal 2 of 6 ADLs; companies should be allowed flexibility in design.

The definitions in the Washington proposal are inconsistent with the NAIC model; for example, "bathing" includes "transferring"; the definition of "cognitive" impairment does not track the NAIC provision and fails to include the level of assistance required. "Transferring" and "toileting" are combined and should be separated; this violates (g) which prohibits insurers from combining ADLs

In the employer group marketplace, it is important that all members of the group have uniform benefits regardless of their state of residence. Adoption of the NAIC version will help assure this.

Delete "continence" (which is a state) as an ADL and replace it with "toileting" (which is an activity). Reformat the section so that the ADLs are all subsections of one section.

Response: This entire section has been edited to follow the NAIC model.

"Illness or infirmity" in (1) may not include "chronic conditions" or "disabilities" and, therefore, (1) should be amended.

Response: We disagree; "illness or infirmity" should include chronic conditions and disabilities.

WAC 284-54-170 Minimum standards -- Alternate Care

This rule mandates home health care in a nursing home only policy; you should not do this. Alternate plans of care are appropriate only in a comprehensive long-term care insurance policy. Consumers continue to want an institutional only policy.

It is difficult to design and price for an "unstructured benefit" that is mandated. As written the benefit would be impossible to administer and price. You could help by permitting specific dollar caps on structural improvements. It is not appropriate to mandate a one-time cost under a daily benefit amount. These are unknown/unknowable services/devices to be provided; you're asking us to price the unknown.

This rule mandates inclusion of an unknowable future benefit triggered by an agreement between the parties that is not part of the contract; there will be extreme confusion about what is and what is not covered; the issue will be whether the promises made were undeliverable/undelivered

Companies often offer alternative plans of care with the agreement of the insured if it is in the best interest of the insured, but these are extra-contractual

Insureds may be victimized by entities providing structural improvements and neither the insurer

nor the health care agency providing care can protect against this

"Otherwise eligible for benefits" is a phrase that is easily misunderstood

Durable medical equipment is often provided in an ancillary benefit, and is not part of what is commonly included in an alternate plan of care

An alternate plan of care benefit mandate is inconsistent with policies that pay benefits based on "functional loss" (where benefits are paid once the insured is ADL-dependent regardless of the receipt of professional services)

This idea has merit, but a written it is impossible to administer and price. A broader definition of "nursing home" to include facility-only coverage would benefit policyholders in much the same way as the alternate plan of care benefit suggested

Plan of services is more precise than plan or treatment

Adding a mandated alternate plan of care benefit will increase the premium by 15% on a policy covering licensed professional home care, 40% to a nursing home only policy, and nothing to a "disability model" LTC policy (assuming 65 year old insured)

Alternate plans of care that are agreed to now are used by insurers to help claimants regain their lost functional capacity and to engage in activities of daily living; they are extra-contractual by nature; they are appropriate only in policies that cover both institutional and home care.

Response: Based on the comments received, this section is withdrawn. Because it is so important to assure benefits will be meaningful in the future, it will be reviewed for adoption at a later date.

WAC 284-54-180 Reductions in benefits -- a/k/a policy "down-grades"

A policyholder should not be able to reduce his or her benefits below the insurer's minimum level of benefits. The policyholder already has a contractual right to reduce coverage; this provision may permit a person to go below the minimum amount sold by the company.

Response: While some insurers make "down grades" routinely available, not all insurers do. This section makes it a right of the policyholder to reduce his or her benefits. It is anticipated that the insured will not be able to reduce benefits to less than the minimum amount sold by the insurer. If that is not clear, a change may be necessary.

WAC 284-54-190 Non-duplication with federal or state benefits

Contracts that are "guaranteed renewable" are prohibited from changing or eliminating benefit features unless they are mutually agreed upon and consented to by both parties; this rule is not necessary and should not be adopted; the wording is imprecise and vague.

Response: The rule is included precisely because these contracts are guaranteed renewable. At some point in the future, Congress or a state legislature may adopt a program of government-provided benefits that will duplicate some or all of the benefits of a policyholder's long-term care insurance program. LTC policies are level premium contracts; this means that premiums in the early years exceed

the pure premium needed to fund the benefit. LTC level premium policies are designed this way so that the premiums in later years will not increase as the mathematical probability of use of the benefits increases. Level premiums mean that the insureds have an "interest" in the policy which should be protected by regulators. If government benefits duplicate policy benefits at some future date, the insured who purchased the policy several years ago may no longer be in good health and, therefore, may be unable to purchase a new policy which does not duplicate benefits for which she or he is paying premium. This rule permits insurers to amend contracts with then have duplicate benefits so that policies remain valuable. The wording may appear imprecise, that is because it is unknown what the future holds; it is anticipated that more specific guidelines will be made available at a time when details are known.

WAC 284-54-253 Unintentional Lapse

Proof of impairment should be no more restrictive than the policy benefit trigger [see WAC 284-54-253(2)(a)].

Response: Thank you for the suggested change; your suggestion is better than the rule as proposed.

Subsection (2)(b) goes beyond the NAIC model. By extending the period to pay premiums you could create problems with lapsing and re-lapsing until the final premiums are paid and the policy is current.

Response. Based on the public comment and concerns about what is a "reasonable" period of time raised by a number of people, this part of subsection (2) is deleted.

It is not clear whether the offer is to be in the contract or should be made by a mailing.

Response: The rule is written to permit the insurer to include the provision in its contract forms, but to operate whether or not such a provision is included in the contract. It is anticipated that an insurer will give notice to the insured in a mailing of his or her opportunity to designate a third party to receive past-due notice of premium and to change the designee, or update the information. This could be included in the annual notice of premium due.

What should an insurer do if there is no response from the insured?

Response: The rule requires the insurer to provide an opportunity for the insured to designate a third party to receive notice of past due premium; the rule does not require the insured to provide such information to the company. If the insured does not respond to requests for information it may be appropriate for the company to make further inquiry; what the company does will depend on the circumstances.

What is adequate record keeping?

Response: "Adequate" will depend on the circumstances. Recordkeeping is adequate if the insurer can find information needed by it, the Commissioner, or the insured or his or her representative.

when did it ask and can the insurer verify that insureds were offered the opportunity to name a third party to receive past due notice of premium; if a person is named, who is that person, what is that person's address, when were updates requested, etc.

This section is unnecessary when the insured is a member of a group where the premiums are paid by payroll deduction; it is only necessary to invoke this requirement after the insured has left the group.

Response: The rule was amended to address this issue.

The offer of inflation protection should be made to the policyholder, not to the insured, at time of application; in group coverage, the policyholder makes the determinations of benefits in a group contract. In most group contracts, the average age of the insured is younger than in individual sales; most group contracts include inflation protection.

Response: After consideration of the public comment, this change was made.

WAC 284-54-300 and -350 Disclosure Form

Delivery of the disclosure form should remain the same as it is now; it is costly to keep records of each person to whom a brochure is given.

What is "initial solicitation" and must a person collecting information prefatory to even seriously considering an insurance purchase be forced to sign a statement that he or she has received and understands the material received.

Response: In response to public comments, the rule will not change the timing of delivery of the disclosure form. Insurers should include information that will permit potential applicants to make meaningful choices in their brochures.

Compliance with the ADA requirements may be a problem.

Response: The Americans With Disabilities Act is a federal law which must be complied with. The rule reflects its requirements.

Inclusion or the comparison sheet with the disclosure form is inappropriate.

Response: We disagree. Comparisons are best made before a purchase. The form facilitates comparison by the individual apart from any pressure of an agent.

You should use the NAIC LTC Shopper's Guide.

Response: Insurers can deliver the NAIC LTC Shopper's Guide; however, its use is not mandatory in this state at this time.

The agent, not the company, should be required to keep the records of to whom disclosure forms are provided.

Response: The agent is the agent of the insurer, not the insured; it is the responsibility of the

insurer to see that the forms are maintained and that the agent's actions are in compliance with these rules.

Under "home/community-based care" you should separately list "physician" and "nursing services" since home health agencies do not provide physician services. Under "other," you should list various forms of therapy, i.e., physical, occupational, speech, other therapy.

Response: We appreciate the suggestions and will consider them in a future rule-making.

Is this disclosure form in lieu of or in addition to an outline of coverage? The regulation should say.

Response: Chapter 284-54 WAC does not require an insurer to use an outline of coverage; it requires the use of the disclosure form as set forth in WAC 284-54-300 and 284-54-350. If an insurer chooses to use an outline of coverage, the disclosure form would be in addition to that form; it is not in lieu of an outline of coverage.

Why are lab services, prescription and physician services listed under home/community-based care? Is it to remind people that these are not covered?

Response: Yes.

Should these forms be "free form fill in" or preprinted?

Response: They should be pre-printed unless the insurer chooses to permit its agents to fill the forms in at point of sale. If agents fill in the forms at point of sale, the insurer (principal) will be held responsible for the promises made.

"Home care" should be "home-based care" as defined in the WACs.

Response: The definition of "community-based care" was not amended in this rule-making.

BCWA provides a rate sheet for people to calculate their own rates; can we continue to use this process?

Response: Yes, use of a rate sheet which guidelines for calculation of rates by the person interested in "designing" his or her own policy is acceptable. It is "substantially similar" to the requirements in the rule.

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EX 38
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NO. 63916-1-I
COURT OF APPEALS
DIVISION I
OF THE STATE OF WASHINGTON

LEROY BUSHNELL, a personal representative of the Estate of EVELYN
BUSHNELL,

Plaintiff-Appellant,

vs.

MEDICO INSURANCE COMPANY, a Nebraska corporation, and
MEDICO LIFE INSURANCE COMPANY, a Nebraska corporation,

Defendant-Appellees.

APPELLEE MEDICO'S MOTION FOR RECONSIDERATION

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I. IDENTITY OF MOVING PARTY

Pursuant to RAP 12.4, Defendant-Appellee Respondents Medico Insurance Company and Medico Life Insurance Company (collectively, "Medico") respectfully request that the Court reconsider its February 7, 2011 decision on the following basis:

(1) The Court held that with acceptance of each renewal premium a new contract was formed. In reaching this conclusion, the Court misapplied the rule from *Tebb v. Continental Casualty Co.* Such a conclusion on the facts of this case expands *Tebb* beyond the basic tenets of contract law, resulting in a novation of the insurance contract by the Court;

(2) The Court held that the policy did not lapse until after the grace period. As demonstrated below, in reaching this conclusion, the Court misapprehended the policy and assumed or created a "waiver of premium" provision that does not exist; and

(3) The Court held that bad faith is a question of fact, simply based on the argument that the policy is a continuing contract and the policy lapsed. Because these conclusions should be reconsidered, the Court also should reconsider remand of the bad faith claim.

II. STATEMENT OF RELIEF SOUGHT

Medico seeks reconsideration of the decision to conclude that (1) no payment is required by Medico because the policy is a continuing contract for insurance, (2) the 3-day prior hospitalization requirement remained in effect, and/or (3) Ms. Bushnell's policy lapsed and would

thereby limit any claim to sixteen days. In addition, Medico seeks reconsideration of the decision to conclude that there were insufficient facts presented to support a claim for bad faith.

III. FACTS RELEVANT TO MOTION

Evelyn Bushnell (hereafter, "Ms. Bushnell") purchased an insurance policy from Medico, which was issued effective on October 9, 1986 (hereafter, "Ms. Bushnell's policy").¹ The policy contains a 3-day prior hospitalization clause, requiring such a hospitalization before benefits would be triggered.² Ms. Bushnell's policy contains a Grace Period clause, allowing a 31-day grace period of policy coverage following non-payment of premium;³ a Renewal Agreement⁴ applying an Elimination Period, defined as the number of days for which benefits are eliminated in consideration for a reduced premium;⁵ and included a Term of Coverage provision.⁶ Her policy does not include any waiver of premium provision.

In 1986, the Washington State Legislature passed the "Long-Term Care Insurance Act."⁷ The legislature specifically stated that portion of the act that concerns us here, regarding prior hospitalization stay

¹ CP 35; CP 550; CP 030-038.

² CP 032 at Part G(3).

³ CP 033 at Part M(3).

⁴ CP 030 at Part B.

⁵ CP 031 at Part F(2).

⁶ CP 034 at Part M(12).

⁷ CP 167.

requirements, was to "apply to policies and contracts issued on or after January 1, 1988."⁸ The Washington Administrative Code, promulgated under the Long-Term Care Insurance Act, prohibits prior hospitalization stay requirements in long-term care contracts.⁹

Ms. Bushnell paid her premium on February 1, 2007.¹⁰ This payment was for coverage period January 1, 2007–February 28, 2007.¹¹

On February 24, 2007, Ms. Bushnell was admitted to Lake Vue Gardens Convalescent Center, a nursing facility, without previously being hospitalized.¹²

No premium was received by Medico on February 1, 2007, so Ms. Bushnell was sent a reminder notice.¹³

On March 6, 2007, Medico received timely notice of Ms. Bushnell's Proof of Loss Claim.¹⁴

On March 12, 2007, Medico sent Ms. Bushnell another notice, explaining that she was in her 31-day grace period and that her coverage would lapse if prompt action was not taken.¹⁵

⁸ CP 168.

⁹ WAC 284-54-150(7).

¹⁰ CP 615.

¹¹ CP 615.

¹² CP 601; CP 604.

¹³ CP 552; CP 556–57.

¹⁴ CP 430; CP 585; CP 602.

¹⁵ CP 553; CP 556; CP 558.

statute and regulations.¹⁸ The *Tebb* court established that the intent of the parties, as determined by the insurance policy, determines whether a policy is a continuous contract for insurance or a renewal policy, established anew with each premium paid.¹⁹ That court noted that the option to accept or reject the individual renewal premium is a demonstration of the intent to effectuate a new contract between the parties.²⁰

Citing *Tebb*, this Court noted two instances of policy language from Ms. Bushnell's policy in its decision that the policy is a renewal policy: (a) the Renewal Agreement,²¹ and (b) the Term of Coverage.²² To follow *Tebb*, both of these provisions indicate that the parties' intent was for a continuous contract of insurance.

- a. Medico does not have the option to reject Ms. Bushnell's individual policy

The policy at issue in *Tebb* was found to be a renewal policy based upon the policy language.²³ As noted by this Court, the *Tebb* court decided that the right of the insurer to accept or reject the renewal was conclusive evidence that the parties intend to create a new contract upon the

¹⁸ See *Tebb v. Cont'l Casualty Co.*, 71 Wn.2d 710, 712, 430 P.2d 597 (1967).

¹⁹ *Id.* at 713.

²⁰ *Id.*

²¹ CP 030 at Part B.

²² CP 034 at Part M (12).

²³ *Tebb*, 71 Wn.2d at 714.

acceptance of the renewal premium. The *Tebb* court found it determinative that the policy language at issue in *Tebb* granted the insurer the right to reject renewal at the insurer's discretion:

The policy in question gives the defendant the option to accept or reject any renewal premium so there is no automatic continuation of the policy by payment of premiums. The insurer had the right to exercise its discretion in granting a renewal of the policy. In the words of the policy, "it [the policy] **may be renewed with the consent of the Company**"²⁴

The policy language in Ms. Bushnell's policy is in stark contrast with the *Tebb* policy language regarding renewal:

As long as you pay the renewal premium then in effect on the date it is due or during the 31-day grace period, we cannot refuse to renew your policy unless we do the same to all policies of this form issued to person of your class (for example, age) in your state. Your policy stays in force during your grace period. No refusal of renewal will affect a claim existing in a confinement period.

We can change your premium only if we do the same to all policies of this form issued to persons of your class (for example, age) in your state and we will notify you in advance of the due date.²⁵

The policy is clear: Medico has no discretion regarding Ms. Bushnell's individual policy. Medico cannot refuse to renew the policy, nor change the premiums, unless all like policies within the state are similarly altered. This is not indicative of a renewal contract. This Court's determination that the policy is a renewal policy, established anew with each premium

²⁴ *Tebb*, 71 Wn.2d at 713 (emphasis added).

²⁵ CP 030 at Part B (emphasis added).

paid, is contrary to the facts and holding of *Tebb*.

Under *Tebb*, the renewal provision is conclusive evidence of the parties' intention. Based on Ms. Bushnell's policy's renewal provision, Ms. Bushnell's policy should be found a continuous contract for insurance. Little case law in Washington addresses this issue. Other jurisdictions have addressed it and concur that when the insurer has no discretion regarding renewal of the policy, the policy is not a renewal policy, but a continuous contract for insurance.²⁶ In the Federal case from Mississippi, *Oates*, the issue regarded the use of a variable deductible, which was valid at the time the Equitable issued a major medical policy to Oates. Years later, a Mississippi regulation was enacted prohibiting the use of variable deductibles. Similar to the facts of this case, the *Oates* court was required to determine if the policy was continuous or if the policy was a renewal policy prior to its determination of whether the variable deductible provision was valid. The court noted "[w]hether the renewal of a policy of insurance constitutes a new and independent contract or whether it is instead a continuation of the original contract 'primary depends upon the intention of the parties as ascertained from the instrument itself.'"²⁷

Just like Ms. Bushnell's policy, the policy at issue in *Oates* was a guaranteed renewable policy, maintained in force by the insured's

²⁶ See, e.g., *Oates v. Equitable Assurance Soc. of the United States*, 717 F. Supp. 449, 452 (S.D. Miss. 1988).

²⁷ *Id.* (quoting 18 COUCH ON INSURANCE 3D § 68:40 at 41).

payment of monthly premiums, the amount of which was subject to change only if the same change is made applicable to all policies of the class.²⁸ "Although the policy speaks in terms of 'renewal' at the end of each 'term of coverage' (here, successive one month terms) by payment of the premium amount due, it is clear that the parties contemplated one continuous contract of insurance and not separate successive contracts of one month each."²⁹ Similarly, Ms. Bushnell's policy is a continuous contract of insurance. The *Oates* court held that the regulation regarding variable deductibles enacted after the policy date did not apply to the policy.

The *Oates* court found basic contract law principles governed, noting:

It is somewhat ironic that Equitable's guarantees to its insured of lifetime medical coverage now lend support to the court's conclusion that the company may properly rely on a provision of the policy to deny coverage. However, it must be borne in mind that the parties to a contract of insurance are free to define the scope of coverage to be afforded subject only to the condition that the provisions of the policy do not contravene any statute or public policy of the state. And, since Mississippi law in effect on the date of issuance of the *Oates* policy did not prohibit the inclusion of a variable deductible such as that contained in the *Oates* policy, that provision is binding.³⁰

This Court also must enforce the contract entered into by the parties.

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Oates*, 717 F. Supp. at 452 n.3.

Washington law in effect on the date of issuance of Ms. Bushnell's policy did not prohibit a mandatory 3-day hospital stay as a condition of benefits. That contract provision is binding.³¹

Ms. Bushnell's policy is a continuous policy. The hospital stay requirement should be enforced as agreed by the parties. The conclusion that the policy at issue contemplated continuous coverage is consistent with the circumstances behind long-term care insurance: people purchase them to ensure coverage as they grow older and are more likely to need it. If a policy's premiums could be increased, or if it could simply be

³¹ A factually identical case has been found, although the court in question did not elect to publish the decision. See *Haley v. AIG Life Ins. Co.*, 2002 U.S. Dist. LEXIS 1114 (D.N.D. Jan. 24, 2002). In *Haley*, the insurer issued a long-term care policy with a prior hospitalization requirement prior to the enactment of a statute that prohibited such a clause. The statute was not retroactive. The insured argued that each renewal of her policy created a new policy and the *Haley* court examined the contract to determine the parties' intent. It concluded that the parties intended a continuous contract, stating:

Crucially, plaintiff's policy had a guaranteed renewal clause: The company had no right to refuse renewal so long as plaintiff paid her premium. Further, the insurer could not unilaterally change the premium, unless it did so for all policies on a class-wide basis. Several courts have concluded that this sort of language indicates an intent to view subsequent renewals as continuations of the existing contract, rather than creations of a new one, which prevents application of statutes enacted after a contract's original effective date.

Haley, 2002 U.S. Dist. LEXIS at *8. The plaintiff's policy in *Haley* has the identical language as Ms. Bushnell's policy. Ms. Bushnell's policy is properly found to be a continuous contract, and application of statutes after the original effective date is thus prevented.

See also *Hudson v. Reserve Life Ins. Co.*, 245 S.C. 615 (1965) (holding a guaranteed renewable policy contemplated continuous coverage with each renewal, so later-enacted statutes did not apply).

cancelled as the insured got older, it would be of little use. Viewing each renewal of the policy as a new contract, however, would give an insurer the right to do exactly that. In fact, the insurers here may well have changed the premiums to reflect the removal of the hospitalization requirement had there been such a change.³²

b. The Court misapprehended the "Term of Coverage" provision.

The Term of Coverage provision, does not evidence intent contrary to a continuous policy. The provision states as follows:

Your coverage states on the Policy Date at 12 o'clock noon standard time where you live. It ends at 12 o'clock noon the same standard time in the first renewal date. *Each time you renew your policy, the new term begins with the old term ends.*³³

Ms. Bushnell's Term of Coverage provision does not state or indicate that each time the premium is paid the policy is renewed. Rather, the provision defines the term of coverage for each premium and implies the continuous nature of the policy.

2. The Court's application of a rebuttable presumption, not required by the Washington Supreme Court in *Tebb*, was unwarranted.

This Court's interpretation of *Tebb*'s holding imposes a rebuttable presumption: "Quoting Appleman on Insurance Law & Practice, section 7648 at 419 (1943), the court held that unless a contrary intention is

³² Although not binding precedent on this Court, the logic of *Haley* is directly applicable as reflected in the preceding paragraph.

³³ CP 034 at Part M(12) (emphasis added).

clearly shown, each time a policy is renewed, a new contract is formed.”³⁴

But *Tebb* had no such holding. The quote in full is as follows:

A renewal contract has been stated by many jurisdictions to be a new, and a separate and distinct contract, unless the intention of the parties is shown clearly that the original and renewal agreements shall constitute one continuous contract.

The *Tebb* court went on to search for evidence of intent in the contract. *Tebb* found such evidence in the carrier’s right to reject the premium. In *dicta*, *Tebb* suggested the policy may be continuing where, as here, the carrier does not have that right.³⁵ Nowhere did *Tebb* create a rebuttable presumption of separate contracts.

B. Misapplication of *Tebb* in this matter has the effect of a novation, contrary to Medico’s contractual rights under the constitution.

There is no dispute that Ms. Bushnell’s policy and its terms were valid and enforceable at the time the policy was issued. Retroactive application of Chapter 48.84 RCW is a violation of Medico’s constitutional right to contract when case law, including *Tebb*, indicates that the parties intended a continuing contract for insurance.

The United States Constitution states: “No state shall adopt any law impairing the obligation of contracts.”³⁶ Our state constitution echoes that guarantee: “No ... law impairing the obligations of contracts shall

³⁴ Opinion at 10.

³⁵ *Tebb*, 71 Wn.2d at 713.

³⁶ U.S. Const. Art. I, § 10.

ever be passed.”³⁷

Washington case law regarding insurance contracts is in agreement. An insurer cannot be compelled to extend coverage beyond the insurance contract.³⁸ “The underlying rationale is that an insurance company should not be required to pay for a loss for which it received no premium.”³⁹

The effect of this Court’s decision is to force Medico into a contract that it did not make. The renewal and term provisions are conclusive evidence of the parties’ intent to enter into a continuous contract for insurance. Medico had no discretion regarding Ms. Bushnell’s individual contract. The bargain Medico and Ms. Bushnell entered into was for one with a 3-day prior hospitalization requirement, and the premiums reflected that benefit limitation.

This Court’s characterization of the policy as a renewal policy effectively would create a novation of the contract. It forces Medico to pay a benefit for which it received no premium. This is contrary to the U.S. Constitution, the Washington State Constitution, and Washington’s law

³⁷ Wash. Const. Art. I, § 23.

³⁸ See, e.g., *Coventry Assocs. v. Am. States Ins.*, 136 Wn.2d 269, 280, 961 P.2d 933 (1998) (stating that “[A]n insurer is [not] required to pay claims which are not covered by the contract or take other actions inconsistent with the contract”); *Shows v. Pemberton*, 73 Wn. App. 107, 110, 868 P.2d 164 (1994) (stating that “an insurer may be estopped, by its conduct or its knowledge or by statute, from insisting upon a forfeiture of a policy, yet under no conditions can the coverage or restrictions on the coverage be extended by the doctrine of waiver or estoppel.”).

³⁹ *Saunders v. Lloyd’s of London*, 113 Wn.2d 330, 336, 779 P.2d 249 (1989).

regarding insurance contracts.

C. **Because Ms. Bushnell's policy lapsed for non-payment, the benefit period under which Ms. Bushnell is eligible is March 16, 2007, through March 31, 2007.**

This Court appears to have assumed a waiver of premium provision that is not in Ms. Bushnell's policy. An insurance policy is a contract.⁴⁰ Interpretation of an insurance contract is a matter of law.⁴¹ A court may not give an insurance contract a strained or forced construction that would lead to an extension or restriction of the policy beyond what is fairly within its terms.⁴² "Clear and unambiguous policy language must be enforced as written."⁴³ Here, Ms. Bushnell was required regularly to pay premiums, regardless of claims filed. Her failure to keep the payments current supported dismissal of her claim.

In its opinion, this Court did not specifically instruct the trial court to enter judgment on the contract claim, stating only, "We reverse dismissal of Bushnell's claim for coverage under the policy, but remand on the question whether Medico acted in bad faith."⁴⁴ It may be that the issue of liability on the contract claim remains open for further litigation

⁴⁰ See *Woo v. Fireman's Fund Ins. Co.*, 161 Wn.2d 43, 52, 164 P.3d 454 (2007); *Stouffer & Knight v. Continental Co.*, 96 Wn. App. 741, 747, 982 P.2d 105 (1999).

⁴¹ *Stouffer*, 96 Wn. App. at 747.

⁴² *Teague Motor Co. v. Federated Serv. Ins. Co.*, 73 Wn. App. 479, 482, 869 P.2d 1130 (1994).

⁴³ *Id.*

⁴⁴ Opinion at 14.

before the trial court, and the lapse issue can be revisited by the trial court. Clarification is sought. If the opinion forecloses further consideration of coverage, Medico urges reconsideration because the lapse for nonpayment supports a very limited coverage period.

1. Ms. Bushnell's continued payment of policy premiums were required regardless of claims filed

A waiver of premium clause is a contract provision that suspends the premium payment upon proper notice of a claim.⁴⁵ Ms. Bushnell's policy does not contain a waiver of premium clause.⁴⁶ Appellants have never claimed that Ms. Bushnell's insurance policy contained a waiver of premium provision. Ms. Bushnell's contract provides further: "We will NOT pay benefits for: (1) loss while this coverage is not in force"⁴⁷

If this Court has remanded only for a determination of bad faith claims, and impliedly has instructed the trial court to enter judgment on the coverage claim,⁴⁸ then this Court overlooked analyzing whether Ms. Bushnell was entitled to any benefit after her policy had lapsed. She is not. The Court's analysis assumes a waiver of premium such that Ms. Bushnell was not required to continue payment under the policy after her claim was

⁴⁵ See, e.g., 5 COUCH ON INSURANCE 3D, § 75:20, at 75-40 (stating that "The effect of the waiver of premiums clause is to waive the insured's obligation to pay the specified premiums where notice of the required degree of disability is given within the required time.").

⁴⁶ CP 030-038.

⁴⁷ CP 030 at Part D(1).

⁴⁸ See Opinion at 14. The remand instructions appear ambiguous.

filed. This is contrary to the insurance contract. The contract does not contain a waiver of premium provision. A court may not extend a policy beyond what is fairly within its terms.⁴⁹ In order for the policy to continue, and the benefits to be paid under Ms. Bushnell's policy, the premiums had to be paid.⁵⁰

Appellant's reference, without citation, to the known loss doctrine does not prove otherwise.⁵¹ "Known loss' relieves an insurer of liability where the insured had knowledge of the risk or loss prior to the time the policy bound."⁵² The known loss doctrine has no effect on the contractual provisions at issue in Ms. Bushnell's insurance contract, nor does it have any application here. This loss was not known to either side when the contract was entered into. Ms. Bushnell's insurance required payment of premiums to remain in effect, regardless of any claims submitted or benefits paid. To construe otherwise is to add a provision to Ms. Bushnell's contract that does not exist and is an error of law.

2. Ms. Bushnell's last premium payment was made on February 1, 2007, and she received proper notice of the policy's impending lapse.

Ms. Bushnell's policy states "Your policy will lapse if you do not

⁴⁹ *Teague Motor Co.*, 73 Wn. App. at 482.

⁵⁰ CP 030-038.

⁵¹ Appellant's Reply Brief at 3 n.2.

⁵² *Mut. of Enumclaw Ins. Co. v. USF Ins. Co.*, 164 Wn.2d 411, 418 n.2, 191 P.3d 866 (2008).

pay your premium before the end of the grace period.”⁵³ The general rule is that failure of an insured to pay a renewal premium by the due date results in a lapse of coverage as of the last day of the policy period.⁵⁴ Ms. Bushnell failed to pay a renewal premium by March 1, 2007. Her coverage lapsed as of the last day of the policy period, February 28, 2007.

It is undisputed that the last payment Ms. Bushnell made was on February 1, 2007.⁵⁵ Ms. Bushnell was sent a reminder notice on February 1, 2007, and a “Past Due Notice” on March 12, 2007.⁵⁶ Ms. Bushnell had the opportunity to continue coverage under the policy but failed to do so. No further payments were made. With no payments for coverage, the coverage was no longer in force as of February 28, 2007 (with the exception of the Grace Period, which is discussed next).⁵⁷ She would be entitled to no payments after that date.

3. Ms. Bushnell’s benefits were extended by application of the policy’s Grace Period and limited by application of the policy’s Elimination Period.

Ms. Bushnell’s policy contains a 31-day grace period: “Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace

⁵³ CP 033 at Part M(4).

⁵⁴ *Safeco Ins. Co. v. Irish*, 37 Wn. App. 554, 558, 681 P.2d 1294 (1984).

⁵⁵ CP 615.

⁵⁶ CP 552–53, CP 556–58.

⁵⁷ CP 030 at Part D(1).

period.”⁵⁸ Thus, regardless of lack of payment, Ms. Bushnell’s policy remained in force until March 31, 2007, but no longer.

Ms. Bushnell’s policy also contains a 20-day elimination period, which is the “number of days for which benefits are eliminated in consideration for a reduced premium.”⁵⁹ The period starts on the date the benefits would otherwise begin and is in effect for 20 days.⁶⁰ The 20-day elimination period began upon the date of the claim, February 24, 2007, and was in effect for 20 days. Thus, Ms. Bushnell is not eligible for benefits until after the 20-day elimination period ended on March 16, 2007.

The entire contract must be construed to give force and effect to each clause.⁶¹ Applying all the applicable provisions of Ms. Bushnell’s policy, Ms. Bushnell would be eligible for benefits only for the period of March 16, 2007, through March 31, 2007.⁶²

D. Because Ms. Bushnell’s policy is a continuing policy and, in addition lapsed, denial of benefits was made in good faith.

If the Court reconsiders based on the above, this Court’s remand for a determination of bad faith also should be revised. Medico’s denial of benefits under Ms. Bushnell’s policy was valid and done in good faith.

⁵⁸ CP 033 at Part M(3).

⁵⁹ CP 031 at Part F(2).

⁶⁰ *Id.*

⁶¹ *Stouffer*, 96 Wn. App. at 749.

⁶² *Id.*

Because it is a continuing contract for insurance, the 3-day prior hospitalization requirement is valid. In addition, Ms. Bushnell's policy lapsed for non-payment.

Medico's denial of benefits was valid and proper. Thus, there is no need to remand for a determination of bad faith.

V. CONCLUSION

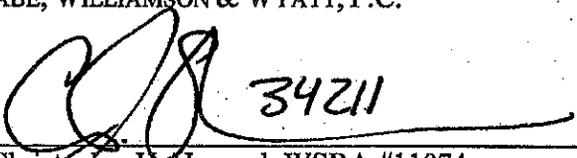
Based upon the precedent of *Tebb*, which found the discretion of the insurer over the renewal of the policy as evidence of intent of a renewal policy, this Court should reconsider its decision that Ms. Bushnell's policy is a renewal policy. Medico had no discretion over the renewal of Ms. Bushnell's policy. Under *Tebb*, Ms. Bushnell's policy should be found a continuing contract for insurance.

Even if the policy is a renewal policy, this Court failed to analyze whether Ms. Bushnell's policy allowed for a waiver of premium. It did not; thus, Ms. Bushnell is not entitled to benefits once coverage under the policy has lapsed. Construing all provisions of Ms. Bushnell's policy, she is entitled to benefits from March 16, 2007, through March 31, 2007.

Respectfully submitted this 28th day of February, 2011.

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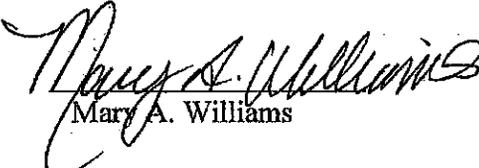
CERTIFICATE OF SERVICE

I hereby certify that on the 28th day of February, 2011, I caused to be served the foregoing APPELLEE MEDICO'S MOTION FOR RECONSIDERATION on the following party at the following address:

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by:

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Mary A. Williams

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COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION I

LEROY BUSHNELL, as the Personal Representative
of the Estate of EVELYN BUSHNELL, Deceased,

Appellant,

v.

MEDICO INSURANCE COMPANY, a Nebraska Corporation and
MEDICO LIFE INSURANCE COMPANY, a Nebraska Corporation,

Respondents.

BRIEF OF RESPONDENTS

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I. INTRODUCTION

This lawsuit arises from the denial of coverage under a Skilled and Intermediate Nursing Policy issued to Evelyn Bushnell by Respondents (hereafter "Medico"). The Policy, issued on October 9, 1986, provided nursing care coverage for any condition following the hospitalization for that condition of at least three days. Upon the enactment of the Washington State Long-Term Care Insurance Act, RCW 48.84, effective January 1, 1988, insurers could no longer issue *new* policies containing hospitalization clauses.

On February 24, 2007, Ms. Bushnell was admitted to a nursing home without any prior hospitalization. On March 1, 2007, her Policy lapsed for failure to make any further premium payments. She made a claim for benefits which was denied because (1) she had not been hospitalized prior to going to the nursing home, per the policy terms, and (2) her policy lapsed for failure to pay the required premiums.

Ms. Bushnell filed suit challenging the denial of her claim arguing that the hospitalization clause was not valid because of the change in the law. Both parties filed motions for summary judgment on the coverage issue and on the claim that Respondents Medico acted in bad faith.

The court granted summary judgment in favor of Medico finding that the hospital clause was valid, Ms. Bushnell was not entitled to

coverage, and that Medico did not act in bad faith. (CP 367-69)
Appellant moved for reconsideration which was denied. Appellant
appeals the Order Granting Summary Judgment and the Order Denying
Reconsideration.

**II. RESPONSES TO "ASSIGNMENTS OF ERROR" AND
"ISSUES RELATED TO ASSIGNMENTS OF ERROR"**

**A. RESPONSES TO APPELLANT'S ASSIGNMENTS OF
ERROR**

1. The hospitalization clause was valid because the
policy was issued prior to the effective date of the law prohibiting such
clauses.

2. Ms. Bushnell was not entitled to coverage as a
matter of law.

3. There is no evidence that Medico committed any
unfair or deceptive acts in the sale and marketing of the nursing care
policy.

4. There is no evidence that Medico acted
unreasonably in denying the claim.

5. Appellant was not entitled to costs and attorney's
fees.

**B. RESPONSES TO APPELLANT'S ISSUES PERTAINING
TO ASSIGNMENTS OF ERROR**

1. Insurers were not prohibited from offering an insurance policy with a three-day hospital stay requirement prior to January 1, 1988.

2. Ms. Bushnell's policy did not change with the changes in the law because the law did not have retroactive application to policies issued prior to January 1, 1988.

3. The hospital stay requirement was valid and did not violate public policy at the time it was issued.

4. The trial court judge is allowed to decide an issue based on the law he sees appropriate regardless of whether or not a party initially raised a particular case in their argument.

5. Estoppel does not apply to this case to prevent the trial court judge from deciding the issues based on whatever grounds he deems proper.

6. The trial court did not inject any issue of intent.

7. There is no evidence that Medico was deceptive and misleading in marketing a policy with a hospitalization clause prior to January 1, 1988.

8. There is no evidence that Medico was deceptive and misleading in marketing a policy which it was bound to honor and could not cancel as long as Ms. Bushnell paid her premiums.

9. There is no evidence that Medico did not conduct a reasonable investigation of Ms. Bushnell's claim.

10. There is no evidence of bad faith on the part of Medico.

III. STATEMENT OF THE CASE

A. STATEMENT OF FACTS¹

Evelyn Bushnell purchased an insurance policy for nursing care (Skilled and Intermediate Nursing Policy No. OB78225; Form 3355) from Respondents on **October 8, 1986**. (CP 13; CP 552) (Hereafter referred to as the "Policy.") The Policy is not a long-term care insurance policy as contemplated by RCW 48.84. (CP 79; 448-49; 579, 597) The Policy provided benefits for skilled nursing care and intermediate nursing care upon meeting certain conditions, including (a) paying premiums; and (2) being confined to a hospital for three days prior to entering nursing care for treatment of the condition for which the customer had been hospitalized. It is clear this was a policy to provide coverage for a limited

¹ Appellant designated his trial brief and attached exhibits as Clerk's Papers for this appeal (CP 295-351). In his opening brief, Appellant has cited some of the exhibits to his trial brief as evidence. Respondents objects to these documents as proper evidence for this appeal. This case did not go to trial, but was decided on summary judgment. None of the exhibits to the trial brief were admitted into evidence below nor were they considered by the court on summary judgment. (CP 367-68) The trial brief and exhibits should not be relied upon or cited in this appeal. Appellant also relies on facts submitted in a declaration in support of his Motion for Reconsideration. (CP 370-95) These "facts" are also not properly part of the record. A separate Motion to Strike was filed by Medico on November 30, 2009, and is incorporated by reference herein.

number of conditions, i.e. those which required hospitalization first, rather than all conditions that might require long-term care for which hospitalization would not necessarily be needed or expected.

On February 24, 2007, Ms. Bushnell was admitted to Lake Vue Gardens Convalescent Center, a nursing facility, without previously being hospitalized. (CP 601, 604) On March 6, 2007, Medico received Ms. Bushnell's Proof of Loss claim for benefits under her policy.² (CP 430, 585, 602) On June 20, 2007, benefits were denied because Ms. Bushnell had not been hospitalized for three days prior to her admission to Lake Vue and because her policy had lapsed for non-payment. (CP 47)

1. The Policy

The Policy essentially consists of five pages plus a one-page schedule of benefits. (CP 30-35; attached as Appendix A) It is not a long, complicated policy and does not contain any fine print.

The Policy was issued to Ms. Bushnell, effective on October 9, 1986. (CP 35; CP 550) This is stated on the Policy Schedule. (CP 35) Appellant admitted in his October 12, 2007 letter to Medico that the policy was issued on October 9, 1987. (CP 50) In his complaint, he admitted the Policy was issued on or about October 8, 1986, that Ms. Bushnell paid her

² Medico never asserted that the Proof of Loss or claim for benefits was untimely as alleged in Appellant's brief at page 19 without citation to any facts. Medico never asserted that the date the claim was received had any effect on the denial of coverage.

first premium (for the first year) before the policy was issued, and that she then tendered her first annual renewal premium payment on November 1, 1987. (CP 13) These facts support the fact that the policy was issued effective as of October 9, 1986.

Appellant asserts that the Policy "was issued after the long term care act took effect." (Appellant's brief at 15) He claims it was issued on January 28, 1987, based on a letter purporting to enclose a copy of the policy to Ms. Bushnell. (Appellant's brief at 6) (See CP 353) This letter does not state the date the Policy was issued and is simply not probative of the issue date. Also, RCW 48.84, and in particular WAC 284-54-150(7) concerning hospitalization clauses, were effective only for policies issued after January 1, 1988, RCW 48.84.910, a year after the issue date claimed by Appellant.³

2. The Policy Lapsed

The Policy was in force as long as Ms. Bushnell paid the required premiums. Premiums were \$124.60 for each 60-day period and remained unchanged for the duration of her policy. (CP 552, 853) The Policy granted a 31-day grace period for payment:

³ The Policy required a six-month waiting period for coverage of pre-existing conditions: "Conditions you have had in the five years before your Policy Date are not covered until your policy has been in force at least six months." (CP 30, Part C) The six-month waiting period for pre-existing conditions thus ended on April 9, 1987. The waiting period did not change the issue date of the Policy.

PART B: RENEWAL AGREEMENT

As long as you pay the renewal premium then in effect on the date it is due or during the 31-day grace period, we cannot refuse to renew your policy Your policy stays in force during your grace period.

(CP 30)

PART M: POLICY PROVISIONS

(3) Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period. You always have your grace period unless your policy will not be renewed. . . .

(4) Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period.

(CP 33)

Ms. Bushnell's last payment was received by Medico on February 1, 2007. (CP 615) This payment, on the last day of the grace period, was for the coverage period January 1, 2007-February 28, 2007. (CP 615) When no payment was received for the March 1, 2007-April 30, 2007, premium period, Ms. Bushnell was sent a reminder notice. (CP 552, 556-557) When no premium was received during the regular payment period, a "Past Due Notice" was sent on March 12, 2007, advising that coverage would lapse unless prompt action was taken. (CP 553, 556, 558) No further payments were made and coverage lapsed on March 1, 2007. (See CP 615) These facts have never been disputed.

The Policy also had a 20-day waiting (“elimination”) period before payments would begin if there was coverage:

PART F: DEFINITIONS

(2) “Elimination Period” means the number of days for which benefits are eliminated in consideration for a reduced premium. The elimination period, if any, starts on the date that benefits would otherwise begin and it is in effect for the number of days shown on the Schedule.

(CP 31) The Schedule stated a 20-day elimination period. (CP 35) If there was coverage under Ms. Bushnell’s policy, she would not have been entitled to payment of any benefits until March 16, 2007 (twenty days after entering a nursing care facility). However, it is undisputed that policy premiums were not paid for any coverage period after February 28, 2007.

3. Hospitalization Clause

The Policy contained a provision, as a prerequisite to benefits, requiring a three-day hospitalization for the medical condition causing the need for care prior to nursing home admission:

PART G: SKILLED NURSING CARE AND IMMEDIATE NURSING CASE BENEFITS

To be eligible to receive benefits under Part G (a) and Part G (b), your confinement must:

- (1) be in a Nursing Facility;
- (2) be recommended by a physician;

- (3) start within 14 days after required hospital confinement of at least three days in a row; and,
- (4) be for the continued treatment of the condition(s) for which you were hospitalized.

(CP 32) Paragraph (3) of this provision is referred to as a "hospitalization clause."

Ms. Bushnell was admitted directly from her home to Lake Vue Gardens Convalescent Center, a nursing facility, on February 24, 2007. She was not hospitalized prior to being admitted to Lake Vue. (See CP 611).

On June 20, 2007, after investigating the claim, Medico advised Ms. Bushnell that there was no coverage because she had not been hospitalized before her admission to the nursing facility **and also** because the Policy had lapsed due to lack of premium payments. (CP 47)

4. Medico's Procedures and Investigation

Donald Lawler is Senior Vice President and General Counsel⁴ for Medico. He has been employed with Medico since 1992. (CP 578) One of his responsibilities has been to insure that all Medico policies are in compliance with state laws, including Washington. (CP 580) He and the Medico legal and compliance departments are at all times knowledgeable

⁴ He is licensed in Nebraska and Iowa. (CP 579)

of Washington state law. They use many resources on an ongoing basis to stay current and provide company employees with current knowledge of applicable laws. (CP 580) Mr. Lawler's credentials as an insurance professional and attorney, his ability to read, understand, and evaluate Washington law, and competence to train Medico employees about Washington law have never been disputed.

It is also Mr. Lawler's responsibility along with the legal and compliance departments to evaluate whether any changes in the law require an amendment or issuance of a new policy. (CP 581) For Medico to sell any policy in the State of Washington, it must first submit the policy to the Insurance Commissioner for approval. (CP 580-81) Only after it has been determined to be in compliance with state law will it be made available for purchase. (CP 581) The Policy purchased by Ms. Bushnell, Form 3355, Skilled and Intermediate Nursing policy, had been approved by the Insurance Commissioner before it was offered to her for sale. (CP 79, 584) It has been on file with the Insurance Commissioner and in good standing, that is, no changes have been required, ever since its approval. It is still an approved policy today. (CP 584) There is no dispute that the policy purchased by Ms. Bushnell was in compliance with Washington law in October 1986.

Medico was aware of the enactment of RCW 48.84. It understood

that it could no longer offer policy Form 3355 for sale after December 31, 1987. (CP 584) It created policy Form 3358, Long Term Care Insurance Policy. The new policy was approved by the Insurance Commissioner and subsequently offered for sale as of January 1, 1988. (CP 582-83) The new policy eliminated the hospitalization clause and broadened coverage compared to Form 3355 — the nursing care policy. (CP582) The premium for the new policy was substantially higher because of the expanded coverage; the 60-day premium for Form 3358 coverage is \$312.70 compared to \$124.50 for a 60-day period for the limited Form 3355 coverage. (CP 583)

Kimberly Jackson of the Medico Claims Service Department reviewed Ms. Bushnell's claim for coverage. (CP 585) Mr. Lawler and Shelly Richard — Ms. Jackson's supervisor and Director of Claims — supervised evaluation of the claim. (CP 585-86) Both Ms. Jackson and Ms. Richard have extensive ongoing training and experience. (CP 586) These facts have not been disputed.

Ms. Jackson reviewed the applicable policy, collected and reviewed a considerable number of medical records, correspondence and other documents regarding Ms. Bushnell's medical status. (CP 585) After review and evaluation of the claim, she ascertained that Ms. Bushnell had entered Lake Vue directly from her home without being previously

hospitalized. (CP 586) Ms. Jackson also reviewed the payment history and determined that no premiums had been made for any period after February 28, 2007. (CP 586) Ms. Bushnell was timely notified of the coverage determination. (CP 47-48, 586) These facts have not been disputed.

There is no evidence that Ms. Bushnell ever requested the expanded coverage provided by policy form 3358 or that she paid the additional premiums for the expanded long-term care coverage under the new policy form.

B. STATEMENT OF PROCEDURE

By letter dated October 12, 2007, Ms. Bushnell, through her son Leroy Bushnell (Appellant herein) and her attorney, challenged the denial of coverage claiming that the enactment of RCW 48.84, The Washington Long Term Care Insurance Act, subsequent to the issuance of her policy, invalidated the hospitalization clause. (CP 50-51) She argued that the provision contained in Part M (13) controlled. Part M (13) stated:

PART M: POLICY PROVISIONS

(13) Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

(CP 34) Ms. Bushnell did not address her failure to pay premiums. (CP

50-51) Upon Appellant's dispute of the denial of coverage, Mr. Lawler reviewed the Washington laws and regulations and determined that the denial of coverage was correct. (CP 586-87) He responded on October 16, 2007, stating that the policy was issued prior to the effective date of the Long-Term Care Insurance Act and that it conformed to all laws in effect at that time. (CP 53, 587)

Ms. Bushnell, again through her son and her attorney, filed a complaint with the Office of the Insurance Commissioner on November 9, 2007, again arguing that the hospitalization clause contravenes RCW 48.84, the Washington Long-Term Care Insurance Act, and that the Policy itself required it to conform to Washington law. (CP 55-56) Medico responded by providing a copy of its October 16, 2007 letter and stated that the hospitalization clause was valid for policies issued prior to January 1, 1988. (CP 587, 625) The Insurance Commissioner closed the complaint, taking no action against Medico. (CP 627)

Ms. Bushnell filed a complaint⁵:

1. Seeking a judgment declaring that (a) the hospitalization clause as a prerequisite to coverage violates the Washington Long-Term Care Insurance Act; (b) the hospitalization clause is contrary to public policy; and (c) that Plaintiff is entitled to

⁵ For this appeal, "complaint" refers to Plaintiff's "Second Amended Complaint." (CP 11-18)

receive skilled and intermediate nursing benefits under the Policy.

2. Alleging breach of written contract;
3. Alleging violation of the Consumer Protection Act;
4. Alleging violation of the Insurance Fair Conduct Act; and
5. Alleging bad faith.

(CP 11-18)

Appellant filed a "Motion for Partial Summary Judgment" as to:

1. The enforceability of the hospitalization clause;
 2. Bad faith for failing to conduct a reasonable investigation;
 3. Bad faith for unreasonably and unjustly denying coverage;
- and
4. The right to treble damages for bad faith.

(CP 80-94)

Medico also filed a Motion for Summary Judgment as to all the issues raised in the complaint. (CP 97-115⁶) Judge John Erlick granted Medico's motion, denied Appellant's motion, and dismissed all the claims.

⁶ Respondents initially filed their Motion for Summary Judgment by calling it "Defendants' Response and Counter Motion for Summary Judgment." (CP 97-115) Recognizing that the title was confusing, a few days later, Respondents re-filed the document properly calling it "Defendant's Motion for Summary Judgment." (CP 559-77) The two documents are identical except for page 1. Judge Erlick's Order only refers to the first document as being considered on summary judgment, which is of no consequence because the two documents are the same. This is only brought to this court's attention because the title of the first document is confusing.

(CP 367-69) In his Order, Judge Erlick held that: "The hospital stay requirement found in Ms. Bushnell's policy is valid and Ms. Bushnell is not entitled to coverage as a matter of law," and "Medico's denial of coverage was reasonable and not in bad faith." (CP 368) Appellant filed a Motion for Reconsideration and submitted a new declaration of Leroy Bushnell with additional facts not previously submitted.⁷ (CP 370-95) Per King County LCR 59(b), Judge Erlick denied reconsideration without requesting a response from Respondents. (CP 421)

Appellant now appeals the Order Granting Summary Judgment and the Order Denying Plaintiff's Motion for Reconsideration.

IV. SUMMARY OF ARGUMENT

There are two main issues in this case: (1) is the hospitalization clause enforceable? and (2) did coverage lapse for non-payment? Resolution of the other issues raised by Appellant flows from a determination of these primary issues.

The hospitalization clause is valid and enforceable because Ms. Bushnell's policy was issued prior to the effective date of RCW 48.84, Washington's Long-Term Care Insurance Act. It conformed to state law "on the Policy date" and remains a policy in good standing today.

⁷ Again, Respondents object to the court considering Appellant's declaration in support of his Motion for Reconsideration because it does not fall within the parameters of CR 59 and Medico had no opportunity to respond to those new "facts." See Note 1 *supra* and Respondents' Motion to Strike filed on November 30, 2009.

The policy was enforceable by Ms. Bushnell as long as she complied with its provisions. Medico did not have the option to cancel her policy as long as she paid the premiums. Ms. Bushnell's policy lapsed when she failed to pay any premiums. Regardless of the hospitalization clause, Ms. Bushnell did not pay for any coverage for any time when she might have been eligible for such.

There was no coverage for Ms. Bushnell because she had not been hospitalized and because she failed to pay the required premiums. Medico did not act in bad faith in denying coverage for valid reasons.

V. ARGUMENT

A. THE STANDARD OF REVIEW OF AN ORDER GRANTING SUMMARY JUDGMENT.

The appellate court reviews summary judgment orders *de novo* and engages in the same inquiry as the trial court. *Bordeaux, Inc. v. American Safety Insurance Company*, 145 Wn. App. 687, 693, 186 P.3d 1188 (2008). "Interpretation of an insurance policy is a question of law, reviewed *de novo*." *Id.* Determining whether or not the hospitalization clause was enforceable is a question of law. This is not a case involving an exclusion of coverage, but rather whether the hospitalization clause is valid at all in light of a subsequent change in the law.

In this case, both sides were moving parties. The claims process and investigation in this case was not disputed. Failure to pay premiums was not disputed. The appellate court will make the same inquiry as the trial court. *See, e.g.* CR 56(c). It will view the facts and their reasonable inferences. *Degel v. Majestic Mobile Manor, Inc.*, 129 Wn.2d 43, 48, 914 P.2d 728 (1996). The reasonable inferences from the undisputed facts are that Medico properly and timely investigated the claim, complied with the law, and denied the claim in good faith.

B. THE POLICY LAPSED FOR NON-PAYMENT.

This appeal can be easily decided on the issue of payment. “[T]he general rule is that failure of an insured to pay a renewal premium by the due date results in a lapse of coverage as of the last day of the policy period.” *Safeco Ins. Co. v. Irish*, 37 Wn. App. 554, 557, 681 P.2d 1294 (1984). Ms. Bushnell never paid any policy premiums for any coverage period after February 28, 2007. This fact has never been disputed. In fact, Appellant admits that no premiums were paid after Ms. Bushnell went into the nursing home. (Appellant’s brief at page 7) Medico denied coverage based on the failure to pay policy premiums. (CP 47)

Medico raised this issue below. (CP 166-67) Appellant never responded to this issue at that time. Again on appeal, Appellant has not cited any law that allows coverage when there has been no payment. The

Policy was clear in requiring payment of premiums as a condition of coverage and warning that the Policy would lapse for non-payment. (CP 30, 33, Part B and Part M (3) & (4)) The Policy lapsed as of March 1, 2007, for non-payment.

Furthermore, there was no coverage for any days prior to the policy lapsing on March 1, 2009, because of the 20-day "Elimination Period." Coverage would have only been effective after the elimination period ran on March 16, 2007 (twenty days after February 24, 2007, the date Ms. Bushnell entered Lake Vue). The Policy had lapsed for non-payment before that date. It must be noted that the "Elimination Period" does not eliminate the duty to pay premiums.

Appellant seems to be arguing that Medico claimed the policy lapsed somehow based on the date the claim was made. (Appellant's brief at 19.) This is not correct. Medico never raised any issue about the timing of Ms. Bushnell's notice of claim. Medico has only raised "lapse" as a basis for denial of the claim because of non-payment of the required premiums.

There was no coverage for Ms. Bushnell because she failed to pay her premiums and coverage was properly denied on that basis.

C. THE HOSPITALIZATION CLAUSE WAS A VALID CONDITION OF COVERAGE IN THE POLICY WHICH WAS ISSUED PRIOR TO THE EFFECTIVE DATE OF

RCW 48.84, THE LONG-TERM CARE INSURANCE ACT.

1. The Washington Long Term Care Insurance Act, RCW 48.84, was not in effect when the Policy was issued to Ms. Bushnell.

In 1986, the Washington State Legislature passed the "Long-Term Care Insurance Act." When the Legislature enacted the Act it stated specifically that RCW 48.84.060⁸ was to take effect on November 1, 1986, and the remainder of the Act was to "apply to policies and contracts *issued* on or after **January 1, 1988.**" RCW 48.84.910 (emphasis added). The Legislature did not apply the Act to policies *renewed* on or after January 1, 1988.

The Insurance Commissioner was given the mandate to adopt rules for implementing the Act. RCW 48.84.030. The rules were filed on July 9, 1987 (*See* WAC 284-54, *et seq.*), and included WAC 284-54-150(7) which provides: "No insurer may offer a contract form which requires

⁸ RCW 48.84.060, as originally enacted in 1986, defined prohibited practices under the Act:

No agent, broker, or other representative of an insurer, contractor, or other organization selling or offering long-term care insurance policies or benefit contracts may: (1) Complete the medical history portion of any form or application for the purchase of such policy or contract; (2) knowingly sell a long-term care policy or contract to any person who is receiving Medicaid; or (3) use or engage in any unfair or deceptive act or practice in the advertising, sale, or marketing of long-term care policies or contracts.

prior hospitalization as a condition of covering institutional or community based care.”

In October 1986, when Medico sold and issued the Policy to Ms. Bushnell, there was no statutory or WAC provision prohibiting the hospitalization clause. The Policy could not violate an Act that was not in effect. The Policy and its terms were valid and enforceable at the time the Policy was *issued*.

2. RCW 48.84 does not apply retroactively to the Policy.

- (a) Retroactive application of RCW 48.84 would violate Medico's Constitutional rights.

It must first be emphasized that the Legislature clearly expressed its intention in RCW 48.84.910 that the Act and its implementing rules were prospective only from **January 1, 1988**, in other words, the Act was not to have retroactive effect. RCW 48.84.910.

The United States Constitution states: “No state shall adopt any law impairing the obligations of contracts.” U.S. Const. Art. I, §10. Our state constitution echoes that guarantee: “No ... law impairing the obligations of contracts shall ever be passed.” Wash. Const. Art. I §23. Simply stated, when retroactivity is an attempt to regulate or modify the rights of the parties to an existing contract this action is unconstitutional.

“Indeed, in most instances a statute that attempts to regulate or modify the rights of parties to a prior insurance contract is unconstitutional.” 2 Couch on Insurance 3d, §19:6, at 19-14 (1995).

- (b) Each renewal of the Policy did not create a new contract.

Appellant argues that with each annual premium paid, the Policy renewal was a new contract. This argument fails for several reasons:

First, RCW 48.84.910 specifically applies the Act to policies “issued,” not renewed, “on or after January 1, 1988.” The statute does not say that the Act applies to policies “issued and in force on January 1, 1988” as argued by Appellant. (Appellant’s brief at 16.)

Second, the conformity clause in the Policy is consistent with the constitutional rights of the parties. (CP 34) Conformity clauses refer to existing statutes and are “not to be construed as consent by the insurer that the contract may be thereafter modified by statutes subsequently enacted.” 2 Couch on Insurance 3d, §19:6, at 19-14 (1995). The “Policy Date” is October 9, 1986, more than one year before the Act took effect. The Act did not exist on the “Policy Date.”

Third, RCW 48.84.910 specifically made the Act prospective only. In specifically addressing the prospectivity of the Act, the Legislature implicitly recognized the constitutional rights of insurers not to have the

policies they issued before January 1, 1988 modified by the Washington Long-Term Care Insurance Act and its related WAC rules. The explicit language in RCW 48.84.910 cannot be changed in an attempt to incorporate the mandates of the Act into an insurance policy *issued before* January 1, 1988. The constitutional rights of Medico and the reasoning of Couch should prevail in these circumstances.

D. THE TRIAL JUDGE DID NOT ERR IN CONSIDERING OR BASING HIS RULING ON VALID CASE LAW.

Appellant argues that the trial judge improperly injected the argument that the Policy was a "continuous contract" and thus valid under *Tebb v. Continental Casualty Co.*, 71 Wn.2d 710, 430 P.2d 597 (1967).⁹ He also argues that he had no opportunity to address *Tebb*.

It must first be noted that there has been no record provided to this Court to support Appellant's version of Judge Erlick's actions or

⁹ The issue on which *Tebb* bore could hardly have taken Appellant by surprise since, in fact, Appellant first broached the issue of whether the policy became a "new" policy upon each renewal in his Motion for Summary Judgment. (CP 87-88) Likewise, Respondents addressed the issue below in Medico's supplemental memorandum in opposition to Appellant's summary judgment motion. (CP 290-91) While Medico did not specifically cite the *Tebb* decision, it relied on analogous authority from Washington UIM decisions, in which the courts have also confronted the need to distinguish between new and renewal policies. See *Johnson v. Farmers Ins. Co. of Wash.*, 117 Wn.2d 558, 570-74, 817 P.2d 841 (1991). Appellant never filed a memorandum in response to Medico's opposition memorandum. Thus, far from "injecting" the issue of continuous vs. new policies into the proceedings *ab initio*, Judge Erlick merely invited the parties to respond to authority that his own research must have disclosed bearing on an issue the parties themselves had already placed before him.

comments.¹⁰ Appellant admits he knew the court wanted to discuss *Tebb*. (Appellant's brief at 19) He cited *Tebb* in the brief he filed the day before hearing on the motions for summary judgment. (CP 359) There is no record that Appellant requested additional time to address *Tebb* prior to the hearing, at the hearing, or after even the hearing. Only now, for the first time on appeal does he complain he had no opportunity to address *Tebb*.

1. The relevance of *Tebb*.

Tebb v. Continental Casualty Co., 71 Wn.2d 710, 430 P.2d 597 (1967), addresses the issue of whether or not renewal of an insurance policy represents a continuation of the original policy and its terms or instead a new policy which must incorporate new law. In 1942, Continental Casualty issued a policy to Neal Tebb for accidental death. The policy did not provide a grace period for payment of premiums. *Id.* at 711. In 1951, the legislature enacted a mandatory 30-day grace period. *Id.* at 712. Tebb paid his premiums through August 1964. He failed to pay the September premium. He died on September 7, 1964. *Id.* at 711. The insurer denied coverage and argued that the policy was a continuous

¹⁰ Appellant has not provided a Report of Proceedings of the hearing on the summary judgment motions and consequently cannot rely on discussions that are not part of the record on appeal.

contract and the statutory grace period could not be incorporated into the contract. *Id.* at 712.

Notably, the *Tebb* court found that the policy gave the insurer the option to exercise its discretion to accept or reject any renewal premium. This key fact was pivotal to holding that there was no automatic continuation of the policy by paying premiums. *Id.* at 713. The court determined that upon renewal, *Tebb's* policy was a new contract. The court held that when a renewal is subject to the insurer's consent that is a conclusive indication that the parties intended a new contract upon the acceptance of renewal. *Id.* at 714.¹¹

Continental Casualty was not required to accept *Tebb's* renewal premiums. Ms. Bushnell's policy, on the other hand, mandated that Medico accept premium payments: "As long as you pay the renewal premium . . . we cannot refuse to renew your policy." (CP 30, Policy Part B) Under the logic of *Tebb*, based on the terms of the Policy, Ms. Bushnell's policy was a "continuous policy" rather than a "term policy" and subsequently enacted law is not incorporated into the contract. *Cf. Tebb*, 71 Wn.2d at 714 (new law is part of "term" policy).

¹¹ Court relied on *Perkins v. Associated Indemnity Corp.*, 189 Wash. 8, 63 P.2d 499 (1936). In that case, the effect of the court's holding was that an accident policy issued for one year with the option to renew from term to term with the consent of the insurer was a term policy, not a continuous one.

Appellant relies on Part M, Policy Provisions paragraph (12) to argue that the Policy itself indicates it is meant to be a “term” rather than “continuous” contract.¹² (Appellant’s brief at 23.) Part M (12) states that a “term of coverage” starts at noon on the Policy Date and ends at noon on the first renewal date. It states that “Each time you renew your policy, the new term begins when the old term ends.” Appellant argues that this indicates an intent that “new coverage” begins when the policy is renewed.

The intention of the parties to the contract is to be ascertained by the four corners of the instrument. *See Ryan v. Harrison*, 40 Wn.App. 395, 400, 699 P.2d 230 (1985). The unexpressed intention of one party is not given any weight. *Wheeler v. Rocky Mountain Fire & Cas. Co.*, 124 Wn.App. 868, 872, 103 P.3d 240 (2004). Part M (12) does not say a “new policy” starts on renewal. It also does not use the phrase “term coverage.” It simply says a “new term” begins. “Term” is not defined.

Generally, to find the intended meaning of undefined terms, the courts give them their plain, ordinary, and popular meaning as would be understood by the average insurance purchaser. *Wheeler v. Rocky Mountain Fire & Cas. Co.*, 124 Wn.App. at 872. Where no ambiguity exists one should not be created by a strained interpretation of the policy.

¹² This issue is raised for the first time on appeal.

Whiteside v. New York Life Ins. Co., 7 Wn.App. 790, 792, 503 P.2d 1107 (1972). It is unlikely an insurance purchaser would read either “new” or “term” to mean “different coverage” as Appellant suggests. He has not provided any authority that such words used in an insurance policy are to be interpreted as he suggests.

To further show that the Policy is not ambiguous or in need of the radical interpretation suggested by Appellant, a dictionary may be consulted to define a word in an insurance contract. *Whiteside*, 7 Wn.App. at 792. Merriam-Webster defines “term” as “end, termination; *also*: a point in time assigned to something (as a payment).” *Merriam-Webster Online Dictionary*, retrieved 11/13/09, from <http://www.merriam-webster.com/dictionary/term>.

Finally, the court should look to the words and phrases in the policy surrounding the undefined term as a guide to its meaning. *Whiteside*, 7 Wn.App. at 792. In this case, Part M (12) and the word “term” must be read together with the clear language mandating renewal in Part B (CP 30) and the Schedule (CP 35).¹³ In doing so, the only logical reading of “new term” is in the context of premiums due. The Schedule states the renewal premiums in increments up to an annual

¹³ A Schedule which constitutes a part of an insurance contract should be read and construed with the entire policy. See *Primerica Life Ins. Co. v. Madison*, 114 Wn.App. 364, 366, 57 P.3d 1174 (2002) (a rider is part of a policy).

premium. (CP 35) It would not be possible to pay for a policy such as this unless a policyholder selected a defined "term of coverage" for paying premiums. The only reasonable interpretation of Part M (12) is one that is consistent with the other terms in the Policy¹⁴ and is that the Policy must be renewed as long as premiums are paid and payment of premiums are due in up to one-year term increments.

2. Tebb is not a different ground for denial of coverage in this case.

Appellant claims that relying on *Tebb* was inappropriate because Medico had not argued that Ms. Bushnell's Policy was a "continuous" policy. He also argues that *Tebb* was not raised as a basis for denial of coverage and consequently Medico is estopped from relying on it now, citing *Bosko v. Pitts & Still, Inc.*, 75 Wn.2d 856, 864, 454 P.2d 229 (1969). Finally he argues that the trial judge improperly injected a new issue into the case by raising *Tebb*.

(a) The Bushnell Policy was a "Continuous" Policy.

Medico denied coverage on the basis that Ms. Bushnell had not been hospitalized prior to admission to nursing care as required by her Policy and for lack of payment. *Tebb* does not provide a new basis to deny coverage; it did not create a new issue. It merely furnishes further

¹⁴ (and is also consistent with Constitutional rights)

support for the position that the hospitalization clause was valid and a proper basis to deny Ms. Bushnell's claim. Appellant has cited no authority holding that an insurer must provide an insured a Memorandum of Authorities listing every possible statute, case, or other legal authority supporting a decision to deny coverage.

(b) Estoppel does not apply in this case.

The cases relied on by Appellant for his position that Medico is estopped from raising "continuous" policy argument are factually distinguishable. In *Bosko v. Pitts & Still, Inc.*, 75 Wn.2d 856, 864, 454 P.2d 229 (1969), Bosko, a contractor, built a sewer line for the city of Tacoma. It had an insurance policy with Lloyds to cover any damages arising out of the construction. *Id.* at 857. Bosko negligently dumped waste that led to a landslide which caused damage to a railroad engine and tracks. *Id.* at 858. Lloyds denied coverage claiming that the situation was one of trespass that was not covered by the policy and damage to the engine did not exceed the deductible. *Id.* at 859. Only after a lawsuit was filed did Lloyds raise a claim that there was no coverage because Bosko had motor vehicle insurance that would cover any damage caused by the dump trucks. This was an improper denial of coverage under a completely separate policy provision than had been previously asserted. Lloyds was estopped from raising it. *Id.* at 864.

In *Moore v. Nat. Accident Soc'y*, 38 Wash. 31, 80 P. 171 (1905), the insurer denied coverage for failure to give timely notice of the claim. *Id.* at 32. At trial the case was dismissed on the basis that Moore had failed to furnish proof of his injury. The court held that this was a different condition of the policy which the insure had waived it when it denied the claim without originally raising this ground. *Id.* The insurer was estopped from relying on a different policy provision. Medico has only relied on the hospitalization clause and the payment clause in denying Ms. Bushnell's claim.¹⁵ As previously noted (*see* note 9, *supra*), it is Appellant, rather than Medico or the trial court, that initially raised the "new" policy issue.

As stated above, any reliance on *Tebb* is not a denial of coverage based on a different policy provision. Furthermore, no prejudice has resulted to Appellant from Medico not citing *Tebb* in its denial letter to Ms. Bushnell. She did not forgo pursuing other coverage or another possible solution to her situation.

¹⁵ The out-of state cases cited by Appellant are likewise distinguishable. In each case the insurer belatedly raised a new ground to deny coverage based on a different policy provision. *See, e.g. Lancon v. Employers Nat. Life Ins. Co.*, 424 S.W.2d 321, 323 (Tex. Civ. App. 1968) (claim denied because loss did not occurred with time period allowed; later insurer claimed injury not related to covered accident. Insurer was not estopped to raise second basis because there was no evidence it knew the facts to support second basis at time claim originally denied); *Middlebrook v. Banker's Life & Cas. Co.*, 126 Vt. 432, 436, 234 A.2d 346 (1967) (insurer denied claim based on fraud; at the close of trial, it raised additional defense that the sickness claimed by plaintiff did not fall within the policy definition of sickness. The insurer was estopped from raising the late defense).

- (c) Judge Erlick may have been proactive but he was not inappropriate.

Appellant has not cited any authority for the proposition that a trial judge may decide a matter on summary judgment based only on the authorities submitted by the parties. CR 56 contains no such restriction. In this case, it was within Judge Erlick's discretion to guide oral argument and his duty to decide the law. This is not the same situation once a case is on appeal where the general rule is that an issue or theory, not first presented to the trial court will not be considered on appeal. *Hanson v. City of Snohomish*, 121 Wn.2d 552, 557, 852 P.2d 295 (1993); RAP 2.5(a). RAP 12.1(b) provides:

If the appellate court concludes that an issue which is not set forth in the briefs should be considered to properly decide a case, the court may notify the parties and give them an opportunity to present written argument on the issue raised by the court.

Certainly, if the Court of Appeals may ask for briefing on an issue not raised in the trial court, a trial court judge may ask for briefing or argument on the applicability of a particular case if it was not cited by the parties (particularly where, as noted previously, the parties themselves have first raised the issue in the trial court).

E. THE HOSPITALIZATION CLAUSE WAS NOT CONTRARY TO PUBLIC POLICY AT THE TIME THE POLICY WAS ISSUED OR AT THE TIME THE CLAIM FOR COVERAGE WAS MADE.

Appellant claims the hospitalization clause is void because it is against public policy. This issue has not been directly addressed in Washington. However, an identical policy provision was held not to violate public policy in *Brock v. Guaranty Trust Life Insurance Company*, 175 Ga. App. 275, 333 S.E.2d 158 (1985). In that case, the plaintiff was admitted to a nursing home for Alzheimer's disease. She subsequently had two hospitalizations for urinary tract infections. Following her second hospitalization, she sought benefits under her nursing care policy. There was no dispute that she returned to the nursing facility for her Alzheimer's condition. "The record established that Mrs. Brock's confinement in the nursing home was at no time preceded by a period of hospitalization for Alzheimer's disease." *Id.* at 277, 333 S.E.2d at 160.

The plaintiff in *Brock* argued that the hospitalization clause was contrary to public policy. *Id.* The court noted that there was no authority for that position. *Id.* It reflected: "The public policy of this state is created by our Constitution, laws and judicial decisions." *Id.* The court held that there was "no established public policy impediment . . . to an insurer limiting coverage only to those first hospitalized and then confined to the nursing home for the same sickness that necessitated the hospital care." *Id.* at 277. "It would be up to the legislature in this instance to

declare the public policy sought by plaintiff, as we do not believe it within the proper sphere of judicial policy-making but more appropriately within the realm of political decisions.” *Id.*

At the time the Policy was issued to Ms. Bushnell, there was no legislatively suggested or mandated public policy that hospitalization clauses were not allowed. The Washington State Legislature explicitly expressed a public policy in RCW 48.84.910 to uphold *as written* insurance policies issued before January 1, 1988. Thus, at the time the claim for benefits was made in 2007, public policy was that the Long-Term Care Act was not applicable to policies issued prior to January 1, 1988, and consequently, policy provisions, such as the hospitalization clause, pre-dating the Act did not violate public policy.

Public policy in Washington “is generally determined by the Legislature and established through statutory provisions.” *Cary v. Allstate Ins. Co.*, 130 Wn.2d 335, 340, 922 P.2d 1335 (1996). “Generally, a contract which is not prohibited by statute, condemned by judicial decision, or contrary to the public morals contravenes no public policy.” *Bates v. State Farm*, 43 Wn. App. 720, 725, 719 P.2d 171 (1986). The starting place to look for public policy is applicable legislation. *Cary v. Allstate Ins. Co.*, 130 Wn.2d at 340. Said another way, a contract not

prohibited by statute is not against public policy. For example, in *Cary*, the plaintiff challenged an insanity exclusion. The court held:

Although Washington courts will not enforce limitations in insurance contracts which are contrary to public policy and statute, insurers are otherwise free to limit their contractual liability. This court has occasionally questioned the wisdom of certain exclusion clauses, but it has rarely invoked public policy to limit or void express terms in an insurance contract even when those terms seem unnecessary or harsh in their effect.

Id. at 339-40, 348 (footnotes omitted).

The terms of the Washington Long-Term Care Insurance Act, except for those specified in RCW 48.84.060, were expressly stated not to apply to policies issued before January 1, 1988. RCW 48.84.910. Statutes are to be given prospective effect only, unless there is legislative intent to the contrary. *Dragonslayer v. Washington State Gambling Commission*, 139 Wn. App. 433, 448, 161 P.3d 428 (2007). Since public policy derives from legislation and judicial decisions, public policy also should have prospective effect only. The clear legislative intent of the Act was that it was to have prospective effect only. Thus, as stated above, there was no stated public policy, legislative or otherwise, in Washington, contrary to the hospitalization clause at the *time the Policy was issued* and at the *time the claim for benefits was made*. Public policy was that the Long-Term Care Act was not applicable to policies issued prior to January 1, 1988.

Consequently, the hospitalization clause in Ms. Bushnell's policy did not violate public policy.¹⁶

F. THE TRIAL COURT DID NOT ERR IN HOLDING THAT MEDICO'S DENIAL OF COVERAGE WAS REASONABLE AND NOT IN BAD FAITH.

1. There are no facts in the record to support a claim of unfair and deceptive sales and marketing of the Policy.

Appellant complains about unfair or deceptive sales and marketing of the Policy to him in violation of RCW 48.84.060. Appellant did not raise this issue in his motion for summary judgment (CP 80-94), or in his opposition to Medico's motion for summary judgment (CP 352-50). He raised it for the first time in his motion for reconsideration of the summary judgment order. (CP 409-10) As stated several times above, the "facts" submitted to the court raising this issue were in a declaration filed with Appellant's motion for reconsideration. Medico was not given the opportunity to respond to those "facts." Those "facts" are not properly before this court and should not be considered.

¹⁶ This case is a completely different situation than that presented in *Mutual of Enumclaw v. Wiscomb*, 95 Wn.2d 373, 622 P.2d 1234 (1980), cited by Appellant. That case concerned a "family exclusion" in an auto policy that conflicted with RCW 46.29, the compulsory financial responsibility law. There was no discussion about when the auto policy had been issued and whether the policy was valid when issued.

(See Note 1, *supra*, and Respondent's Motion to Strike filed November 30, 2009.)¹⁷

2. Appellant never raised a question of fact as to the investigation, claims handling, or denial of Ms. Bushnell's claim. Judge Erlick properly held that Medico did not act in bad faith.

Appellant argues that determining if an insurer acted reasonably is a question of fact. However, the undisputed facts before the trial court showed that Medico gathered all necessary information and considered the terms of the Policy and its payment history before denying the claim. Appellant never submitted any facts or law to show that Medico's actions were deficient or unreasonable. He never submitted any facts or law to show that Medico personnel could not reasonably rely on its legal and compliance departments or upon their on-going training as to the viability of policies issued by the company. Ms. Jackson, Ms. Richard and, in particular, Mr. Lawler were well aware of the process for approval of a policy, the review of policy form 3355 in light of the enactment of the Washington Long-Term Care Act, and the determination that the new law did not affect policies issued prior to January 1, 1988. Medico knew the

¹⁷ At no time has Appellant disputed any of the facts surrounding the investigation, evaluation, and denial of the claim. He complained that Medico did not consult a Washington attorney before denying the claim. (CP 91) This was the only specifically detailed wrongdoing he claimed to substantiate his claim of a bad faith investigation or claim handling. He never cited any authority that requires an insurer to consult local counsel before denying a claim. Appellant has not raised this issue on appeal.

hospitalization clause would not be valid in any *new* policy *issued* after December 31, 1987, and it took action to change future policies.

Appellant never raised a question of fact that would have entitled him to relief under CR 56. On the other hand, Medico showed that there was no question of fact and it was entitled to judgment as a matter of law. Consequently, Judge Erlick found that denial of coverage was reasonable and not in bad faith. Here on appeal, Appellant still has not pointed to any question of fact. Judge Erlick should be affirmed.

G. APPELLANT WAS NOT ENTITLED TO ATTORNEY'S FEES BELOW AND IS NOT ENTITLED TO FEES ON APPEAL.

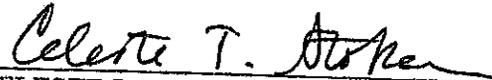
Appellant is only entitled to attorney's fees if he prevails. He did properly did not prevail below and should not prevail here. *See Olympic Steamship Co. v. Continental Ins. Co.*, 117 Wn.2d 37, 53, 811 P.2d 673 (1991). No attorney's fees should be awarded.

VI. CONCLUSION

The hospitalization clause in Ms. Bushnell's Policy is valid. She failed to pay premiums for any coverage after February 28, 2007. Medico properly investigated the claim and reasonably denied it. Based on undisputed facts, Medico was properly entitled to judgment as a matter of law. Summary judgment and dismissal of all claims against Medico were, therefore, entirely appropriate. Respondents Medico

respectfully request this Court to affirm Judge Erlick's Order Granting
Summary Judgment and Order denying reconsideration.

Respectfully submitted this 25th day of November 2009.



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Appendix

- A. CP 30-35, Policy and Schedule
- B. CP 47-48, Denial Letter, June 20, 2007
- C. CP 367-69, Order Granting Defendants' Motion for Summary Judgment and Denying Plaintiff's Motion for Summary Judgment.

APPENDIX A

CP 30-35, Policy and Schedule

DUPLICATE



MEDICO LIFE INSURANCE COMPANY

Omaha, Nebraska A Stock Company

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.**

The premium you, the Insured, paid put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

ALPHABETICAL GUIDE TO YOUR POLICY

	Part		Part
Benefits	G, H, I & J	Other Important Provisions	M
Definitions	F	Payment Of Claims	L
Exceptions	D	Pre-Existing Conditions Limitation	C
How To File A Claim	K	Renewal Agreement	B
Maximum Benefits	E	Right To Return	A

PART A

PLEASE READ 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us or to the agent who sold it to you within 30 days after you receive it. We will return your money. That will mean your policy was never in force.

PART B

RENEWAL AGREEMENT

As long as you pay the renewal premium then in effect on the date it is due or during the 31-day grace period, we cannot refuse to renew your policy unless we do the same to all policies of this form issued to persons of your class (for example, age) in your state. Your policy stays in force during your grace period. No refusal of renewal will affect a claim existing in a confinement period.

We can change your premium only if we do the same to all policies of this form issued to persons of your class (for example, age) in your state and we will notify you in advance of the due date.

PART C

PRE-EXISTING CONDITIONS LIMITATION

Conditions you have had in the five years before your Policy Date are NOT covered until your policy has been in force at least six months. This applies to any injury you received or a sickness making itself known or medically treated within five years before your Policy Date. A sickness makes itself known when it would cause a prudent person to seek medical advice or treatment.

PART D

EXCEPTIONS

We will NOT pay benefits for:

- (1) loss while this coverage is not in force;
- (2) suicide or attempted suicide;
- (3) intentional, self-inflicted injury;
- (4) mental or nervous disorder in the absence of organic brain disease; and
- (5) services for which no charge normally is made.

SKILLED AND INTERMEDIATE NURSING POLICY

ML3358W

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PART E**MAXIMUM BENEFITS**

The maximum benefits we will pay during your lifetime are shown in the Schedule. After the maximum benefits have been paid, your coverage ends.

PART F**DEFINITIONS**

- (1) "Confinement Period" starts with the first full day you are confined in a covered facility and either receive benefits under this policy or would be qualified to receive benefits except for an elimination period. It ends when you are no longer confined in a covered facility. If you are in a confinement period, a return to the hospital for less than three days in a row will not start a new confinement period. A return to the hospital for three days in a row or more, however, will start a new confinement period.
- (2) "Elimination Period" means the number of days for which benefits are eliminated in consideration for a reduced premium. The elimination period, if any, starts on the date that benefits would otherwise begin and it is in effect for the number of days shown on the Schedule. Only one elimination period will be applied to any one confinement period.
- (3) "Home Confinement" means your continuous confinement while under the regular care and attendance of a physician (a) in your home or blood relative's home or (b) in that part of a hospital used as a convalescent or rest home or self-care facility. Visits to the doctor's office or hospital for diagnosis or treatment do not terminate confinement.
- (4) "Hospital" means a place licensed or recognized as a hospital by the appropriate authority of the state in which it is located. It does NOT mean that part of a hospital or institution which is licensed or used principally as a continued- or extended-care facility, convalescent nursing facility, nursing or rest home, or home for the aged. **NO BENEFITS ARE PAYABLE FOR HOSPITAL CONFINEMENT.**
- (5) "Injuries" mean accidental bodily injuries. They must be received while your policy is in force. Also, they must result in loss independent of sickness and other causes.
- (6) "Sickness" means a sickness or disease that first manifests itself more than 90 days after your Policy Date.
- (7) "Nursing Facility" (under Part G of this policy) means a facility or that part of one which: (a) is operated pursuant to law; (b) is engaged in providing, in addition to room and board accommodations, skilled nursing care or intermediate nursing care under the supervision of a duly licensed physician; (c) provides continuous 24-hour-a-day nursing service by or under the supervision of a graduate professional registered nurse (R.N.) or licensed practical nurse (L.P.N.); and (d) maintains a daily medical record of each patient. It is NOT a place that is primarily used for: rest; the care and treatment of mental diseases or disorders, drug addiction or alcoholism; or custodial or educational care.
- (8) "Skilled Nursing Care" means active nursing and/or restorative rehabilitation services given to treat an unstable health condition. There must be a care plan for the patient's recovery which is carried out on a daily basis. A physician must certify that you need such care. These services must medically require the skills of licensed or certified technical or professional personnel pending stabilization. It is NOT: supportive services of a stabilized condition; care which can be learned and given by unlicensed or uncertified medical personnel; routine health care services; general maintenance; routine administration of oral or nonprescription drugs; or general supervision of routine daily activities.
- (9) "Intermediate Nursing Care" means nursing care ordered by a physician to treat a covered injury or sickness. This care must be given, under the supervision of a physician, by licensed or certified nursing personnel. These services include, but are not limited to: active nursing or maintenance therapy; a care plan less than the level of skilled nursing care; supervision of a stabilized health condition; or environmental control to insure the patient's safety. A physician must certify that you need such care. It does NOT include skilled nursing or custodial care.

- (10) "Custodial Care Facility" means a facility or that part of one that regularly provides room, board, and personal help in feeding, dressing and other essential daily living activities. It must give care to three or more residents who, not needing daily nursing care, cannot properly care for themselves due to age, sickness, disease, or physical or mental impairment. The facility must be licensed by the state in which it is located to provide such custodial care. The owner or administrator cannot be related to you by blood or marriage.
- (11) "Custodial Care" means that care usually given to residents of a custodial care facility who, not needing daily nursing care, cannot properly care for themselves due to age, sickness, disease, or physical or mental impairment. A physician must certify that you need such care.
- (12) "Physician" means a licensed practitioner of the healing arts acting within the scope of his/her license.
- (13) "Schedule" is attached to and is a part of this policy.
- (14) "You" or "Your" means the Insured named in the Schedule.
- (15) "We," "Us" or "Our" means Medico Life Insurance Company.

PART G**SKILLED NURSING CARE AND
INTERMEDIATE NURSING CARE BENEFITS**

To be eligible to receive benefits under Part G(a) and Part G(b), your confinement must:

- (1) be in a Nursing Facility;
- (2) be recommended by a physician;
- (3) start within 14 days after required hospital confinement of at least three days in a row; and
- (4) be for the continued treatment of the condition(s) for which you were in the hospital.

G(a) SKILLED NURSING CARE BENEFIT

When you are confined and get Skilled Nursing Care, we will pay the benefit shown in the Schedule subject to any elimination period shown in the Schedule. The maximum number of days payable in a confinement period and during your lifetime is shown in the Schedule.

Every 30 days during this time, your physician must certify that Skilled Nursing Care is still needed. The physician cannot be a proprietor or employee of the Nursing Facility. The director or administrator must certify you actually receive this level of care.

G(b) INTERMEDIATE NURSING CARE BENEFIT

When you are confined and get Intermediate Nursing Care, we will pay the benefit shown in the Schedule. The benefit we pay will be subject to any elimination period shown in the Schedule for a confinement period. The maximum number of days payable in a confinement period and during your lifetime is shown in the Schedule.

PART H**CUSTODIAL CARE BENEFIT**

When you are confined in a Custodial Care Facility and get Custodial Care, we will pay the benefit shown in the Schedule. The maximum number of days payable in a confinement period is shown in the Schedule. The confinement must:

- (1) begin immediately after confinement in a Nursing Facility for which we paid you Skilled Nursing Care or Intermediate Care benefits for 20 or more days in a row; and
- (2) be for the continued treatment of the condition(s) for which you were in the Nursing Facility.

PART I**HOME CONFINEMENT BENEFIT**

When you are confined at home immediately after a hospital stay of at least three days in a row, we will pay you the benefit shown in the Schedule. We will pay up to the same number of days as your prior hospital stay.

When you go directly from a hospital to a Nursing Facility and are then immediately home confined, we will pay up to the number of days as your combined stays.

The maximum number of days payable in a confinement period will not exceed 90. A benefit for home confinement will not be paid if we pay benefits under Custodial Care for the same confinement period.

PART J AMBULANCE BENEFIT

When you need a licensed ambulance service to or from a hospital where you are confined as a resident bed patient, we will pay the ambulance benefit shown in the Schedule. Our payment will be limited to one such benefit during any one confinement period.

PART K HOW TO FILE A CLAIM

- (1) **Notice of Claim:** You must give us written notice of a claim within 20 days (30 days in Mississippi; 60 days in Kentucky; 6 months in Montana) after loss starts or as soon as you can. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our agents.
- (2) **Claim Forms:** When we receive your notice, we will send you forms for filing proof of loss. If these forms are not sent to you in 15 days, you will have met the proof of loss rule below if, in 90 days after the loss began, you gave us a written statement of what happened.
- (3) **Proof of Loss:** You must give us written proof of your loss in 90 days or as soon as you can. But proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART L PAYMENT OF CLAIMS

All benefits will be paid as soon as we receive proof of loss.

The benefit (if any) for loss of your life will be paid to the beneficiary. Other losses will be paid to you. If no beneficiary is named, the benefit will be payable to your estate. Any other accrued benefits unpaid at your death may, at our option, be paid either to the beneficiary or to your estate.

If any benefit is payable to your estate, to a minor, or to any person not able to give a valid release, we may pay up to \$1,000.00 to any person we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

PART M POLICY PROVISIONS

- (1) **Entire Contract; Changes:** This policy, with any attachments (and the copy of your application, if attached), is the entire contract of insurance. No agent may change it in any way. Only an officer of ours can approve a change. That change must be shown in the policy.
- (2) **Time Limit on Certain Defenses:** After two years from the Policy Date, no misstatements, except fraudulent misstatements in the application for the policy, can be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.
No claim for loss that starts more than six months after the Policy Date can be reduced or denied on the grounds that a condition not excluded from coverage existed prior to the Policy Date.
- (3) **Grace Period:** Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period. You always have your grace period unless your policy will not be renewed. We will send you notice of nonrenewal at least 30 days before your premium is due.
- (4) **Reinstatement:** Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application, your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to accidental injury that begins after the date your policy was put in force. Also, it will cover only loss due to sickness that begins more than ten days after the date the policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to the policy. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid. But it will not be used for any period more than 60 days before the reinstatement date.

- (5) **Physical Examination:** We, at our expense, can have you examined as often as needed while a claim is pending.
- (6) **Legal Action:** You can't bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can't start such an action more than three years (five years in Kansas) after the date written proof of loss is required.
- (7) **Change of Beneficiary; Assignment:** Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.
- (8) **Misstatement of Age:** If your age has been misstated, the amount payable will be that which the premium would have bought at the correct age.
- (9) **Intoxicants and Narcotics:** We will not be liable for loss sustained because of your being intoxicated. Nor will we be liable for loss sustained because of your being under the influence of a narcotic. This provision will not apply to narcotics given on the advice of a physician.
- (10) **Illegal Occupation:** We will not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony. Nor will we be liable for any loss to which a contributing cause was your being engaged in an illegal occupation.
- (11) **Other Insurance With Us:** You may have only one policy like this one at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.
- (12) **Term of Coverage:** Your coverage starts on the Policy Date at 12 o'clock noon standard time where you live. It ends at 12 o'clock noon on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.
- (13) **Conformity With State Statutes:** The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

This policy is signed in our behalf by our President and Secretary.

A. L. Blomengardt
Secretary



William M. Busch
President

MEDICO™ LIFE INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NE 68124

DUPLICATE
SCHEDULE

POLICY NO. - 0E78225

POLICY TYPE - 3355

INSURED - EVELYN R BUSHNELL
ZL F BUSHNELL
PO BOX 1450
ISSAQUAH WA 98027-0059

POLICY DATE..... 10/09/1986

----- RENEWAL PREMIUMS -----	
60-DAY.....	\$124.50
SEMI-ANNUAL.....	\$373.50
ANNUAL.....	\$684.30

POLICY LIFETIME MAXIMUM BENEFITS.....	\$190,000.00
LIFETIME MAXIMUM BENEFIT DAYS PAYABLE	
SKILLED NURSING CARE.....	2190
INTERMEDIATE NURSING.....	360
ELIMINATION PERIOD FOR ANY ONE	
CONFINEMENT PERIOD.....	20 DAYS
SKILLED NURSING CARE DAILY BENEFIT	
FIRST 20 DAYS IN A CONFINEMENT PERIOD.....	\$.00
21ST DAY UP TO 101ST DAY.....	\$40.00
101ST DAY THRU 2210TH DAY.....	\$80.00
INTERMEDIATE NURSING CARE DAILY BENEFIT	
FIRST PAYABLE DAY IN A CONFINEMENT PERIOD THRU 180 DAYS.....	\$20.00
181ST THRU 360TH PAYABLE DAY.....	\$40.00
CUSTODIAL CARE DAILY BENEFIT.....	
MAXIMUM DAYS PER CONFINEMENT PERIOD.....	\$15.00 180
HOME CONFINEMENT DAILY BENEFIT.....	\$15.00
AMBULANCE BENEFIT.....	\$25.00

POLICY 3355 PLAN 3 OPTION B

APPENDIX B

CP 47-48, Denial Letter, June 20, 2007



MEDICO GROUP

Medico Insurance Company • Medico Life Insurance Company

June 20, 2007

COPY

Evelyn R. Bushnell
%L F Bushnell
Po Box 1450
Issaquah, WA 98027

Policy Number: OB78225

Dear Mrs. Bushnell;

In order for benefits to be provided under this policy, certain requirements must be met. Based on the information received from Lake Vue Gardens, it has been determined that these policy requirements have not been met for the nursing facility care you have been receiving since 02-24-2007. Please let me take a moment to explain this claims determination.

For policy terms, benefits for skilled or intermediate care will be payable as long as the insured meets the following conditions:

- 1.) Be in a nursing facility;
- 2.) Be recommended by a physician;
- 3.) Start within 14 days after required hospital confinement of at least 3 days in a row;
- 4.) Be for the continued treatment of the conditions for which they were in the hospital.

Based on the documentation received from Lake Vue Gardens, you were admitted directly in the nursing facility from your home. Since you did not have a prior hospitalization for at least 3 days before your admit into Lake Vue Gardens, the policy requirements have not been met and benefits cannot be provided at this time.

Also, please be advised that your long term care policy lapsed on 03-01-07 as we did not receive a renewal premium from you.

If there is any additional information that you feel would affect the handling of this claim, please submit copies of the medical documentation in the yellow envelope that is provided and we will be happy to reconsider this claims determination.

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6700 • fax (402) 391-6467 • www.gor-medico.com

Reproduced Image for Policy OB78225, BUSHNELL, Claim Number 980003

CP 47



COPY

MEDICO GROUP

Medico Insurance Company • Medico Life Insurance Company

I am sorry that I could not write to you more favorable at this time. If you should have any questions or concerns regarding this information, please do not hesitate to contact me directly at 402-391-6900 Ext-339.

Sincerely,

Kimberly A. Jackson
Claims Service Department

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6900 • fax (402) 391-6489 • www.go-medico.com

Reproduced Image for Policy 0878225, BUSHNELL, Claim Number 980003

10/24/2007

Page 128

Reproduced Image for Policy 0878225, BUSHNELL, Claim Number

12/17/2007

CP48

APPENDIX C

CP 367-69, Order Granting Defendants' Motion for Summary
Judgment and Denying Plaintiff's Motion for Summary Judgment

FOR YOUR INFORMATION
KEOLKER & SWERK

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2009 JUN -4 AM 11:31
KING COUNTY
SUPERIOR COURT CLERK
SEATTLE, WA

The Honorable John Erlick
Date: June 4, 2009
Time: 9:00a.m.

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SUPERIOR COURT OF WASHINGTON
IN AND FOR THE COUNTY OF KING

EVELYN R. BUSHNELL, individually, and
LEROY F. BUSHNELL, individually, as
attorney in fact, and as guardian ad litem for
EVELYN R. BUSHNELL,

Plaintiff,

v.

MEDICO INSURANCE COMPANY, a
Nebraska Corporation, and MEDICO LIFE
INSURANCE COMPANY, a Nebraska
Corporation,

Defendants.

No. 07-2-38744-7SEA

Defendants'
ORDER GRANTING ~~PLAINTIFF'S~~
MOTION FOR ~~PARTIAL~~ SUMMARY
JUDGMENT AND DENYING *Plaintiff's*
~~DEFENDANTS' CROSS-~~MOTION FOR
SUMMARY JUDGMENT

[PROPOSED]

THIS MATTER having come before the court on Plaintiff's Motion for Summary
Judgment and Defendants' Motion for Summary Judgment, and having reviewed the
following pleadings:

1. Plaintiff's Motion for Summary Judgment;
2. Declaration of Randall C. Johnson in Support of Plaintiff's Motion for Summary
Judgment and attachments thereto;
3. Defendants Response and Counter Motion for Summary Judgment;

ORDER GRANTING ~~PLAINTIFF'S~~ *Defendants'* MOTION FOR
SUMMARY JUDGMENT - 1

COPY

BADGLEY ~ MULLINS
LAW GROUP PLLC
Columbia Center
701 Fifth Avenue, Suite 4750
Seattle, Washington 98104
Telephone: (206) 621-6566
Fax: (206) 621-9666

CP367

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- 4. Declaration of Donald K. Lawler and attachments thereto;
- 5. Defendants' Motion for Summary Judgment;
- 6. Defendants' Opposition to Plaintiff's Motion for Summary Judgment;
- 7. Declaration of Celeste T. Stokes in Support of Defendants' Opposition to Plaintiff's Motion for Summary Judgment and attachments thereto;
- 8. Declaration of Donald Lawler and attachments thereto;
- 9. Defendants' Supplemental Opposition to Plaintiff's Motion for Summary Judgment;
- 10. Supplemental Declaration of Donald Lawler and attachments thereto;
- 11. Declaration of Counsel Supporting Defendants' Supplemental Opposition to Summary Judgment and attachments thereto, and
- 12. Plaintiffs' Response in Opposition to Defendants' Motion for Summary Judgment.

The Court having heard oral arguments, and having reviewed the files and pleadings herein, it is hereby ORDERED that ^{Defendant's} ~~Plaintiff's~~ Motion for ~~Partial~~ Summary Judgment is GRANTED and ^{Plaintiff's} ~~Defendants' Cross-~~ Motion for Summary Judgment is DENIED.

It is further ORDERED, ADJUDGED, and DECREED that:

- 1. The hospital stay requirement found in Ms. Bushnell's policy is ^{not} ~~invalid~~ and Ms. Bushnell is entitled to coverage as a matter of law. JPE
- 2. Medico's denial of coverage was ^{not} ~~unreasonable~~ and in bad faith, ~~and in violation of Washington law.~~
- 3. The case is dismissed with prejudice. JPE

^{Defendants'}
ORDER GRANTING ~~PLAINTIFF'S~~ MOTION FOR
SUMMARY JUDGMENT - 2

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CP368

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3. ~~Plaintiff is granted a trebling of damages proven at trial pursuant to RCW
48.30.015.~~

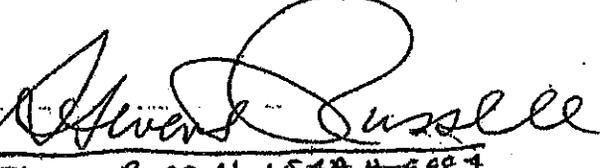
4. ~~Plaintiff is granted leave to file a supportive declaration attesting to fees for a
reasonableness hearing.~~

Done in open Court this 4th day of June, 2009.


JUDGE JOHN ERLICK

Presented By:


Randall C. Johnson, WSBA # 24556
Mark K. Davis WSBA # 38713
Attorneys for Plaintiff Leroy Bushnell


Steven Russell, WSBA # 6487
Celeste Stokes, WSBA # 12180

Defendants!
ORDER GRANTING PLAINTIFF'S MOTION FOR
SUMMARY JUDGMENT - 3

BADGLEY ~ MULLINS
LAW GROUP PLLC
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Seattle, Washington 98104
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CP 369

EX 38
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APR 18 2011

BADOLEY-MULLINS LAW

NO. 63916-1-I

COURT OF APPEALS
DIVISION I
OF THE STATE OF WASHINGTON

LEROY BUSHNELL, a personal representative of the Estate of EVELYN
BUSHNELL,

Plaintiff-Appellant,

vs.

MEDICO INSURANCE COMPANY, a Nebraska corporation, and
MEDICO LIFE INSURANCE COMPANY, a Nebraska corporation,

Defendant-Appellees.

PETITION FOR REVIEW

Christopher H. Howard, WSBA #11074
Averil Budge Rothrock, WSBA #24248
Colin Folawn, WSBA #34211
Virginia R. Nicholson, WSBA #39601
SCHWABE, WILLIAMSON & WYATT, P.C.
U.S. Bank Centre
1420 5th Avenue, Suite 3400
Seattle, WA 98101-4010
Telephone 206.622.1711
Fax 206.292.0460
Attorneys for Defendant-Appellees

COPY

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I. IDENTITY OF PETITIONERS

Defendants-Respondents Medico Insurance Company and Medico Life Insurance Company (collectively, "Medico") petition for discretionary review pursuant to RAP 13.1(a) and 13.3(a)(1).

II. CITATION TO COURT OF APPEALS DECISION

Medico seeks review of the published February 7, 2011, decision of Division One of the Washington Court of Appeals, No. 63916-1-I (Appendix A). The Court of Appeals denied reconsideration on March 17, 2011 (App. B). These rulings terminated review.

III. ISSUES PRESENTED FOR REVIEW

1. Did the Court of Appeals misinterpret the Supreme Court's *Tebb v. Continental Casualty Co.* decision when it decided that the policy at issue was a renewal policy subject to recent regulations and not a continuous contract? In so doing, did the Court create a previously unrecognized presumption in favor of claimants that should not stand?

2. Does the Court of Appeals' application of regulations effective as to policies "issued" after January 1, 1988, to this 1986 policy contravene the express legislative intent of RCW 48.84.910?

3. When the Court of Appeals directed judgment to the claimant who had ceased paying premiums, did it misconstrue the contract, Washington law and prevailing insurance principles to create a

waiver of premium provision not found in the contract? Does Washington law allow a court to write a "waiver of premium clause" into a contract that does not contain one?

4. Does application of the regulations effective January 1, 1988, to the 1986 policy violate Medico's constitutional protections from impairment of contract pursuant to U.S. Const. Art. I, § 10 and Wash. Const. Art. I, § 23?

5. If this Court reverses the Court of Appeals' decision on the contract claim, should it reinstate the trial court's dismissal of the bad faith claims?

IV. STATEMENT OF THE CASE

This case concerns denial of benefits under a policy for skilled and intermediate nursing. Medico denied benefits to the claimant for failing to satisfy a condition of the policy, and for failure to pay premiums. The trial court granted summary judgment to Medico. The Court of Appeals reversed, finding for the claimant on the policy, and remanding the bad faith claim for trial.

1. The Policy as Issued

Evelyn Bushnell purchased a "Skilled and Intermediate Nursing Policy" from Medico issued October 9, 1986 ("the policy"). CP 30-38 (App. C); CP 550. She was entitled to pay premiums every 60 days, semi-

annually or annually. CP 35 (App. C).

The policy contains a three-day prior hospitalization clause, requiring such a hospitalization before benefits are triggered. CP 32 at Part G(3) (App. C). Pursuant to this clause, benefits are not due if a claimant goes directly to a long-term care facility without a three-day hospitalization.

The policy includes a Term of Coverage provision providing that each "renewal" of the policy starts a new "term":

Your coverage starts on the Policy Date at 12 o'clock noon standard time where you live. It ends at 12 o'clock noon on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.

CP 34 at Part M(12) (App. C).

The policy contains a "Renewal Agreement" setting forth the requirement that Medico renew Bushnell's individual policy:

As long as you pay the renewal premium . . . on the date it is due or during the 31-day grace period, we cannot refuse to renew your policy unless we do the same to all policies in this form issued to persons of your class . . . in your state.

We can change your premium only if we do the same to all policies of this form issued to persons of your class . . . in your state and we will notify you in advance of the due date.

CP 30 at Part B (App. C).

The policy also contains a conformity clause tied to the Policy

Date, stating:

The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.”

CP 34 at Part M(13) (App. C) (emphasis added). The policy states the “Policy Date” as “10/09/1986.” CP 35 (App. C).

Bushnell’s policy contains a grace period clause, allowing a 31-day grace period of policy coverage following non-payment of premium, CP 33 at Part M(3) (App. C). If the premium is not paid by the end of the grace period, the policy “will lapse.” *Id.* The policy is also subject to a 20-day “elimination period,” which is the number of days for which benefits are eliminated in consideration for a reduced premium. CP 31 at Part F(2), CP 35 (App. C). The policy does not include any waiver of premium provision.

2. Subsequent Legislative Changes

After issuance of this policy to Bushnell, the Legislature passed the “Long-Term Care Insurance Act,” RCW 48.84. CP 167. This legislation authorized the commissioner to adopt rules establishing standards for chronic care coverage. RCW 48.84.030(2) (App. D). New regulations promulgated under that act prohibit prior hospitalization stay requirements in long-term care contracts. WAC 284-54-150(7) (App. E). The legislature provided that these adopted administrative rules “**shall apply to policies**

and contracts issued on or after January 1, 1988.” RCW 48.84.910
(emphasis added) (App. F).

3. The Proof of Loss, Failure to Pay Premiums,
and Denial of Coverage

This appeal next concerns events in 2007. Bushnell timely mailed her \$124.50 60-day premium on February 1, 2007. CP 615, 35, 41. This payment was for a coverage period January 1, 2007–February 28, 2007. CP 552, 615. This was the last payment that Bushnell made. CP 554. Medico sent reminder notices about past due premiums and a notice explaining that she was in her 31-day grace period and that her coverage would lapse if she did not promptly pay the premium. CP 553; CP 556; CP 558.

On February 24, 2007, without previously being hospitalized, Bushnell was admitted to Lake Vue Gardens Convalescent Center, a nursing facility. CP 601; CP 604.

On March 6, 2007, Medico received timely notice of Bushnell’s Proof of Loss Claim. CP 430; CP 585; CP 602.

Medico denied coverage because (1) Bushnell had not complied with the prior hospitalization clause, and (2) the policy had lapsed for failure to pay the premium CP 554; CP 47 (App. G).

4. Procedural History of the Litigation

Bushnell sued Medico in King County Superior Court, alleging

claims based on breach of contract, the CPA, the IFCA and bad faith. CP 11-20. The Honorable John Erlick found the hospital stay requirement valid and ruled that Bushnell was "not entitled to coverage as a matter of law." CP 368 (App. H). Judge Erlick dismissed the remaining claims because Medico's denial of coverage "was reasonable and not in bad faith." *Id.*

After Bushnell appealed, the Court of Appeals reversed. *Decision*, p. 14 (App. A). The Court of Appeals did not view the 1986 policy as a continuing policy under *Tebb v. Continental Casualty Co.*, 71 Wn.2d 710, 712, 430 P.2d 597 (1967) (App. K); instead, the Court of Appeals viewed the policy as a renewal policy "re-issued" every time Bushnell made a premium payment. *Decision*, p. 12 ("We conclude that under the terms of the long-term skilled nursing care policy issued by Medico to Bushnell, upon acceptance of each renewal premium, a new contract was formed."). Under this view, the Court applied the later regulations to the policy because the Court considered a new policy formed after January 1, 1988. *Id.* The Court, therefore, held that the hospital stay requirement "no longer applied." *Id.* The Court also held that the conformity clause of the policy amended the policy to conform with state law effective after January 1988. *Id.* at 12-13. The Court of Appeals impliedly directed judgment for Bushnell on the policy and expressly awarded Bushnell *Olympic*

Steamship fees and costs. *Decision*, p. 14 (App. A).

The Court rejected Medico's argument that even if the hospital stay requirement is invalid, Bushnell is not entitled to judgment because of her failure to pay premiums. *Decision*, pp. 13-14. See *Respondent's Brief*, pp. 17-18 (App. I); *Motion for Reconsideration*, pp. 13-17 (App. J). The Court of Appeals remanded the bad faith claims without discussion. *Decision*, p. 14 (App. A).

5. Record on Review

The Court of Appeals granted Medico's motion to strike citations in Bushnell's appellate briefing to pleadings not considered by the trial court in deciding the summary judgment, including Bushnell's trial brief, attached exhibits, and a declaration by Leroy Bushnell submitted in support of a motion for reconsideration the resolution of which was not assigned error. *Decision*, p. 2, note 1. This Court also should not consider these materials.

V. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

The Supreme Court should accept review because the Court of Appeals' decision conflicts with a prior Supreme Court decision, raises issues of substantial public interest concerning interpretation of insurance contracts and application of new regulations to insurance contracts, and

presents a significant question of constitutional law. The precedential value of the Decision should be reviewed because the insurance issues presented are important to many Washington residents.

If review is accepted and the Court reverses, it also should consider whether the bad faith claims should have been remanded.

A. **The Decision Conflicts with the Supreme Court Decision *Tebb v. Continental Casualty Co.***

This Court should accept review under RAP 13.4(b)(1), because the Court of Appeals' decision conflicts with this Court's decision in *Tebb, supra* (App. K). In *Tebb*, this Court addressed when an insurance contract is a continuous contract and when it is a renewal contract. The former is not subject to subsequent legislation while the latter is. 71 Wn.2d at 712. The *Tebb* court established that the intent of the parties, as determined by the insurance policy, controls the issue. *Id.* at 713.

The *Tebb* court noted that an insurer's option to accept or reject the individual renewal premium is a demonstration of intent to effectuate a new contract between the parties. *Id.* The policy at issue in *Tebb* granted the insurer unfettered right to accept or reject a renewal. *Tebb*, 71 Wn.2d at 713 (quoting policy provision that policy "may be renewed with the consent of the Company ..."). Based on this provision, the policy was found to be a renewal policy. *Tebb*, 71 Wn.2d at 714. *Tebb* holds that the right of the insurer to accept or reject the renewal is conclusive evidence

that the parties intended to create a new contract upon the acceptance of the renewal premium.

If the policy at issue here is a continuous contract, the recent prohibition of hospitalization stay requirements is inapplicable because the prohibition did not exist when the contract was formed. Citing *Tebb*, the Court of Appeals reasoned that both the Renewal Agreement clause and the Term of Coverage clause support its conclusion that the policy is a renewal policy. *Decision*, p. 12 (App. A), citing CP 30 at Part B and CP 034 at Part M (12) (App. C). But under *Tebb*, both of these provisions indicate that the parties' intent was for a *continuous contract* of insurance, contrary to the appellate court's decision.

- a. Because Medico does not have the option to reject Bushnell's individual policy renewal, the appellate court should have found a continuous policy under *Tebb*.

The policy is a continuous policy because Medico had no option to reject Bushnell's policy renewal. The provision regarding renewal, in contrast to the provision at issue in *Tebb*, evidences intent for a continuous contract. Medico had no discretion to refuse to renew Bushnell's policy when she presented the premium as originally priced, as the policy states:

As long as you pay the renewal premium then in effect on the date it is due or during the 31-day grace period, we cannot refuse to renew your policy unless we do the same to all policies of this form issued to person of your class (for example, age) in your state. Your policy stays in force

during your grace period. No refusal of renewal will affect a claim existing in a confinement period.

We can change your premium only if we do the same to all policies of this form issued to persons of your class (for example, age) in your state and we will notify you in advance of the due date.

CP 30 at Part B (emphasis added) (App. C). This language starkly contrasts the language from the policy at issue in *Tebb*. Medico has no discretion regarding Bushnell's individual policy. Medico cannot refuse to renew the policy, nor change the premiums, unless all like policies within the state are similarly altered. This is not indicative of a renewal contract. The Court of Appeal's determination that the policy is a renewal policy, established anew with each premium paid, is contrary to the Renewal Agreement provision and *Tebb*. Based on the policy's renewal provision, the policy should be found a continuous contract for insurance.

Case law from other jurisdictions addressing this issue is consistent with *Tebb* and conflicts with the Court of Appeals' decision. *See Oates v. Equitable Assurance Soc.*, 717 F. Supp. 449, 452 (S.D. Miss. 1988)(guaranteed renewable policy where amount of premium was only subject to change if same change was made to all policies of the class held a continuous contract not subject to subsequent regulation) (App. L) (quoting 18 COUCH ON INSURANCE 3D § 68:40 at 41) (“[w]hether the renewal of a policy of insurance constitutes a new and independent

contract or whether it is instead a continuation of the original contract 'primarily depends upon the intention of the parties as ascertained from the instrument itself.'"); *Hudson v. Reserve Life Ins. Co.*, 245 S.C. 615, 141 S.E.2d 926 (1965) (holding a guaranteed renewable policy contemplated continuous coverage with each renewal, so later-enacted statutes did not apply) (App. M). The *Oates* case specifically addressed a provision where the premium could not be changed unless all policies of the class were changed. *Id.* The *Oates* court held the policy to be continuous. *Id.* The Renewal Agreement provision supports reversal.

- b. Because the "Term of Coverage" provision does not contemplate a new policy, the appellate court should have found a continuous policy under *Tebb*.

The Court of Appeals erred when it held that the Term of Coverage provision evidences intent contrary to a continuous policy. The provision defines the term of coverage for each premium, as follows:

Your coverage states on the Policy Date at 12 o'clock noon standard time where you live. It ends at 12 o'clock noon the same standard time in the first renewal date. *Each time you renew your policy, the new term begins when the old term ends.*

CP 34 at Part M(12) (emphasis added). This provision does not indicate that a new "policy" begins at each renewal. It indicates that a new "term" begins under the existing policy, i.e., "your policy." The language indicates a single, continuous policy.

The Court of Appeals' decision conflicts with *Tebb* by incorrectly characterizing the policy as a renewal policy. This Court should accept review.

c. The Decision establishes a rebuttable presumption not endorsed by *Tebb*.

This Court should review the rebuttable presumption created by the Court of Appeals that this Court has not previously recognized. The appellate court articulated the presumption by erroneously paraphrasing *Tebb*, stating that the *Tebb* court "held that unless a contrary intention is clearly shown, each time a policy is renewed, a new contract is formed." *Decision*, p. 11 (App. A). But *Tebb* had no such holding. The *Tebb* court stated the inquiry not as a rebuttable presumption, but as a question of fact regarding intent, as follows:

A renewal contract has been stated by many jurisdictions to be a new, and a separate and distinct contract, unless the intention of the parties is shown clearly that the original and renewal agreements shall constitute one continuous contract.

Tebb, Wn.2d at 713 (App. K). The *Tebb* court went on to search for evidence of intent in the contract. *Id.* *Tebb* found such evidence in the carrier's right to reject the premium. *Id.* *Tebb* suggested the policy may be continuing where, as here, the carrier does not have that right. *Id.* Nowhere did *Tebb* create a rebuttable presumption of separate contracts.

This Court should accept review to reject the new rebuttable

presumption articulated by the appellate court that is absent from *Tebb*.

B. The Decision Raises Issues of Substantial Public Interest Concerning Insurance Contracts and Applicability of New Regulations.

This Court should accept review under RAP 13.4(b)(4). The case involves issues of substantial public interest concerning the proper application of *Tebb*, discussed above, and concerning retroactive application of insurance regulations and legislation. The published decision should not be the last word on proper application of Chapter 48.84 and WAC 284-54-150 or similar legislation. The Legislature specifically provided that the new regulations only would apply to “policies and contracts *issued* on or after January 1, 1988.” The record does not support the conclusion that this policy was “issued” after January 1, 1988.

This Court should decide whether the 1988 regulations should apply to the 1986 policy not only under *Tebb* as argued in Section A, but exclusively based on the Legislature’s specific direction that the changes would only apply to “policies and contracts *issued* on or after January 1, 1988.” CP 168 (emphasis added). The policy was never *re-issued*. It was delivered once as of October 9, 1986. CP 35 (“Policy Date”). The Complaint alleges a single issuance “on or about October 8, 1986.” CP 13, lines 4-5. Applying the language used by the Legislature, the policy is not

subject to the new regulations. This is plain based on the record and the legislation without resort to the *Tebb* analysis. The Court of Appeals' decision to apply the 1988 regulations to this policy contradicts the intent expressed by the Legislature.

The Court of Appeals' decision contravenes the intent of the Legislature. It should not serve as precedent for future application of the Act and associated regulations.

C. **The Decision Conflicts with Common Law and Insurance Principles Regarding Lapse of Premium.**

This Court should accept review under RAP 13.4(b)(4), because the case involves issues of substantial public interest concerning insurance policies in light of the Court of Appeals' departure from recognized common law and insurance principles regarding lapse.

The Court of Appeals interpreted the policy as if it contained a waiver of premium provision that is absent. A waiver of premium clause is a contract provision that suspends the premium payment upon proper notice of a claim. *See, e.g.,* 5 COUCH ON INSURANCE 3D, § 75:20, at 75-40 (stating that "The effect of the waiver of premiums clause is to waive the insured's obligation to pay the specified premiums where notice of the required degree of disability is given within the required time."). Not only is such a clause absent from the policy, but the policy provides that it will

lapse "if you do not pay your premium before the end of the grace period," CP 33 at Part M(4) (App. C), and that no benefits will be paid for "loss while this coverage is not in force" CP 030 at Part D(1) (App. C).

The general rule is that failure of an insured to pay a renewal premium by the due date results in a lapse of coverage as of the last day of the policy period. *Safeco Ins. Co. v. Irish*, 37 Wn. App. 554, 558, 681 P.2d 1294 (1984), *rev. denied*, 102 Wn.2d 1013 (1984). Interpretation of an insurance contract is a matter of law. *Stouffer & Knight v. Continental Cas. Co.*, 96 Wn. App. 741, 747, 982 P.2d 105 (1999). A court may not give an insurance contract a construction "which would lead to . . . an extension . . . of the policy beyond that fairly contemplated by its terms." *Teague Motor Co. v. Federated Serv. Ins. Co.*, 73 Wn. App. 479, 482, 869 P.2d 1130 (1994). "Clear and unambiguous policy language must be enforced as written." *Id.*

Here, the policy required Bushnell to pay regular premiums, regardless of claims filed. Her failure to keep the payments current supported dismissal of her claim, or alternatively supported coverage for the very limited period of March 16, 2007 (the day the 20-day elimination period ended), through March 31, 2007 (the last day of the grace period).

The Court of Appeals' published decision wrongly interprets the policy as if it contains a waiver of premium provision that is absent. The

Court of Appeals' misapprehension of the law is evidenced by its statement that "even if the 20-day elimination period is taken into account, coverage did not lapse until after the grace period." *Decision*, p. 14. If coverage lapsed at all, as the Court acknowledged is possible, Bushnell is not entitled to her full claim for breach of contract.

The published decision erroneously finds for Bushnell on the full amount of her coverage claim regardless of the proper rules on lapse and waiver of premium. The improper analysis should not stand as precedent.

D. Application of the 1988 Regulations to the Policy Violates the Impairment of Contracts Clauses of the U.S. and Washington Constitutions.

This Court should accept review under RAP 13.4(b)(3) due to the constitutional issues presented. If Chapter 48.84 RCW applies to the policy at issue to invalidate the hospital stay requirement, its application is unconstitutional under U.S. Const. Art. I, § 10 and Wash. Const. Art. I, § 23. The Court should accept review to determine this important issue of Constitutional law.

This Court first should note that the Legislature intended to avoid constitutional problems by specifically providing that the changes to the law would only apply to policies issued after January 1, 1988. Because the Court of Appeals' decision ignores this express legislative intent, the constitutional issue arises.

The United States Constitution states: "No state shall adopt any law impairing the obligation of contracts." U.S. Const. Art. I, § 10. Washington's state constitution echoes that guarantee: "No ... law impairing the obligations of contracts shall ever be passed." Wash. Const. Art. I, § 23. These two constitutional provisions are in substantially the same language and to the same effect. *Tremper v. Northwestern Mut. Life Ins. Co.*, 11 Wn.2d 461, 463-64, 119 P.2d 707 (1941).

In *Tremper*, this Court held that retroactive application of a statute involving calculation of interest in insurance policies was unconstitutional as applied. *Id.* The insurance company issued Mr. Tremper a life insurance policy, payable at death. *Id.* 462. Mr. Tremper sought and received cash advances on his policy. *Id.* Upon failure of Mr. Tremper to pay the interest due, the insurer added the interest to the principal sum, which resulted in Mr. Tremper being charged compound interest. *Id.* When the debt equaled the full cash surrender value of the policy, the insurer cancelled the policy. *Id.*

After the policy had issued, the Legislature passed an act permitting the compounding of interest upon non-payment of interest on such loans. *Tremper*, 11 Wn.2d at 463-64. The interest charges were lawful under the new legislation. Mr. Tremper sued to recover the cash value of the policy minus the loan amount as calculated with simple

interest. *Id.* at 461. The question before the court was whether application of the new act to Mr. Tremper's life insurance policy was an unconstitutional impairment of his contract. *Id.* at 463.

The *Tremper* court acknowledged that the obligation of a contract is impaired by a statute "which alters its terms by imposing new conditions or which lessens its value." *Id.* at 464. It stated that one test to determine whether a statute impairs substantive rights of the assured is "whether the value of the contract, by legislation, has been diminished." *Id.* The court found that the insurer reduced the value of Mr. Tremper's policy by compounding its interest when it had no right to do so. *Id.* The court held that the statute as applied to Mr. Tremper's prior contract, interfered with his substantial rights and was unconstitutional. *Id.*

This Court should accept review to determine whether application of a statute enacted after Bushnell and Medico entered the contract for insurance interferes with Medico's contractual rights. Under *Tremper*, Chapter 48.84 impairs the rights of Medico if the value of the contract has been diminished. It has. Medico and Bushnell negotiated a policy that included a three-day hospital stay requirement. Bushnell paid for that policy. Application of the subsequently enacted statute changed the terms of Bushnell's policy. The Court of Appeals' decision gives her the benefit of a no-hospital stay provision that she did not pay for. This diminishes

the value of the contract to Medico.

A statute may override the freedom of contract under the constitution only where "the exercise of the police power [is] reasonably necessary in the interest of the health, safety, morals and welfare of the people." *Ketcham v. King County Medical Service Corp.*, 81 Wn.2d 565, 502 P.2d 1197 (1972). This Court cannot say that applying the new regulations to Medico's 1986 policy was reasonably necessary, as even the Legislature stated its express intent that the new regulations not apply.

There is no dispute that Bushnell's policy and its terms were valid and enforceable when the policy was issued in October 1986. The effect of the appellate court's decision is to force Medico into a contract that it did not make in violation of Medico's constitutional rights.

VI. CONCLUSION

This Court should accept review. The Court of Appeals' published decision conflicts with Washington case law, the express intent of the Washington legislature, and established principles of insurance law. It potentially violates Medico's constitutional rights. The published decision is faulty. This Court should review the significant issues concerning insurance because the ramifications are widespread. The decision affects not only the specific legislation and regulations at issue, but by analogy all types of policies, statutes and regulations. The issues are significant and

important to the public. Review is justified.

Respectfully submitted on this 15th day of April, 2011.

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APPENDIX

- A. Court of Appeals' Decision
- B. Court of Appeals' Order Denying Reconsideration
- C. Policy (CP 30-38)
- D. RCW 48.84.030
- E. RCW 48.84.910
- F. WAC 284-54-150
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- M. *Hudson Reserve Life Ins. Co.*,
245 S.C. 615, 141 S.E.2d 926 (1965)

APPENDIX-A

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

LEROY BUSHNELL, as personal
representative of the Estate of EVELYN
BUSHNELL,

Appellant,

v.

MEDICO INSURANCE COMPANY, a
Nebraska Corporation, and MEDICO
LIFE INSURANCE COMPANY, a
Nebraska Corporation,

Respondents.

No. 63916-1-1

PUBLISHED OPINION

FILED: February 7, 2011

SCHINDLER, J. — Leroy Bushnell, as the personal representative of the Estate of Evelyn Bushnell (Bushnell), appeals summary judgment dismissal of the lawsuit against Medico Insurance Company of Nebraska (Medico) for denial of coverage under a nursing care insurance policy issued to Evelyn Bushnell in 1987. Medico denied Bushnell's claim for nursing care benefits on the grounds that the three-day prior hospitalization requirement was not met, and coverage lapsed for nonpayment. On cross motions for summary judgment, the trial court ruled that as a matter of law, the three-day hospital stay requirement is valid and Bushnell is not entitled to

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coverage. The court also ruled Medico's denial of coverage was reasonable and not in bad faith, and dismissed Bushnell's lawsuit with prejudice. We reverse and remand.

FACTS

The facts are not in dispute.¹ In October 1986, Leroy Bushnell, as the attorney in fact and on behalf of his mother Evelyn Bushnell, submitted an application to Medico for a nursing care insurance policy. In January 1987, Medico issued a "Skilled and Intermediate Nursing Policy" to Evelyn Bushnell effective October 9, 1986.

The policy provides benefits for medically required skilled and intermediate nursing care for an unstable health condition. The "Schedule" sets forth the skilled and intermediate nursing care benefits with a lifetime maximum of \$190,000. As a condition of receiving nursing benefits, the policy requires confinement in a qualified nursing facility that is recommended by a physician "within 14 days after required hospital confinement of at least three days in a row" for the "continued treatment of the condition(s) for which you were in the hospital."

The policy states that "[a]s long as you pay the renewal premium . . . on the date it is due or during the 31-day grace period," Medico "cannot refuse to renew your policy unless we do the same to all policies of this form issued to persons of your class . . . in your state." The policy also states that the "provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform."

¹ Medico filed a motion to strike the citations in the appellant's brief to the "Declaration of Leroy Bushnell" in support of the motion for reconsideration, and to Bushnell's trial brief and attached exhibits. We grant the motion to strike. These pleadings were not considered by the court on summary judgment. RAP 9.12.

In November 1986, the legislature enacted the Long-Term Care Insurance Act, chapter 48.84 RCW (the Act). The Act governs the sale and content of long-term insurance policies. Effective January 1, 1988, the regulations implementing the Act prohibit insurance companies from requiring prior hospitalization as a condition of receiving nursing care benefits.²

Bushnell timely paid renewal premiums for more than 20 years. In December 2006, when Evelyn was no longer able to care for herself, she went to live with her son, Leroy. On February 1, Leroy paid the renewal premium for the 60-day period from January 1, 2007 through February 28, 2007.

On February 21, 2007, Evelyn's doctor concluded that she had suffered a stroke the previous December and needed full-time skilled nursing care. On February 24, Evelyn was admitted to a skilled nursing care facility, Lake Vue Gardens Convalescent Center. On February 24, Leroy submitted a "Claimant's Proof of Loss" for nursing care benefits to Medico.

On June 20, Medico denied Bushnell's claim for nursing care benefits because Evelyn did not comply with the three-day prior hospitalization requirement and coverage under the policy lapsed for nonpayment. The letter states, in pertinent part:

- Per policy terms, benefits for skilled or intermediate care will be payable as long as the insured meets that [sic] following conditions:
- 1.) Be in a nursing facility;
 - 2.) Be recommended by a physician;
 - 3.) Start within 14 days after required hospital confinement of at least 3 days in a row;
 - 4.) Be for the continued treatment of the conditions for which they were in the hospital.

Based on the documentation received from Lake Vue Gardens, you were admitted directly in the nursing facility from your home. Since you did not have a prior hospitalization for at least 3 days before your

² WAC 284-54-150(7).

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admit into Lake Vue Gardens, the policy requirements have not been met and benefits cannot be provided at this time.

Also, please be advised that your long term care policy lapsed on 03-01-07 as we did not receive a renewal premium from you.

On October 12, Bushnell's attorney wrote a letter asking Medico to reconsider the decision to deny coverage for nursing care benefits. The letter cites the regulation prohibiting an insurer from requiring hospitalization as a condition to receiving benefits. The letter also cites the provision in the policy that automatically amends the terms of the policy to conform with the laws of the state of Washington.

Relying on the language of the Act that states, "[T]his chapter shall apply to policies and contracts issued on or after January 1, 1988," Medico denied Bushnell's claim for nursing care benefits.

Because the policy was issued prior to the effective date of either the statute or regulation, it did conform with the laws of the state of Washington on the policy date.

On November 9, Bushnell filed a notice of violation of the Insurance Fair Conduct Act, chapter 48.30 RCW, with the Insurance Commissioner. On November 28, the commissioner issued notice of closure.

As the attorney in fact and on behalf of his mother, Leroy Bushnell sued Medico for denial of coverage. Bushnell sought a declaratory judgment that the prior three-day hospitalization provision in the policy was invalid under the Act and contrary to public policy. Bushnell alleged causes of action for breach of contract, violation of the Consumer Protection Act,³ violation of the Insurance Fair Conduct Act, and bad faith denial of coverage.⁴

³ Chapter 19.86 RCW.

⁴ After Evelyn died in August 2008, Leroy pursued the lawsuit as personal representative of the Estate.

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Bushnell filed a motion for partial summary judgment. Bushnell argued that as a matter of law, the three-day hospital stay requirement was invalid, and Medico acted in bad faith in denying coverage. Bushnell asserted that when Evelyn renewed the policy after January 1, 1988, the effective date of the regulations implementing the Act, the three-day hospital stay condition no longer applied.

Medico filed a cross motion for summary judgment. Medico argued that the policy was not subject to the Act because the three-day hospital stay requirement was valid when the policy was issued. Medico also argued that the terms of the policy did not change because "this policy was simply a continuation of the policy originally issued on October 9, 1986, and thus never became a policy issued on or after January 1, 1988" [under] RCW 48.84.910." Without regard to the validity of the three-day hospital stay requirement, Medico argued that coverage was properly denied because the policy lapsed for nonpayment.

Before the hearing on the cross motions for summary judgment, the court asked the parties to address a Washington State Supreme Court case that addresses the effect of a later enacted law on coverage under an insurance policy.⁵

Following the hearing, the court granted Medico's motion for summary judgment and dismissed Bushnell's lawsuit with prejudice. The court ruled that "[t]he hospital stay requirement found in Ms. Bushnell's policy is valid and Ms. Bushnell is not entitled to coverage as a matter of law." The court also ruled that "Medico's denial of coverage was reasonable and not in bad faith." The court denied Bushnell's motion for reconsideration.

⁵ Tebb v. Cont'l Cas. Co., 71 Wn.2d 710, 430 P.2d 597 (1967).

Bushnell appeals the order granting summary judgment and the order denying the motion for reconsideration.

ANALYSIS

Bushnell contends the trial court erred in ruling the three-day hospital stay is valid and Medico did not act in bad faith in denying coverage. Bushnell argues that when Bushnell renewed the policy after the effective date of the regulations implementing the Act in January 1988, the three-day hospital stay requirement was eliminated and no longer applied. Medico asserts that neither the Act or the regulations apply retroactively, the Act does not apply to renewals under the terms of the policy, and the three-day prior hospitalization requirement remained in effect.⁶

We review summary judgment de novo. Woo v. Fireman's Fund Ins. Co., 161 Wn.2d 43, 52, 164 P.3d 454 (2007). Summary judgment is proper when the pleadings and affidavits show there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. CR 56(c).

Interpretation of an insurance contract is a question of law that we review de novo. Woo, 161 Wn.2d at 52. We construe an insurance policy as a whole, and give a fair, reasonable, and sensible construction as would be given by the average person purchasing insurance. Kitsap County v. Allstate Ins. Co., 136 Wn.2d 567, 575, 964 P.2d 1173 (1998). Courts determine coverage under the plain meaning of the policy. Capelouto v. Valley Forge Ins. Co., 98 Wn. App. 7, 13-14, 990 P.2d 414 (1999). We interpret the agreement to give effect to each provision. Smith v. Cont'l Cas. Co., 128

⁶ We reject Bushnell's claim that Medico raises the argument for the first time on appeal that renewals under the policy constitute one continuous contract. The record shows that in response to Bushnell's argument on summary judgment that the three-day hospital stay requirement was eliminated when the policy was renewed after January 1988, Medico argued that the terms of the policy did not change, and the policy "was simply a continuation of the policy originally issued on October 9, 1986."

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Wn.2d 73, 78-79, 904 P.2d 749 (1995). Undefined terms are given their plain, ordinary, and popular meaning. Kitsap County, 136 Wn.2d at 576. Insurance policies are liberally construed to provide coverage wherever possible. Bordeaux, Inc. v. Am. Safety Ins., 145 Wn. App. 687, 694, 186 P.3d 1188 (2008).

If a policy is clear and unambiguous, the court must enforce it as written and not create ambiguity where none exists. Quadrant Corp. v. Am. States Ins. Co., 154 Wn.2d 165, 171, 110 P.3d 733 (2005). An ambiguity exists only if the policy language is susceptible to two different reasonable interpretations. Daley v. Allstate Ins. Co., 135 Wn.2d 777, 784, 958 P.2d 990 (1998). If any ambiguity exists, the language of the policy must be construed in favor of the insured. Bordeaux, 145 Wn. App. at 694.

The meaning of a statute is also a question of law that we review de novo. Dep't of Ecology v. Campbell & Gwinn, LLC, 146 Wn.2d 1, 9, 43 P.3d 4 (2002). The primary objective in interpreting a statute is to ascertain and give effect to the intent of the legislature. King County v. Taxpayers of King County, 104 Wn.2d 1, 5, 700 P.2d 1143 (1985). If the statute is unambiguous, we give effect to that plain meaning as an expression of legislative intent. Campbell & Gwinn, 146 Wn.2d at 9-10. "[T]he court should assume that the legislature means exactly what it says. Plain words do not require construction." City of Kent v. Jenkins, 99 Wn. App. 287, 290, 992 P.2d 1045 (2000) (internal quotation marks omitted) (quoting State v. McCraw, 127 Wn.2d 281, 288, 898 P.2d 838 (1995)).

The legislature enacted the Long-Term Care Insurance Act, chapter 48.84 RCW, in 1986.⁷ The Act governs the content and sale of long-term care insurance and

⁷ LAWS OF 1986, ch. 170. See also LAWS OF 2008, ch. 145; chapter 48.83 RCW (reenacted and amended Long-Term Care Insurance Act for policies issued after January 1, 2009).

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benefit contracts. RCW 48.84.010. RCW 48.84.010 states that the Act "shall be liberally construed to promote the public interest in protecting purchasers of long-term care insurance from unfair or deceptive sales, marketing, and advertising practices," and "[t]he provisions of this chapter shall apply in addition to other requirements of Title 48 RCW." RCW 48.18.130(2) provides that "[n]o insurance contract shall contain any provision inconsistent with or contradictory to any such standard provision used or required to be used."

RCW 48.84.910 sets forth the effective date of the Act. RCW 48.84.910 provides, in pertinent part:

RCW 48.84.060 shall take effect on November 1, 1986, and the commissioner shall adopt all rules necessary to implement RCW 48.84.060 by its effective date including rules prohibiting particular unfair or deceptive acts and practices in the advertising, sale, and marketing of long-term care policies and contracts. The commissioner shall adopt all rules necessary to implement the remaining sections of this chapter by July 1, 1987, and the remaining sections of this chapter shall apply to policies and contracts issued on or after January 1, 1988.

As required by RCW 48.84.910, the insurance commissioner filed regulations implementing the Act in July 1987. WAC 284-54-015 defines the application and scope of the regulations. WAC 284-54-015 provides, in pertinent part:

(1) Except as otherwise specifically provided, this chapter shall apply to every policy, contract, or certificate, and riders pertaining thereto, of an insurer, fraternal benefit society, health care service contractor, or health maintenance organization, if such contract is primarily advertised, marketed, or designed to provide long-term care services over a prolonged period of time, which services may range from direct skilled medical care performed by trained medical professionals as prescribed by a physician or qualified case manager in consultation with the patient's attending physician to rehabilitative services and assistance with the basic necessary functions of daily living for people who have lost some or complete capacity to function on their own. Such contract is "long-term care insurance" or a "long-term care contract," and is subject to this chapter.

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(3) Long-term care contracts not meeting the requirements of this chapter, may not be issued or delivered in this state after December 31, 1987.

The regulations expressly prohibit prior hospitalization as a condition of coverage. WAC 284-54-150 provides, in pertinent part:

No contract may be advertised, solicited, or issued for delivery in this state as a long-term care contract which does not meet the following standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(7) No insurer may offer a contract form which requires prior hospitalization as a condition of covering institutional or community based care.

Medico asserts that the nursing care policy issued to Bushnell is not a long-term care policy under the Act. We disagree. The policy clearly falls within the broad definition of a long-term care insurance policy. RCW 48.84.020(1) defines a long-term care insurance policy as:

[A]ny insurance policy or benefit contract primarily advertised, marketed, offered, or designed to provide coverage or services for either institutional or community-based convalescent, custodial, chronic, or terminally ill care.

The parties agree that the Act does not apply retroactively and that the three-day hospital stay requirement was valid when the policy was issued in January 1987. The question is whether renewal of the policy after the effective date of the regulations in January 1988 eliminated the three-day hospital stay requirement. Bushnell argues that when Evelyn renewed the insurance policy after the effective date of the regulations in January 1988, as a matter of law, there is a new agreement and the three-day hospital stay requirement no longer applied. Bushnell also points to the self-

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executing conformity clause in the policy to argue that the policy was amended and the hospital stay requirement eliminated. Part M(13) of the Medico policy provides:

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Medico argues the Act does not apply to renewals because the Act states that it only applies "to policies and contracts issued on or after January 1, 1988." Medico argues the language of the conformity clause means that the insurance policy cannot be amended after it is first issued.

The Washington Supreme Court in Tebb addressed the question of whether a renewal of an insurance policy creates a new contract that incorporates later enacted laws, or whether a renewal is only a continuation of the original terms of the policy. Tebb v. Cont'l Cas. Co., 71 Wn.2d 710, 712, 430 P.2d 597 (1967).

In Tebb, beginning in 1942, Tebb paid quarterly renewal premiums for an accident and health insurance policy. The policy did not have a provision for a grace period. Tebb, 71 Wn.2d at 711. The policy stated that it "may be renewed with the consent of the Company." Tebb, 71 Wn.2d at 713.

In 1951, the legislature passed a law requiring insurance policies to provide a 31-day grace period. Tebb, 71 Wn.2d at 712 (citing former RCW 48.20.062 (1951)).⁸ Tebb did not pay the premium due on September 1, 1964. On September 7, Tebb died in an accident. Tebb, 71 Wn.2d at 710-11. The insurance company denied benefits because the policy lapsed for nonpayment. Tebb, 71 Wn.2d at 711. The trial court granted summary judgment in favor of Tebb. Tebb, 71 Wn.2d at 711.

⁸ A shorter grace period applies for premiums paid monthly or weekly. RCW 48.20.062.

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On appeal, the Washington State Supreme Court affirmed. Tebb, 71 Wn.2d at 715. Quoting Appleman on Insurance Law & Practice, section 7648 at 419 (1943), the court held that unless a contrary intention is clearly shown, each time a policy is renewed, a new contract is formed.

A renewal contract has been stated by many jurisdictions to be a new, and a separate and distinct contract, unless the intention of the parties is shown clearly that the original and renewal agreements shall constitute one continuous contract.

Tebb, 71 Wn.2d at 713. The court states that the conclusion it reached was consistent with a previous decision, Perkins v. Associated Indemnity Corp., 189 Wn. 8, 63 P.2d 499 (1936), holding that a renewal accident policy issued from term to term is not a continuous policy. Tebb, 71 Wn.2d at 713-14.

The Tebb court decided that the right of the insurer to accept or reject the renewal was conclusive evidence that the parties intended to create a new contract "upon the acceptance of the renewal premium." Tebb, 71 Wn.2d at 714. Accordingly, the court held that because "upon each renewal a new contract is formed, hence, the statutory grace period was incorporated into the contract upon the acceptance of the renewal premiums." Tebb, 71 Wn.2d at 714.

The holding in Tebb is also consistent with Couch on Insurance, section 29:33 (3d ed. rev. 2010). In section 29:33, Couch states, in pertinent part:

Whether the renewal of a policy constitutes a new and independent contract or continuation of the original contract primarily depends upon the intention of the parties as ascertained from the instrument itself.

In the absence of any contrary statutory provision, the parties may effectively designate that the renewal policy shall be regarded as a continuation of the policy or that it shall not be so regarded. Accordingly, it has been held that the rule that a renewal policy constitutes a separate and distinct contract for the period of time covered by the renewal does

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not apply where the extension agreement shows a contrary intention as by stipulating that the original agreement "continues in force." Likewise, where a policy clearly stated that it terminated at the end of the policy period, a new contract with a new effective date was created each time the policy was renewed.

Here, the language of the policy does not indicate any intent that the original terms of the policy constitute one continuous contract or shall continue in force. To the contrary, the policy clearly states that each time the policy is renewed, "the new term begins when the old term ends." The policy states, in pertinent part:

Your coverage starts on the Policy Date at 12 o'clock noon standard time where you live. It ends at 12 o'clock noon on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.

Although under the renewal provision Medico cannot refuse to renew the policy,

Medico expressly reserves the right to not renew.

As long as you pay the renewal premium then in effect on the date it is due or during the 31-day grace period, we cannot refuse to renew your policy unless we do the same to all policies of this form issued to persons of your class (for example, age) in your state. Your policy stays in force during your grace period. No refusal of renewal will affect a claim existing in a confinement period.

We can change your premium only if we do the same to all policies of this form issued to persons of your class (for example, age) in your state and we will notify you in advance of the due date.

We conclude that under the terms of the long-term skilled nursing care policy issued by Medico to Bushnell, upon acceptance of each renewal premium, a new contract was formed. Accordingly, after the effective date of the regulations implementing the Act, the three-day hospital stay requirement no longer applied. Further, under the conformity clause of the policy, upon acceptance of Bushnell's

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renewal payment after implementation of the regulations in January 1988, the policy was amended to conform with state law.

In the alternative, Medico argues that regardless of whether the three-day hospital stay requirement applies, Bushnell is not entitled to coverage because the policy lapsed for nonpayment. There is no dispute that the final renewal premium covered the 60-day period from January 1, 2007 until February 28, 2007. There is also no dispute that the claim arose on February 24 when Evelyn was admitted to a nursing care facility, and that Bushnell submitted a claim to Medico for benefits under the policy on February 24.

Nonetheless, Medico argues that under the terms of the policy, Bushnell was only entitled to benefits after the required 20-day "elimination period," and because the benefits lapsed on March 1, Medico asserts it properly denied benefits.

The unambiguous terms of the policy do not support Medico's argument. The policy defines the "elimination period" as:

[T]he number of days for which benefits are eliminated in consideration for a reduced premium. The elimination period, if any, starts on the date that benefits would otherwise begin and it is in effect for the number of days shown on the Schedule.

The Schedule provides for a 20-day elimination period for skilled nursing care. Medico argues that after taking into account the 20-day elimination period, Bushnell was not entitled to benefits. However, Medico's argument ignores the 31-day grace period provided for in the policy. The policy unambiguously states that during the grace period, "[y]our policy stays in force."

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period. You always have your grace period unless

No. 63916-1-1/14

your policy will not be renewed. We will send you notice of nonrenewal at least 30 days before your premium is due.

Accordingly, even if the 20-day elimination period is taken into account, coverage did not lapse until after the grace period.

We reverse dismissal of Bushnell's claim for coverage under the policy, but remand on the question of whether Medico acted in bad faith. (Whether an insurer acts in bad faith is a question of fact. Safeco Ins. Co. of Am. v. Butler, 118 Wn.2d 383, 395, 823 P.2d 499 (1992).)

Bushnell requests attorney fees on appeal under Olympic Steamship Co., Inc. v. Centennial Insurance Co., 117 Wn.2d 37, 811 P.2d 673 (1991). Upon compliance with RAP 18.1, Bushnell is entitled to attorney fees under Olympic Steamship.

We reverse and remand.

Schweitzer, J.

WE CONCUR:

Edenborn, J.

Grosse, J.

APPENDIX-B

RECEIVED

MAR 18 2011

Schwabe Williamson & Wyatt

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

LEROY BUSHNELL, as personal
representative of the Estate of EVELYN
BUSHNELL,

Appellant,

v.

MEDICO INSURANCE COMPANY, a
Nebraska Corporation, and MEDICO
LIFE INSURANCE COMPANY, a
Nebraska Corporation,

Respondents.

No. 63916-1-I

ORDER DENYING MOTION
FOR RECONSIDERATION

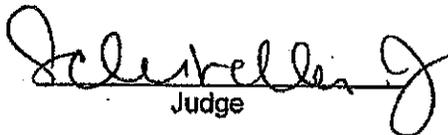
Respondents Medico Insurance Company and Medico Life Insurance
Company filed a motion for reconsideration of the opinion filed in the above
matter on February 7, 2011. A majority of the panel has determined this motion
should be denied.

Now, therefore, it is hereby

ORDERED that respondents' motion for reconsideration is denied.

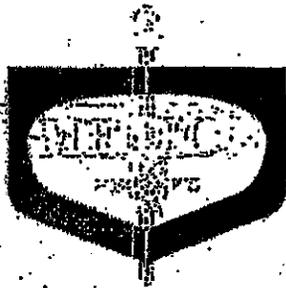
DATED this 17th day of March, 2011.

FOR THE COURT:


Judge

2011 MAR 17 PM 09:55

DUPLICATE



MEDICO LIFE INSURANCE COMPANY

Omaha, Nebraska - A Stock Company

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.**

The premium you, the Insured, paid put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

ALPHABETICAL GUIDE TO YOUR POLICY

Benefits	Part G, H, I & J	Other Important Provisions	Part M
Definitions	F	Payment Of Claims	L
Exceptions	D	Pre-Existing Conditions Limitation	C
How To File A Claim	K	Renewal Agreement	B
Maximum Benefits	E	Right To Return	A

PART A

PLEASE READ 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us or to the agent who sold it to you within 30 days after you receive it. We will return your money. That will mean your policy was never in force.

PART B

RENEWAL AGREEMENT

As long as you pay the renewal premium then in effect on the date it is due or during the 31-day grace period, we cannot refuse to renew your policy unless we do the same to all policies of this form issued to persons of your class (for example, age) in your state. Your policy stays in force during your grace period. No refusal of renewal will affect a claim existing in a confinement period.

We can change your premium only if we do the same to all policies of this form issued to persons of your class (for example, age) in your state and we will notify you in advance of the due date.

PART C

PRE-EXISTING CONDITIONS LIMITATION

Conditions you have had in the five years before your Policy Date are NOT covered until your policy has been in force at least six months. This applies to any injury you received or a sickness making itself known or medically treated within five years before your Policy Date. A sickness makes itself known when it would cause a prudent person to seek medical advice or treatment.

PART D

EXCEPTIONS

We will NOT pay benefits for:

- (1) loss while this coverage is not in force;
- (2) suicide or attempted suicide;
- (3) intentional, self-inflicted injury;
- (4) mental or nervous disorder in the absence of organic brain disease; and
- (5) services for which no charge normally is made.

SKILLED AND INTERMEDIATE NURSING POLICY

ML3355W

CP 630

3/85

PART E**MAXIMUM BENEFITS**

The maximum benefits we will pay during your lifetime are shown in the Schedule. After the maximum benefits have been paid, your coverage ends.

PART F**DEFINITIONS**

- (1) "Confinement Period" starts with the first full day you are confined in a covered facility and either receive benefits under this policy or would be qualified to receive benefits except for an elimination period. It ends when you are no longer confined in a covered facility. If you are in a confinement period, a return to the hospital for less than three days in a row will not start a new confinement period. A return to the hospital for three days in a row or more, however, will start a new confinement period.
- (2) "Elimination Period" means the number of days for which benefits are eliminated in consideration for a reduced premium. The elimination period, if any, starts on the date that benefits would otherwise begin and it is in effect for the number of days shown on the Schedule. Only one elimination period will be applied to any one confinement period.
- (3) "Home Confinement" means your continuous confinement while under the regular care and attendance of a physician (a) in your home or blood relative's home or (b) in that part of a hospital used as a convalescent or rest home or self-care facility. Visits to the doctor's office or hospital for diagnosis or treatment do not terminate confinement.
- (4) "Hospital" means a place licensed or recognized as a hospital by the appropriate authority of the state in which it is located. It does NOT mean that part of a hospital or institution which is licensed or used principally as a continued- or extended-care facility, convalescent nursing facility, nursing or rest home, or home for the aged. **NO BENEFITS ARE PAYABLE FOR HOSPITAL CONFINEMENT.**
- (5) "Injuries" mean accidental bodily injuries. They must be received while your policy is in force. Also, they must result in loss independent of sickness and other causes.
- (6) "Sickness" means a sickness or disease that first manifests itself more than 30 days after your Policy Date.
- (7) "Nursing Facility" (under Part G of this policy) means a facility or that part of one which: (a) is operated pursuant to law; (b) is engaged in providing, in addition to room and board accommodations, skilled nursing care or intermediate nursing care under the supervision of a duly licensed physician; (c) provides continuous 24-hour-a-day nursing service by or under the supervision of a graduate professional registered nurse (R.N.) or licensed practical nurse (L.P.N.); and (d) maintains a daily medical record of each patient.
It is NOT a place that is primarily used for: rest; the care and treatment of mental diseases or disorders; drug addiction or alcoholism; or custodial or educational care.
- (8) "Skilled Nursing Care" means active nursing and/or restorative rehabilitation services given to treat an unstable health condition. There must be a care plan for the patient's recovery which is carried out on a daily basis. A physician must certify that you need such care. These services must medically require the skills of licensed or certified technical or professional personnel pending stabilization.
It is NOT: supportive services of a stabilized condition; care which can be learned and given by unlicensed or uncertified medical personnel; routine health care services; general maintenance; routine administration of oral or nonprescription drugs; or general supervision of routine daily activities.
- (9) "Intermediate Nursing Care" means nursing care ordered by a physician to treat a covered injury or sickness. This care must be given, under the supervision of a physician, by licensed or certified nursing personnel. These services include, but are not limited to: active nursing or maintenance therapy; a care plan less than the level of skilled nursing care; supervision of a stabilized health condition; or environmental control to insure the patient's safety. A physician must certify that you need such care. It does NOT include skilled nursing or custodial care.

- (10) "Custodial Care Facility" means a facility or that part of one that regularly provides room, board, and personal help in feeding, dressing and other essential daily living activities. It must give care to three or more residents who, not needing daily nursing care, cannot properly care for themselves due to age, sickness, disease, or physical or mental impairment. The facility must be licensed by the state in which it is located to provide such custodial care. The owner or administrator cannot be related to you by blood or marriage.
- (11) "Custodial Care" means that care usually given to residents of a custodial care facility who, not needing daily nursing care, cannot properly care for themselves due to age, sickness, disease, or physical or mental impairment. A physician must certify that you need such care.
- (12) "Physician" means a licensed practitioner of the healing arts acting within the scope of his/her license.
- (13) "Schedule" is attached to and is a part of this policy.
- (14) "You" or "Your" means the Insured named in the Schedule.
- (15) "We," "Us" or "Our" means Medico Life Insurance Company.

PART G

SKILLED NURSING CARE AND INTERMEDIATE NURSING CARE BENEFITS

To be eligible to receive benefits under Part G(a) and Part G(b), your confinement must:

- (1) be in a Nursing Facility;
- (2) be recommended by a physician;
- (3) start within 14 days after required hospital confinement of at least three days in a row; and
- (4) be for the continued treatment of the condition(s) for which you were in the hospital.

G(a) SKILLED NURSING CARE BENEFIT

When you are confined and get Skilled Nursing Care, we will pay the benefit shown in the Schedule subject to any elimination period shown in the Schedule. The maximum number of days payable in a confinement period and during your lifetime is shown in the Schedule.

Every 30 days during this time, your physician must certify that Skilled Nursing Care is still needed. The physician cannot be a proprietor or employee of the Nursing Facility. The director or administrator must certify you actually receive this level of care.

G(b) INTERMEDIATE NURSING CARE BENEFIT

When you are confined and get Intermediate Nursing Care, we will pay the benefit shown in the Schedule. The benefit we pay will be subject to any elimination period shown in the Schedule for a confinement period. The maximum number of days payable in a confinement period and during your lifetime is shown in the Schedule.

PART H

CUSTODIAL CARE BENEFIT

When you are confined in a Custodial Care Facility and get Custodial Care, we will pay the benefit shown in the Schedule. The maximum number of days payable in a confinement period is shown in the Schedule. The confinement must:

- (1) begin immediately after confinement in a Nursing Facility for which we paid you Skilled Nursing Care or Intermediate Care benefits for 20 or more days in a row; and
- (2) be for the continued treatment of the condition(s) for which you were in the Nursing Facility.

PART I

HOME CONFINEMENT BENEFIT

When you are confined at home immediately after a hospital stay of at least three days in a row, we will pay you the benefit shown in the Schedule. We will pay up to the same number of days as your prior hospital stay.

Your reinstated policy will cover only loss due to accidental injury that begins after the date your policy was put in force. Also, it will cover only loss due to sickness that begins more than ten days after the date the policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to the policy. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid. But it will not be used for any period more than 60 days before the reinstatement date.

- (6) **Physical Examination:** We, at our expense, can have you examined as often as needed while a claim is pending.
- (6) **Legal Action:** You can't bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can't start such an action more than three years (five years in Kansas) after the date written proof of loss is required.
- (7) **Change of Beneficiary; Assignment:** Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.
- (8) **Misstatement of Age:** If your age has been misstated, the amount payable will be that which the premium would have bought at the correct age.
- (9) **Intoxicants and Narcotics:** We will not be liable for loss sustained because of your being intoxicated. Nor will we be liable for loss sustained because of your being under the influence of a narcotic. This provision will not apply to narcotics given on the advice of a physician.
- (10) **Illegal Occupation:** We will not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony. Nor will we be liable for any loss to which a contributing cause was your being engaged in an illegal occupation.
- (11) **Other Insurance With Us:** You may have only one policy like this one at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.
- (12) **Term of Coverage:** Your coverage starts on the Policy Date at 12 o'clock noon standard time where you live. It ends at 12 o'clock noon on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.
- (13) **Conformity With State Statutes:** The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

This policy is signed in our behalf by our President and Secretary.

A. L. Bloomingdale

Secretary

William M. Brock

President

MEDICO™ LIFE INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NE 68124

DUPLICATE
SCHEDULE

POLICY NO. - 0B78225

POLICY TYPE - 3355

INSURED - EVELYN R BUSHNELL
 ZL F BUSHNELL
 PO BOX 1450
 ISSAQUAH WA 98027-0059

POLICY DATE..... 10/09/1986

RENEWAL PREMIUMS	
60-DAY.....	\$124.50
SEMI-ANNUAL.....	\$373.50
ANNUAL.....	\$684.30

POLICY LIFETIME MAXIMUM BENEFITS.....	\$190,000.00
LIFETIME MAXIMUM BENEFIT DAYS PAYABLE	
SKILLED NURSING CARE.....	2190
INTERMEDIATE NURSING.....	360
ELIMINATION PERIOD FOR ANY ONE	
CONFINEMENT PERIOD.....	20 DAYS
SKILLED NURSING CARE DAILY BENEFIT	
FIRST 20 DAYS IN A CONFINEMENT PERIOD.....	\$.00
21ST DAY UP TO 101ST DAY.....	\$40.00
101ST DAY THRU 2210TH DAY.....	\$80.00
INTERMEDIATE NURSING CARE DAILY BENEFIT	
FIRST PAYABLE DAY IN A CONFINEMENT PERIOD THRU 180 DAYS.	\$20.00
181ST THRU 360TH PAYABLE DAY.....	\$40.00
CUSTODIAL CARE DAILY BENEFIT.....	\$15.00
MAXIMUM DAYS PER CONFINEMENT PERIOD.....	180
HOME CONFINEMENT DAILY BENEFIT.....	\$15.00
AMBULANCE BENEFIT.....	\$25.00

POLICY 3355 PLAN 3 OPTION B

ENDORSEMENT

MEDICO™ LIFE INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NE 68124

POLICY NUMBER - 0B78225

RIDER PAGE 1 OF 1

AMENDING RIDER

This rider is a part of the policy to which it is attached. It makes the following change in your policy.

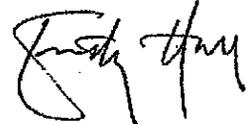
The provision "Misstatement of Age" found in your policy is replaced by the following provision:

Misstatement of Age or Sex: If a covered person's age or sex has been misstated, the amount payable will be that which the premium would have bought at the correct age or sex.

UR-FL-459

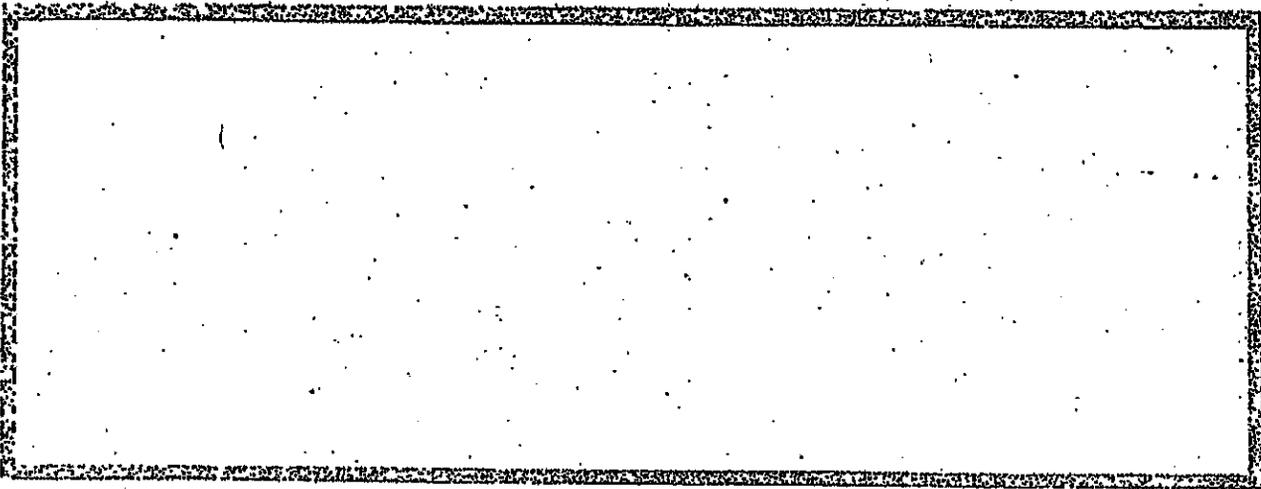
4/83

ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.



CP 136

President
Appendix C - Page 7 of 9



Countersigned by _____

DUPLICATE

Licensed Resident Agent



**MEDICO
LIFE
INSURANCE
COMPANY**

Omaha, Nebraska
A Stock Company

**SKILLED AND
INTERMEDIATE
NURSING POLICY**

ML3955V

3/95



CP 037



MEDICO GROUP

Medico™ Insurance Company
Medico™ Life Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

**PRIVACY NOTICE TO MEDICO™ INSURANCE COMPANY AND
MEDICO™ LIFE INSURANCE COMPANY
POLICYHOLDERS/CERTIFICATEHOLDERS**

Your privacy is our concern. Certain laws regulate the collection, use and disclosure of a consumer or customer's nonpublic information. Medico™ Insurance Company and Medico™ Life Insurance Company do not sell or otherwise disclose any nonpublic personal information about our customers or former customers to anyone outside the Medico™ Group Family, except as permitted by law. ***You don't need to take any action to prevent disclosure;*** this notice is solely for your information.

General Privacy Information: It is the policy of Medico™ Insurance Company and Medico™ Life Insurance Company, their independent agents and those companies whose policies/certificates we administer together with ours to:

- Collect only information necessary or relevant to our business.
- Make a reasonable effort to ensure that information we act upon is accurate, relevant, timely and complete.
- Use only legitimate means to collect information.
- Make personal information available externally only to respond to legitimate business needs, to regulatory or other government authorities or as otherwise permitted by law.
- Limit employees' access to those who need to and are trained in the proper handling of personal information.
- Require anyone outside our corporate family (nonaffiliates) who perform services for us to conform to our privacy standards. We also require them not to use your nonpublic personal information for any other purpose.
- Not to disclose your nonpublic personal information to others for their own marketing purposes.
- Not to reveal your health, character, personal habits or reputation to anyone for marketing purposes.

The following summary explains the kinds of information that Medico™ Insurance Company and Medico™ Life Insurance Company or their agents may collect, what is done with the information and how you can find out about information, if any, we have about you in our records.

What kind of information do we collect about you and from whom? Most of our information comes directly from you. The application you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage from outside sources, such as medical records, credit reports, court records or other public records. We also might obtain information from third parties, such as other insurance companies or financial institutions that you have notified us of.

What do we do with the information collected about you? The information is kept with your application/policy or certificate records. We review it in evaluating your request for insurance coverage and in determining your rates. We will also refer to and use information in our policy/certificate records for purposes related to issuing and servicing insurance policies/certificates and settling claims. Your agent may use information about you in his/her files for insurance marketing purposes or to help you with your overall insurance program.

APPENDIX-D

Rev. Code Wash. (ARCW) § 48.84.030

ANNOTATED REVISED CODE OF WASHINGTON
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*** STATUTES CURRENT THROUGH THE 2010 REGULAR AND 2ND SPECIAL
SESSIONS ***

*** AND RESULTS OF NOVEMBER 2010 ELECTION ***

TITLE 48. INSURANCE
CHAPTER 48.84. LONG-TERM CARE INSURANCE ACT

GO TO REVISED CODE OF WASHINGTON ARCHIVE DIRECTORY

Rev. Code Wash. (ARCW) § 48.84.030 (2011)

§ 48.84.030. Rules -- Benefits-premiums ratio, coverage limitations

(1) The commissioner shall adopt rules requiring reasonable benefits in relation to the premium or price charged for long-term care policies and contracts which rules may include but are not limited to the establishment of minimum loss ratios.

(2) In addition, the commissioner may adopt rules establishing standards for long-term care coverage benefit limitations, exclusions, exceptions, and reductions and for policy or contract renewability.

APPENDIX-E

Rev. Code Wash. (ARCW) § 48.84.910

ANNOTATED REVISED CODE OF WASHINGTON
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*** STATUTES CURRENT THROUGH THE 2010 REGULAR AND 2ND SPECIAL
SESSIONS ***

*** AND RESULTS OF NOVEMBER 2010 ELECTION ***

TITLE 48. INSURANCE
CHAPTER 48.84. LONG-TERM CARE INSURANCE ACT

GO TO REVISED CODE OF WASHINGTON ARCHIVE DIRECTORY

Rev. Code Wash. (ARCW) § 48.84.910 (2011)

§ 48.84.910. Effective date, application -- 1986 c 170

RCW 48.84.060 shall take effect on November 1, 1986, and the commissioner shall adopt all rules necessary to implement RCW 48.84.060 by its effective date including rules prohibiting particular unfair or deceptive acts and practices in the advertising, sale, and marketing of long-term care policies and contracts. The commissioner shall adopt all rules necessary to implement the remaining sections of this chapter by July 1, 1987, and the remaining sections of this chapter shall apply to policies and contracts issued on or after January 1, 1988.

HISTORY: 1986 c 170 § 10.

APPENDIX-F

WAC § 284-54-150

Washington Administrative Code
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***** THIS FILE INCLUDES ALL RULES ADOPTED AND FILED THROUGH THE

***** 11-06 WASHINGTON STATE REGISTER DATED MARCH 16, 2011 *****

**TITLE 284. INSURANCE COMMISSIONER, OFFICE OF
CHAPTER 54. LONG-TERM CARE INSURANCE RULES**

WAC § 284-54-150 (2011)

WAC 284-54-150. Minimum standards--General.

No contract may be advertised, solicited, or issued for delivery in this state as a long-term care contract which does not meet the following standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

- (1) No contract shall limit benefits to an unreasonable period of time or an unreasonable dollar amount. For example, a provision that a particular condition will be covered only for one year without regard to the actual amount of the benefits paid or provided, is not acceptable. Policies or contracts may, however, limit in-patient institutional care benefits to a reasonable period of time. Benefits may also be limited to a reasonable maximum dollar amount, and, as for example in the case of home health care visits, to a reasonable number of visits over a stated period of time.
- (2) If a fixed-dollar indemnity, fee for services rendered or similar long-term care contract contains a maximum benefit period stated in terms of days for which benefits are paid or services are received by the insured, the days which are counted toward the benefit period must be days for which the insured has actually received one or more contract benefits or services. If benefits or services are not received on a given day, that day may not be counted. Waiver of premium shall not be considered a contract benefit for purposes of accrual of days under this section, and long-term care total disability shall not operate to reduce the benefit.
- (3) If a contract of a managed health care plan contains a maximum benefit

period it must be stated in terms of the days the insured is in the managed care delivery system. The days which are counted toward the benefit period may include days that the insured is under a care plan established by the case manager, or days in which the insured actually receives one or more benefits or services.

(4) A long-term care contract must cover skilled, intermediate, and custodial or personal care, whether benefits are for institutional or community based care.

(5) No contract may restrict or deny benefits because the insured has failed to meet Medicare beneficiary eligibility criteria.

(6) No insurer may offer a contract form which requires prior skilled or intermediate care as a condition of coverage for institutional or community based care.

(7) No insurer may offer a contract form which requires prior hospitalization as a condition of covering institutional or community based care.

(8) No long-term care contract may restrict benefit payments to a requirement that the patient is making a "steady improvement" or limit benefits to "recuperation" of health.

(9) All long-term care contracts shall be issued as individual or family contracts only, unless coverage is provided pursuant to a group contract, issued to a bona fide group, which contract provides continuity of coverage equivalent to that which would be provided under a guaranteed renewable individual contract, and otherwise satisfies the commissioner that it is not contrary to the best interests of the public.

Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. 94-14-100 (Order R 94-10), § 284-54-150, filed 7/6/94, effective 8/6/94. Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-150, filed 7/9/87.

APPENDIX-G



MEDICO GROUP

Medico Insurance Company • Medico Life Insurance Company

June 20, 2007

COPY

Evelyn R. Bushnell
%L F Bushnell
Po Box 1450
Issaquah, WA 98027

Policy Number: 0B78225

Dear Mrs. Bushnell;

In order for benefits to be provided under this policy, certain requirements must be met. Based on the information received from Lake Vue Gardens, it has been determined that these policy requirements have not been met for the nursing facility care you have been receiving since 02-24-2007. Please let me take a moment to explain this claims determination.

Per policy terms, benefits for skilled or intermediate care will be payable as long as the insured meets the following conditions:

- 1.) Be in a nursing facility;
- 2.) Be recommended by a physician;
- 3.) Start within 14 days after required hospital confinement of at least 3 days in a row;
- 4.) Be for the continued treatment of the conditions for which they were in the hospital.

Based on the documentation received from Lake Vue Gardens, you were admitted directly in the nursing facility from your home. Since you did not have a prior hospitalization for at least 3 days before your admit into Lake Vue Gardens, the policy requirements have not been met and benefits cannot be provided at this time.

Also, please be advised that your long term care policy lapsed on 03-01-07 as we did not receive a renewal premium from you.

If there is any additional information that you feel would affect the handling of this claim, please submit copies of the medical documentation in the yellow envelope that is provided and we will be happy to reconsider this claims determination.

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6900 • fax (402) 391-6489 • www.gomedica.com

Reproduced Image for Policy 0B78225, BUSHNELL, Claim Number 980003

10/24/2007

Page 126

Reproduced Image for Policy 0B78225, BUSHNELL, Claim Number

CP047

12/17/2007

Page 5

Appendix G - Page 1 of 2



COPY

MEDICO GROUP

Medico Insurance Company • Medico Life Insurance Company

I am sorry that I could not write to you more favorable at this time. If you should have any questions or concerns regarding this information, please do not hesitate to contact me directly at 402-391-6900 Ext-339.

Sincerely,

Kimberly A. Jackson
Claims Service Department

Protecting Your Future Today*

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6900 • fax (402) 391-6489 • www.gomedico.com

Reproduced Image for Policy 0B78225, BUSHNELL, Claim Number 980003

10/24/2007

Page 128

Reproduced Image for Policy 0B78225, BUSHNELL, Claim Number

CP048

12/17/2007

Page 6

Appendix G - Page 2 of 2

FOR YOUR INFORMATION RECEIVED
KEOLKER & SWERK 2009 JUN -4 AM 11:31

KING COUNTY
SUPERIOR COURT CLERK
SEATTLE, WA

The Honorable John Erlick
Date: June 4, 2009
Time: 9:00a.m.

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BADGLEY-MULLINS LAW GRP

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SUPERIOR COURT OF WASHINGTON
IN AND FOR THE COUNTY OF KING

EVELYN R. BUSHNELL, individually, and
LEROY F. BUSHNELL, individually, as
attorney in fact, and as guardian ad litem for
EVELYN R. BUSHNELL,

Plaintiff,

v.

MEDICO INSURANCE COMPANY, a
Nebraska Corporation, and MEDICO LIFE
INSURANCE COMPANY, a Nebraska
Corporation,

Defendants.

No. 07-2-38744-7SEA

^{Defendants'}
ORDER GRANTING ~~PLAINTIFF'S~~
MOTION FOR ~~PARTIAL~~ SUMMARY
JUDGMENT AND DENYING ~~Plaintiff's~~
~~DEFENDANTS' CROSS~~-MOTION FOR
SUMMARY JUDGMENT

[PROPOSED]

THIS MATTER having come before the court on Plaintiff's Motion for Summary
Judgment and Defendants' Motion for Summary Judgment, and having reviewed the
following pleadings:

1. Plaintiff's Motion for Summary Judgment;
2. Declaration of Randall C. Johnson in Support of Plaintiff's Motion for Summary
Judgment and attachments thereto;
3. Defendants Response and Counter Motion for Summary Judgment;

ORDER GRANTING ^{Defendants'} ~~PLAINTIFF'S~~ MOTION FOR
SUMMARY JUDGMENT - 1

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- 4. Declaration of Donald K. Lawler and attachments thereto;
- 5. Defendants' Motion for Summary Judgment;
- 6. Defendants' Opposition to Plaintiff's Motion for Summary Judgment;
- 7. Declaration of Celeste T. Stokes in Support of Defendants' Opposition to Plaintiff's Motion for Summary Judgment and attachments thereto;
- 8. Declaration of Donald Lawler and attachments thereto;
- 9. Defendants' Supplemental Opposition to Plaintiff's Motion for Summary Judgment;
- 10. Supplemental Declaration of Donald Lawler and attachments thereto;
- 11. Declaration of Counsel Supporting Defendants' Supplemental Opposition to Summary Judgment and attachments thereto; and
- 12. Plaintiffs' Response in Opposition to Defendants' Motion for Summary Judgment.

The Court having heard oral arguments, and having reviewed the files and pleadings herein, it is hereby ORDERED that ~~Plaintiff's~~ ^{Defendants'} Motion for ~~Partial~~ Summary Judgment is GRANTED and ~~Defendants' Cross-Motion~~ ^{Plaintiff's} Motion for Summary Judgment is DENIED.

It is further ORDERED, ADJUDGED, and DECREED that:

- 1. The hospital stay requirement found in Ms. Bushnell's policy is ~~invalid~~ ^{not} and Ms. Bushnell is entitled to coverage as a matter of law. JPE
- 2. Medico's denial of coverage was ~~unreasonable~~ ^{not} and in bad faith, and in violation of Washington law.
- 3. The case is dismissed with prejudice. JPE

ORDER GRANTING ~~PLAINTIFF'S~~ ^{Defendants'} MOTION FOR SUMMARY JUDGMENT - 2

CP 368

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3. ~~Plaintiff is granted a trebling of damages proven at trial pursuant to RCW
48.30.015.~~

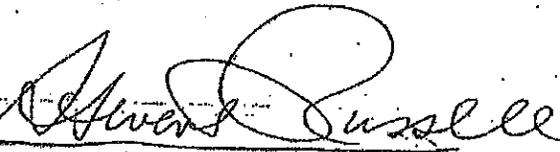
4. ~~Plaintiff is granted leave to file a supportive declaration attesting to fees for a
reasonableness hearing.~~

Done in open Court this 4th day of June, 2009.


JUDGE JOHN ERLICK

Presented By:


Randall C. Johnson, WSBA # 24556
Mark K. Davis WSBA # 38713
Attorneys for Plaintiff Leroy Bushnell


Steven Russell, WSBA # 6987
Celeste Stokes, WSBA # 12180

Defendants:
ORDER GRANTING PLAINTIFF'S MOTION FOR
SUMMARY JUDGMENT - 3

CP 369

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APPENDIX-I

No. 63916-1-I

COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION I

LEROY BUSHNELL, as the Personal Representative
of the Estate of EVELYN BUSHNELL, Deceased,

Appellant,

v.

MEDICO INSURANCE COMPANY, a Nebraska Corporation and
MEDICO LIFE INSURANCE COMPANY, a Nebraska Corporation,

Respondents.

BRIEF OF RESPONDENTS

Celeste T. Stokes, WSBA #12180
Robert W. Swerk, II, WSBA #6665

Attorneys for Respondents
7016 35th Avenue NE
Seattle, WA 98115-5917
(206) 522-7633

In this case, both sides were moving parties. The claims process and investigation in this case was not disputed. Failure to pay premiums was not disputed. The appellate court will make the same inquiry as the trial court. *See, e.g.* CR 56(c). It will view the facts and their reasonable inferences. *Degel v. Majestic Mobile Manor, Inc.*, 129 Wn.2d 43, 48, 914 P.2d 728 (1996). The reasonable inferences from the undisputed facts are that Medico properly and timely investigated the claim, complied with the law, and denied the claim in good faith.

B. THE POLICY LAPSED FOR NON-PAYMENT.

This appeal can be easily decided on the issue of payment. "[T]he general rule is that failure of an insured to pay a renewal premium by the due date results in a lapse of coverage as of the last day of the policy period." *Safeco Ins. Co. v. Irish*, 37 Wn. App. 554, 557, 681 P.2d 1294 (1984). Ms. Bushnell never paid any policy premiums for any coverage period after February 28, 2007. This fact has never been disputed. In fact, Appellant admits that no premiums were paid after Ms. Bushnell went into the nursing home. (Appellant's brief at page 7) Medico denied coverage based on the failure to pay policy premiums. (CP 47)

Medico raised this issue below. (CP 166-67) Appellant never responded to this issue at that time. Again on appeal, Appellant has not cited any law that allows coverage when there has been no payment. The

Policy was clear in requiring payment of premiums as a condition of coverage and warning that the Policy would lapse for non-payment. (CP 30, 33, Part B and Part M (3) & (4)) The Policy lapsed as of March 1, 2007, for non-payment.

Furthermore, there was no coverage for any days prior to the policy lapsing on March 1, 2009, because of the 20-day "Elimination Period." Coverage would have only been effective after the elimination period ran on March 16, 2007 (twenty days after February 24, 2007, the date Ms. Bushnell entered Lake Vue). The Policy had lapsed for non-payment before that date. It must be noted that the "Elimination Period" does not eliminate the duty to pay premiums.

Appellant seems to be arguing that Medico claimed the policy lapsed somehow based on the date the claim was made. (Appellant's brief at 19.) This is not correct. Medico never raised any issue about the timing of Ms. Bushnell's notice of claim. Medico has only raised "lapse" as a basis for denial of the claim because of non-payment of the required premiums.

There was no coverage for Ms. Bushnell because she failed to pay her premiums and coverage was properly denied on that basis.

C. THE HOSPITALIZATION CLAUSE WAS A VALID
CONDITION OF COVERAGE IN THE POLICY WHICH
WAS ISSUED PRIOR TO THE EFFECTIVE DATE OF

NO. 63916-1-I
COURT OF APPEALS
DIVISION I
OF THE STATE OF WASHINGTON

LEROY BUSHNELL, a personal representative of the Estate of EVELYN
BUSHNELL,

Plaintiff-Appellant,

vs.

MEDICO INSURANCE COMPANY, a Nebraska corporation, and
MEDICO LIFE INSURANCE COMPANY, a Nebraska corporation,

Defendant-Appellees.

APPELLEE MEDICO'S MOTION FOR RECONSIDERATION

Christopher H. Howard, WSBA #11074
Averil Rothrock, WSBA #24248
Colin Folawn, WSBA #34211
Virginia R. Nicholson, WSBA #39601
SCHWABE, WILLIAMSON & WYATT, P.C.
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Attorneys for Defendant-Appellees

regarding insurance contracts.

C. Because Ms. Bushnell's policy lapsed for non-payment, the benefit period under which Ms. Bushnell is eligible is March 16, 2007, through March 31, 2007.

This Court appears to have assumed a waiver of premium provision that is not in Ms. Bushnell's policy. An insurance policy is a contract.⁴⁰ Interpretation of an insurance contract is a matter of law.⁴¹ A court may not give an insurance contract a strained or forced construction that would lead to an extension or restriction of the policy beyond what is fairly within its terms.⁴² "Clear and unambiguous policy language must be enforced as written."⁴³ Here, Ms. Bushnell was required regularly to pay premiums, regardless of claims filed. Her failure to keep the payments current supported dismissal of her claim.

In its opinion, this Court did not specifically instruct the trial court to enter judgment on the contract claim, stating only, "We reverse dismissal of Bushnell's claim for coverage under the policy, but remand on the question whether Medico acted in bad faith."⁴⁴ It may be that the issue of liability on the contract claim remains open for further litigation

⁴⁰ See *Woo v. Fireman's Fund Ins. Co.*, 161 Wn.2d 43, 52, 164 P.3d 454 (2007); *Stouffer & Knight v. Continental Co.*, 96 Wn. App. 741, 747, 982 P.2d 105 (1999).

⁴¹ *Stouffer*, 96 Wn. App. at 747.

⁴² *Teague Motor Co. v. Federated Serv. Ins. Co.*, 73 Wn. App. 479, 482, 869 P.2d 1130 (1994).

⁴³ *Id.*

⁴⁴ Opinion at 14.

before the trial court, and the lapse issue can be revisited by the trial court. Clarification is sought. If the opinion forecloses further consideration of coverage, Medico urges reconsideration because the lapse for nonpayment supports a very limited coverage period.

1. Ms. Bushnell's continued payment of policy premiums were required regardless of claims filed

A waiver of premium clause is a contract provision that suspends the premium payment upon proper notice of a claim.⁴⁵ Ms. Bushnell's policy does not contain a waiver of premium clause.⁴⁶ Appellants have never claimed that Ms. Bushnell's insurance policy contained a waiver of premium provision. Ms. Bushnell's contract provides further: "We will NOT pay benefits for: (1) loss while this coverage is not in force"⁴⁷

If this Court has remanded only for a determination of bad faith claims, and impliedly has instructed the trial court to enter judgment on the coverage claim,⁴⁸ then this Court overlooked analyzing whether Ms. Bushnell was entitled to any benefit after her policy had lapsed. She is not. The Court's analysis assumes a waiver of premium such that Ms. Bushnell was not required to continue payment under the policy after her claim was

⁴⁵ See, e.g., 5 COUCH ON INSURANCE 3D, § 75:20, at 75-40 (stating that "The effect of the waiver of premiums clause is to waive the insured's obligation to pay the specified premiums where notice of the required degree of disability is given within the required time.").

⁴⁶ CP 030-038.

⁴⁷ CP 030 at Part D(1).

⁴⁸ See Opinion at 14. The remand instructions appear ambiguous.

filed. This is contrary to the insurance contract. The contract does not contain a waiver of premium provision. A court may not extend a policy beyond what is fairly within its terms.⁴⁹ In order for the policy to continue, and the benefits to be paid under Ms. Bushnell's policy, the premiums had to be paid.⁵⁰

Appellant's reference, without citation, to the known loss doctrine does not prove otherwise.⁵¹ "Known loss' relieves an insurer of liability where the insured had knowledge of the risk or loss prior to the time the policy bound."⁵² The known loss doctrine has no effect on the contractual provisions at issue in Ms. Bushnell's insurance contract, nor does it have any application here. This loss was not known to either side when the contract was entered into. Ms. Bushnell's insurance required payment of premiums to remain in effect, regardless of any claims submitted or benefits paid. To construe otherwise is to add a provision to Ms. Bushnell's contract that does not exist and is an error of law.

2. Ms. Bushnell's last premium payment was made on February 1, 2007, and she received proper notice of the policy's impending lapse.

Ms. Bushnell's policy states "Your policy will lapse if you do not

⁴⁹ *Teague Motor Co.*, 73 Wn. App. at 482.

⁵⁰ CP 030-038.

⁵¹ Appellant's Reply Brief at 3 n.2.

⁵² *Mut. of Enumclaw Ins. Co. v. USF Ins. Co.*, 164 Wn.2d 411, 418 n.2, 191 P.3d 866 (2008).

pay your premium before the end of the grace period.”⁵³ The general rule is that failure of an insured to pay a renewal premium by the due date results in a lapse of coverage as of the last day of the policy period.⁵⁴ Ms. Bushnell failed to pay a renewal premium by March 1, 2007. Her coverage lapsed as of the last day of the policy period, February 28, 2007.

It is undisputed that the last payment Ms. Bushnell made was on February 1, 2007.⁵⁵ Ms. Bushnell was sent a reminder notice on February 1, 2007, and a “Past Due Notice” on March 12, 2007.⁵⁶ Ms. Bushnell had the opportunity to continue coverage under the policy but failed to do so. No further payments were made. With no payments for coverage, the coverage was no longer in force as of February 28, 2007 (with the exception of the Grace Period, which is discussed next).⁵⁷ She would be entitled to no payments after that date.

3. Ms. Bushnell’s benefits were extended by application of the policy’s Grace Period and limited by application of the policy’s Elimination Period.

Ms. Bushnell’s policy contains a 31-day grace period: “Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace

⁵³ CP 033 at Part M(4).

⁵⁴ *Safeco Ins. Co. v. Irish*, 37 Wn. App. 554, 558, 681 P.2d 1294 (1984).

⁵⁵ CP 615.

⁵⁶ CP 552–53, CP 556–58.

⁵⁷ CP 030 at Part D(1).

period.”⁵⁸ Thus, regardless of lack of payment, Ms. Bushnell’s policy remained in force until March 31, 2007, but no longer.

Ms. Bushnell’s policy also contains a 20-day elimination period, which is the “number of days for which benefits are eliminated in consideration for a reduced premium.”⁵⁹ The period starts on the date the benefits would otherwise begin and is in effect for 20 days.⁶⁰ The 20-day elimination period began upon the date of the claim, February 24, 2007, and was in effect for 20 days. Thus, Ms. Bushnell is not eligible for benefits until after the 20-day elimination period ended on March 16, 2007.

The entire contract must be construed to give force and effect to each clause.⁶¹ Applying all the applicable provisions of Ms. Bushnell’s policy, Ms. Bushnell would be eligible for benefits only for the period of March 16, 2007, through March 31, 2007.⁶²

D. Because Ms. Bushnell’s policy is a continuing policy and, in addition lapsed, denial of benefits was made in good faith.

If the Court reconsiders based on the above, this Court’s remand for a determination of bad faith also should be revised. Medico’s denial of benefits under Ms. Bushnell’s policy was valid and done in good faith.

⁵⁸ CP 033 at Part M(3).

⁵⁹ CP 031 at Part F(2).

⁶⁰ *Id.*

⁶¹ *Stouffer*, 96 Wn. App. at 749.

⁶² *Id.*

71 Wn.2d 710, *; 430 P.2d 597, **;
1967 Wash. LEXIS 1006, ***

Helen R. Tebb, as Executrix, Respondent, v. Continental Casualty Company, Appellant

No. 38963

SUPREME COURT OF WASHINGTON, Department One

71 Wn.2d 710; 430 P.2d 597; 1967 Wash. LEXIS 1006

July 27, 1967

CASE SUMMARY

PROCEDURAL POSTURE: Appellant insurer challenged a judgment of the Superior Court for Pierce County (Washington), which found in favor of respondent testatrix in her action to claim the proceeds of an accident and health insurance policy. The insurer admitted all material allegations in its answer, but set up the affirmative defense that a premium had not been paid and the policy had lapsed. Summary judgment was granted in favor of the testatrix.

OVERVIEW: The testatrix's husband's insurance premium was paid for the quarter beginning June 1, 1964, but no payment was made on or before September 1, 1964 for that quarter. The husband died September 7, 1964. The policy had no grace period. On appeal, the court affirmed the trial court's judgment. The court noted that if a new insurance contract was entered into by virtue of the insured paying his insurance premium for the next quarter, the grace period provided by Wash. Rev. Code § 48.18.510 was incorporated therein. The court found that the husband's policy gave the insurer the option to accept or reject any renewal premium so there was no automatic continuation of the policy by payment of premiums. The insurer had the right to exercise its discretion in granting a renewal of the policy. On each reinstatement or renewal of the policy, any statutes or an amendment pertaining to the policy and enacted after its issuance were incorporated into the new policy. The court therefore concluded that the insured was entitled to the 31-day grace period provided by Wash. Rev. Code § 48.18.510 and that the statute was operative as to him.

OUTCOME: The court affirmed the trial court's judgment, which had granted the testatrix's motion for summary judgment.

CORE TERMS: renewal, premium, grace period, new contract, continuous, insurer, coverage, insurance policy, insured, quarterly, continuation, policy issued, renewable, insurance contracts, term policy, statutory provision, continuously, lapsed, renew, insurance coverage, summary judgment, default, renewed, died

LEXISNEXIS® HEADNOTES

[Hide](#)

Insurance Law > Claims & Contracts > Premiums > Grace Periods 

Insurance Law > Disability Insurance > Time Limitations 

HN1 In 1951 the Washington legislature passed a law requiring a grace period in disability insurance policies, 1951 Wash. Laws ch. 229, § 7, p. 708. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

Insurance Law > Disability Insurance > Time Limitations 

HN2 See 1951 Wash. Laws ch. 229, § 7, p. 708.

Insurance Law > Claims & Contracts > Contract Formation

HN3 A renewal of a term policy is in effect a new contract of insurance and must have all the essentials of a valid contract. More Like This Headnote | *Shepardize: Restrict By Headnote*

Insurance Law > Claims & Contracts > Contract Formation

HN4 A renewal contract has been stated by many jurisdictions to be a new, and a separate and distinct contract, unless the intention of the parties is shown clearly that the original and renewal agreements shall constitute one continuous contract. More Like This Headnote | *Shepardize: Restrict By Headnote*

Insurance Law > Claims & Contracts > Contract Formation

HN5 It is clearly the law in the State of Illinois that a contract of annually renewable insurance forms a new contract at each renewal for the purpose of incorporating into the contract the statutory provisions enacted after the creation of the original contract relationship. More Like This Headnote | *Shepardize: Restrict By Headnote*

HEADNOTES / SYLLABUS

[Show](#)

COUNSEL: *Burkey, Marsico & Rovai*, by Stanley J. Burkey, for appellant.

Gordon, Sager, Honeywell, Malanca & Peterson, by Richard J. Jensen, for respondent.

JUDGES: Barnett, J. + Donworth, Weaver, Hunter, and Hale, JJ., concur.

+ Judge Barnett is serving as a judge pro tempore of the Supreme Court pursuant to Art. 4, § 2(a) (amendment 38), state constitution.

OPINION BY: BARNETT

OPINION

[*710] **[**597]** This suit involves a claim for the proceeds of an accident and health insurance policy. The insured, Neal A. Tebb, died as a result of an accident and his wife, as executrix of his estate, claimed the proceeds of the policy. **[*711]** The defendant insurer refused to pay. Mrs. Tebb filed suit and the defendant admitted all material allegations in its answer, but set up the affirmative defense that a premium had not been paid and the policy lapsed. Summary judgment was granted in favor of Mrs. Tebb.

[3]** There is no factual dispute involved in this case. Beginning April 29, 1942, Neal A. Tebb paid premiums for insurance coverage and had coverage under the policy through September 1, 1964. The premiums were due on a quarterly basis, on the first day of March, June, September and December. These due dates are different **[**598]** than stated in the policy as they had been changed by agreement of the parties subsequent to commencement of the insurance coverage.

There is no grace period provision in the policy.

The insurance premium was paid for the quarter beginning June 1, 1964, but no payment was made on or before September 1, 1964. Neal A. Tebb died September 7, 1964. The premium for the quarter beginning September 1, 1964, never has been paid or tendered. In the summary judgment the plaintiff was awarded the \$ 5,000 face amount of the policy less the quarterly premium due at the date of Neal Tebb's death.

The policy has the following provisions on renewal and default in premium payments.

This policy is dated and takes effect on the 29th day of April, 1942 and continues in effect

until the first day of August, 1942; it may be renewed with the consent of the Company for [***4] further consecutive Quarterly periods by the payment in advance of renewal premium. Each such renewal shall continue this policy in force until the first day of the calendar month next succeeding that for which premium has been paid. The Company's acceptance of premium shall constitute its consent to renewal. All periods of insurance shall begin and end at twelve o'clock noon, Standard Time, at the residence of the Insured.

If default be made in the payment of the agreed premium for this policy, the subsequent acceptance of a premium by the Company or by any of its duly authorized [*712] agents shall reinstate the policy but only to cover accidental injury thereafter sustained and such sickness as may begin more than ten days after the date of such acceptance,

HN1 In 1951 the Washington legislature passed a law requiring a grace period in disability insurance policies, Laws of 1951, ch. 229, § 7, p. 708. **HN2** The statute reads in part:

48.20.062 Standard provision No. 3 -- Grace period. There shall be a provision as follows:

Grace Period: A grace period of ___ (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies, and [***5] "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

This statute became effective as of September 1, 1951. RCW 48.20.322.

The defendant argues that this term insurance covering Neal A. Tebb lapsed for nonpayment of the premium. The argument continues with the contention that coverage cannot be rehabilitated by the statutory grace period, RCW 48.20.062. The basis of this contention is that said policy is a continuous contract. In other words, there is no new contract upon the payment of each renewal premium, therefore, concludes the defendant, the statutory grace period could not be incorporated into the policy. Defendant's last contention, based upon the proposition that the contract is continuous, is that to apply the statutory grace period to this insurance policy would violate constitutional provisions prohibiting the passage of laws impairing the obligations of contracts.

[1] These contentions can be resolved by answering a single question. Under the provisions of this policy does the acceptance of a renewal premium by the defendant [***6] effectuate a new contract between the parties or does the acceptance merely extend the old policy? If a new contract is entered into the grace period provided by statute is incorporated therein. RCW 48.18.510. If it is a continuous contract the statutory grace period is not applicable.

[*713] The policy in question gives the defendant the option to accept or reject any renewal premium so there is no automatic [**599] continuation of the policy by payment of premiums. The insurer had the right to exercise its discretion in granting a renewal of the policy. In the words of the policy, "It [the policy] may be renewed with the consent of the Company"

In *Standard Cas. Co. v. Boyd*, 75 S.D. 617, 622, 71 N.W.2d 450 (1955), the issue was whether or not a renewal of an insurance policy had been completed. The court stated: **HN3** "A renewal of a term policy is in effect a new contract of insurance and must have all the essentials of a valid contract." In 13 *Appleman, Insurance Law and Practice*, § 7648 (1943) at 419 it is stated:

HN4 A renewal contract has been stated by many jurisdictions to be a new, and a separate and distinct contract, unless the intention of the [***7] parties is shown clearly that the original and renewal agreements shall constitute one continuous contract. (Footnotes omitted.)

The defendant argues that the policy, read as a whole, indicates the parties intended for it to be a continuous contract. Defendant adverts to several of the policy's provisions as indicative of such intention. One, for example, is that the policy must be in continuous force for 6 months for coverage of tuberculosis or heart trouble. The defendant cites *Hudson v. Reserve Life Ins. Co.*, 245 S.C. 615, 141

S.E.2d 926 (1965), as authority for this proposition. In the *Hudson* case the question was whether or not a statute limiting certain defenses to claims for insurance proceeds would apply to an accident and health policy issued before the effective date of the statute. The policy was issued for an initial term of 2 months and renewable only at the option of the insurer. The court held that a continuous contract was contemplated by the parties and that the statutory provision would not be incorporated into the policy.

[2] We do not elect to follow *Hudson, supra*. In [***8] *Perkins v. Associated Indem. Corp.*, 189 Wash. 8, 63 P.2d 499 (1936), we held an accident policy issued for a year with the option to renew from term to term with the consent of [*714] the insurer was a term policy, not a continuous one. In the instant insurance contract the defendant has the express right to accept or reject the offered renewal premium. This renewal, subject to the defendant's consent, is, in our opinion, the conclusive indication that the parties intended a new contract would be created upon the acceptance of the renewal premium. The fact that several clauses of the policy require coverage to be continuously in force for periods longer than the 4 month term purchased by each renewal premium does not mitigate against our conclusion. Those provisions allowing certain benefits after the policy has been in force for periods in excess of the quarterly period do not overcome the expression of intent in the clause giving the insurer a right to accept or reject the renewal premium. Obviously, if insured and insurer continue the relationship for longer than the required periods of continuous coverage, the insured would be entitled to the benefits of this coverage.

We conclude that the facts of this case indicate that [***9] upon each renewal a new contract is formed, hence, the statutory grace period was incorporated into the contract upon the acceptance of the renewal premiums. Other courts have also come to the same conclusion. In *Thieme v. Union Labor Life Ins. Co.*, 12 Ill. App. 2d 110, 115, 138 N.E.2d 857 (1956), the court stated:

HNS It is clearly the law in this State that a contract of annually renewable insurance forms a new contract at each renewal for the purpose of incorporating into the contract the statutory provisions enacted after the creation of the original contract relationship. *Dickirson v. Pacific Mutual Life Ins. Co.*, 319 Ill. 311 (1926). See also *Klinke v. Great Northern Life Ins. Co.*, 318 Ill. App. 43 (Fourth Dist. -- 1943).

In *Taylor v. American Nat'l Ins. Co.*, 264 Minn. 21, 24-25, 117 N.W.2d 408 (1962), the Minnesota court was faced with [**600] the same problem presented by the instant appeal. The court said:

The policies were renewable only at defendant's [Insurer] option when L. 1957, c. 489, became law. It is [*715] clear that the parties were making a new contract upon defendant's acceptance of the premiums due April 22, 1957, and we [***10] must agree with plaintiff's contention that the statutory law in force and effect at the time became part of the contract as though expressly written therein

On each reinstatement or renewal of the policies, any statutes or amendments pertaining to such policies and enacted after their issuance are incorporated into the new policies. We therefore conclude that the insured was entitled to the 31-day grace period and that the statute is operative as to him.

The trial court was correct in granting the summary judgment. The judgment is affirmed.

in

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APPENDIX-L

717 F. Supp. 449, *; 1988 U.S. Dist. LEXIS 16735, **

OLIVER M. OATES, JR. v. THE EQUITABLE ASSURANCE SOCIETY OF THE UNITED STATES

Civil Action No. E87-0084(L)

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI, EASTERN
DIVISION

717 F. Supp. 449; 1988 U.S. Dist. LEXIS 16735

November 28, 1988, Decided

CASE SUMMARY

PROCEDURAL POSTURE: Defendant insurer filed a motion for summary judgment against plaintiff in an action to determine if a variable deductible provision could be properly utilized by the carrier as the basis for the denial of benefits in regard to a major medical policy of insurance.

OVERVIEW: Defendant issued to plaintiff a lifetime major medical policy of insurance. When plaintiff submitted claims for benefits under the policy, defendant, while agreeing that his claims were for covered charges, refused to pay the claims based on the policy's variable deductible provision. Plaintiff asserted that the variable deductible policy language relied on by defendant in refusing to pay benefits was invalid and unenforceable at the time the policy was issued. The court held that under the state law at the time the policy was issued, there was no regulation in effect prohibiting or limiting the use of variable deductibles. Accordingly, defendant's inclusion of a variable deductible provision within its policy was viable, presumably without restriction, at the time of the issuance of the policy. Defendant's motion for summary judgment was granted.

OUTCOME: The court ordered that defendant's motion for summary judgment be granted because the inclusion of a variable deductible provision within its policy was viable, presumably without restriction, at the time of issuance of the policy.

CORE TERMS: deductible, variable, coverage, premium, issuance, insured, renewal, insurer, summary judgment, policy of insurance, lifetime, medical expense, contract of insurance, successive, monthly, insurance policies, policyholder, carrier, force of law, parties contemplated, medical coverage, independent contract, original contract, continuation, occurrence, pro-rating, guaranteed, continuous, repugnant, inclusion

LEXISNEXIS® HEADNOTES[Hide](#)Insurance Law > Industry Regulation > Insurance Company Operations > General Overview 

HN1  An opinion of an Insurance Commissioner that is in fact an opinion and nothing more is neither a regulation nor a statute and thus does not have the force of law. [More Like This Headnote](#)

Governments > Legislation > Effect & Operation > Retrospective Operation Governments > Legislation > Interpretation Insurance Law > Claims & Contracts > Policy Interpretation > General Overview 

HN2  It is generally the rule that statutes operate prospectively and should not be construed as having a retroactive effect on the provisions of an existing contract of insurance unless the statute clearly evinces a legislative intent that it should apply

retroactively. More Like This Headnote

Governments > Legislation > Effect & Operation > Prospective Operation 

HN3 Statutes subsequently enacted ordinarily do not affect contractual rights, whether the concern be with policies of personal, property, or liability insurance, or bonds; however, where an existing policy is renewed, although the results vary, the better rule is to regard the statute as applicable to the extended contract. More Like This Headnote

Insurance Law > Claims & Contracts > Contract Formation

HN4 Whether the renewal of a policy of insurance constitutes a new and independent contract or whether it is instead a continuation of the original contract primarily depends upon the intention of the parties as ascertained from the instrument itself. More Like This Headnote | *Shepardize: Restrict By Headnote*

COUNSEL: **[**1]** Crymes G. Pittman, Cothorn & Pittman, Jackson, Mississippi.

Rebecca Wiggs, Thomas M. Murphree, Jackson, Mississippi.

JUDGES: Tom S. Lee, United States District Judge.

OPINION BY: LEE

OPINION

[*450] MEMORANDUM OPINION AND ORDER

TOM S. LEE, UNITED STATES DISTRICT JUDGE

This cause is before the court on the motion of defendant, The Equitable Assurance Society of the United States (Equitable), for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. Plaintiff, Oliver M. Oates, Jr., responded to the motion and the court has considered the memoranda of authorities together with attachments submitted by the parties.

On January 28, 1968, Equitable issued to plaintiff a "lifetime major medical policy" of insurance. This lawsuit involves two separate claims made by Mr. Oates, the insured, during a period of time in which plaintiff was covered under the Equitable policy as well as three other health insurance policies, with Golden Rule Insurance, Vulcan Life Insurance and Celtic Life/Horizon Insurance, respectively. When Mr. Oates submitted claims for benefits under the Equitable policy of insurance in 1986 and 1987, Equitable, while agreeing that his claims were for "covered charges" as defined in the policy, refused to pay the claims based **[**2]** on the policy's variable deductible provision. That provision essentially rendered the policy one for excess coverage beyond payments made by other carriers on the same claim since it provided for a variable deductible of (1) \$ 750, the basic deductible, or (2) the amount of benefits provided for covered charges under other medical expense coverage, whichever is greater. As to both of Mr. Oates' claims, Equitable determined that payment from his other carriers exceeded his claimed expenses so that his claim was less than the deductible under the Equitable policy. Accordingly, the company concluded that no benefits were payable. ¹ The issue to be decided on this motion is whether, under the facts presented, the variable deductible provision of the Equitable policy is effective as a valid policy provision and, if so, whether the provision may be properly utilized by the carrier as the basis for denial of benefits.

FOOTNOTES

¹ On February 26, 1986, Mr. Oates submitted a claim for \$ 7567.25 to Equitable. According to Equitable, it determined that plaintiff had already received \$ 11,574.00 from his other insurers on that claim. Similarly, in 1987, according to the Equitable's calculations, Mr. Oates' other insurers had paid \$ 46,119.29 on his claim for \$ 39,756.22.

[3]** Under current Mississippi law, the legal viability of a variable deductible provision in insurance policies is governed by Regulation 84-102 of the Mississippi Department of Insurance which provides in pertinent part as follows:

No insurer doing business within the State of Mississippi shall pro-rate or limit accident and health benefits or integrate benefits through the use of a variable deductible to a policy-owner by reason of his or her ownership or coverage under other accident and health insurance policies with other insurers in instances where such policies are:

- (1) individually underwritten and issued; and
- (2) provide daily indemnity benefits for hospital confinement resulting from accident or sickness without regard to expenses incurred, or,
- (3) provide benefits for specified diseases only, or
- (4) provide benefits for limited occurrences such as confinement in an Intensive Care of Coronary Care Unit of a hospital, first aid out-patient medical expenses resulting from accidents, or specified accidents such as travel accidents, which,
- (5) are made available to the general public on an individual basis; and
- (6) may be obtained and maintained in force by the policyholder regardless **[**4]** of his or her membership or connection with any particular association or organization, and
- (7) regardless of the manner in which premiums therefor are paid.

Both Mr. Oates and Equitable agree that regulation 84-102 has no application to the Equitable policy at issue in the case at bar **[*451]** since the regulation did not become effective until 1984, many years after issuance of the policy. They disagree, however, as to whether, at the time the Equitable policy was actually issued to Mr. Oates, the variable deductible provision was legally effective.

The policy in question was issued on January 28, 1968. Prior to that time, on April 23, 1983, the then Commissioner for the Mississippi Department of Insurance, Walter Dell Davis, had issued an "opinion" that

any provision pro-rating or limiting benefits to the policy holder by reason of other policies with other companies is contrary to the provisions of Sections 5687-01/12, Mississippi Code of 1942, Recompiled.

The opinion also recited the concurrence of the State Attorney General in the department's position. Not until many years after issuance of Equitable's policy to Mr. Oates did the Department of Insurance promulgate a regulation **[**5]** concerning the use of a variable deductible; on March 8, 1978, the Department issued a regulation prohibiting the use of variable deductibles in certain described instances. ² Ultimately, Regulation 84-102, *supra*, superceded the 1978 regulation.

FOOTNOTES

² Like Regulation 84-102, the 1978 regulation prohibited insurers doing business within Mississippi from pro-rating or limiting accident and health insurance benefits by reason of a policyholder's other coverage where such policies were "(1) individually underwritten and issued, (2) or made available to the general public on an individual basis, (3) [could] be obtained and maintained in force by the policyholder regardless of his or her membership or connection with any particular association or organization, and (4) regardless of the manner in which premiums therefor are paid."

Plaintiff asserts that the variable deductible policy language relied on by Equitable in refusing to pay benefits is invalid and unenforceable since at the time the policy was issued, that provision was contrary and repugnant to Mississippi law as established by the 1963 opinion of the Insurance Department which was concurred in by the Mississippi Attorney **[**6]** General. Plaintiff's argument may be stated thusly: A rule or regulation such as the April 23, 1963 opinion of the Insurance

Commissioner has the force of law and since the state of the law at the time of the issuance of a policy of insurance is controlling, the provision in Equitable's policy issued in 1968 was contrary to Mississippi law and accordingly was excluded from and written out of Equitable's policy. This argument, however, proceeds from a false and inaccurate premise. That is, a review of the 1963 ^{HN1} opinion of the Insurance Commissioner demonstrates that it is in fact an opinion and nothing more. It is neither a regulation nor a statute and thus did not have the force of law. See *Frazier v. Lowndes County Board of Education*, 710 F.2d 1097, 1100 (5th Cir. 1983); *Local Union No. 845 v. Lee County Board of Supervisors*, 369 So. 2d 497, 498 (Miss. 1979). Thus, under the state of the law at the time the policy was issued, there was no regulation in effect prohibiting or limiting the use of variable deductibles. Accordingly, Equitable's inclusion of a variable deductible provision within its policy was viable, presumably without restriction, at the time of issuance of the **[**7]** policy. A question arises, though, as to whether the subsequent limitations contained in Regulation 84-102 on the use of variable deductibles apply to the Oates policy.

^{HN2} It is generally the rule that statutes operate prospectively and should not be construed as having a retroactive effect on the provisions of an existing contract of insurance unless the statute clearly evinces a legislative intent that it should apply retroactively. 1 G. Couch, *Cyclopedia of Insurance Law* § 13:15, at 840-41 (2d ed. 1984). This rule encompasses the regulation at issue in the case *sub judice*, Regulation 84-102, the terms of which disclose no intent that it be applied retroactively. In a similar vein, it has been recognized that

^{HN3} statutes subsequently enacted ordinarily do not affect contractual rights, whether the concern be with policies of personal, property, or liability insurance, or bonds; however, where an existing policy is renewed, although the results **[*452]** vary, the better rule is to regard the statute as applicable to the extended contract.

12 J. Appleman, *Insurance Law and Practice* § 7041, at 172-76 (1981).

^{HN4} Whether the renewal of a policy of insurance constitutes a new and independent **[**8]** contract or whether it is instead a continuation of the original contract "primarily depends upon the intention of the parties as ascertained from the instrument itself." 18 Couch, § 68:40, at 41. The Oates policy describes itself as a "lifetime major medical expense policy" which is "guaranteed renewable during the lifetime of the insured." The policy is maintained in force by the insured's payment of monthly premiums, the amount of which is subject to change "only if the same change is made applicable to all policies of [the] class [in which the policy belongs at the time of change]." In addition, the policy provides a three-year benefit period which commences upon the happening of an occurrence and which may be extended beyond three years in certain situations. Although the policy speaks in terms of "renewal" at the end of each "term of coverage" (here, successive one month terms) by payment of the premium amount due, it is clear that the parties contemplated one continuous contract of insurance and not separate successive contracts of one month each. In fact, in correspondence with Oates, Equitable consistently informed him that "your policy is guaranteed renewable; that is, **[**9]** we can never cancel it and you will always have medical coverage." Because the court is of the opinion that the monthly "renewal" of the Oates policy by payment of the monthly premium constituted merely a continuation of the original contract of the parties, the court concludes that statutes and regulations enacted after the original issuance date in 1963 and, specifically Regulation 84-102, do not apply to the Oates policy. This conclusion, coupled with the court's previous determination that the variable deductible provision in the policy was not repugnant to state law at the time of issuance, leads the court to the further conclusion that Equitable's denial of coverage based on that provision was not wrongful. ³ See *Moore v. Metropolitan Life Insurance Company*, 352 N.Y.S.2d 433, 33 N.Y.2d 304, 307 N.E.2d 554 (1973) (renewal by premium payment merely continued in force pre-existing policy where insured could not terminate group policy or change premium rate without consent of employer; statutes enacted subsequent to execution of original policy held inapplicable); *Hudson v. Reserve Life Insurance Company*, 245 S.C. 615, 141 S.E.2d 926 (1965) (where accident and health policy **[**10]** showed parties contemplated continuous insurance rather than successive independent contracts, newly enacted statute held inapplicable to previously issued policy though renewal premiums were paid and accepted after effective date); cf. *Coliseum House, Inc. v. Brock*, 442 So. 2d 778 (La. Ct. App. 1983) (where insured had no absolute right to insurance beyond one year, each subsequent renewal constituted separate contract even though no new policy was involved). ⁴

FOOTNOTES

³ It is somewhat ironic that Equitable's guarantees to its insured of lifetime medical coverage now

lend support to the court's conclusion that the company may properly rely on a provision of the policy to deny coverage. However, it must be borne in mind that the parties to a contract of insurance are free to define the scope of coverage to be afforded subject only to the condition that the provisions of the policy do not contravene any statute or public policy of the state. And, since Mississippi law in effect on the date of issuance of the Oates policy did not prohibit the inclusion of a variable deductible such as that contained in the Oates policy, that provision is binding.

4 The court observes that even if regulation 84-102 were held by the court to apply, defendant would nevertheless be entitled to summary judgment. On its motion, defendant set forth its position that even if regulation 84-102 were controlling, that regulation only prohibits use of a variable deductible under circumstances not present here. In response to the motion, plaintiff failed to demonstrate that the variable deductible in his policy was within the exclusion contemplated by regulation 84-102. In fact, plaintiff's position on the issue was simply that "regulation 84-102 and its meaning is not the issue in this case." This assertion alone is insufficient to withstand defendant's motion.

[11]** Based on the foregoing the court is of the opinion and so finds that defendant's **[*453]** motion for summary judgment is well taken and should be granted.

Accordingly, it is ordered that defendant's motion for summary judgment is granted.

ORDERED this 28th day of November, 1988.

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245 S.C. 615, *; 141 S.E.2d 926, **;
1965 S.C. LEXIS 305, ***

Robert V. HUDSON, Appellant, v. RESERVE LIFE INSURANCE COMPANY, Respondent

No. 18340

Supreme Court of South Carolina

245 S.C. 615; 141 S.E.2d 926; 1965 S.C. LEXIS 305

April 28, 1965

DISPOSITION: [***1] Affirmed.

CASE SUMMARY

PROCEDURAL POSTURE: Plaintiff insured brought an action against defendant insurer on an accident and health insurance policy. A trial court, South Carolina, ruled against the insured and he appealed.

OVERVIEW: The sole question on appeal was whether S.C. Code § 37-474 (1962) applied to the insurance policy, which was issued for an initial term in 1954. The loss occurred in 1961. The court held that it did not. The Act was prospective in its operation, and, therefore, inapplicable to contracts which were in existence at the time of its adoption. This raised the question of whether the insurance in force after the payment and acceptance of each renewal premium was a new and independent contract or an extension or continuation of the original contract. The court found that it was clear from the terms of the policy that the parties contemplated continuous insurance, rather than successive independent contracts. First, there was a disparity in cost between the first two months and the monthly premium. The first two months included the cost of writing the policy. This disparity in cost was a strong indication that continuous insurance was contemplated. Second, the exclusion of loss resulting from certain diseases until the policy had been in force for six months was even more persuasive of the view that it was continuous. Thus, the court affirmed.

OUTCOME: The court affirmed the judgment.

CORE TERMS: premium, renewal, losses resulting, disease, default, paying, successive, initial payment, independent contract, insuring agreement, reinstatement, misstatements, originating, continuous, sickness, coverage, monthly, grace

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HN1 The Act of 1956 (South Carolina) was prospective in its operation, and, therefore, inapplicable to contracts which were in existence at the time of its adoption. More Like This Headnote | *Shepardize*: Restrict By Headnote

COUNSEL: Messrs. Lumpkin, Kemmerlin & Medlock, of Columbia, for Appellant, cite: As to a policy of insurance, which by its terms is renewable at the option of the insurer only, becoming, upon the insurer choosing to renew it, a new contract of insurance so as to incorporate within the new contract statutory provisions enacted after the creation of the original contract but prior to the new contract created by the insurer electing to renew: 138 N.E. (2d) 857, 12 Ill. App. (2d) 110; 23 Am. Jur. 812, Fraud and Deceit, Sec. 48.

Joseph L. Nettles, Esq., of Columbia, for Respondent, cites: As to rule of statutory construction being that an act will not be given retrospective effect in the absence of very clear provision: 218 S.C. 22, 61

S.E. (2d) 399; 1 Couch (2d) 548; 193 S.C. 368, 8 S.E. (2d) 314; 29 Am. Jur. 716, Anno., 78 A.L.R. 617.

JUDGES: Brailsford, Justice. Taylor, C.J., and Moss, Lewis and Bussey, JJ., concur.

OPINION BY: BRAILSFORD

OPINION

[*616] [**927] The parties agree that the sole question involved on this appeal is whether Section 2, (c) item 2 of Act No. 829 of the General Assembly of South Carolina for 1956, which is codified as Section [***2] 37-474, Code of Laws 1962, applies to a policy of accident and health insurance, issued by respondent to appellant on December 28, 1954, for an initial term of two months, and which, by virtue of the payment of successive premiums as provided by the policy, was of force on April 10, 1961, when a covered loss occurred.

The Code section is a part of Title 37, Chapter 6, relating to accident and health insurance, and provides that "each [*617] such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in this section," including:

"(2) A provision as follows:

"TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements; made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such two-year period."

It is conceded that ^{HNI} the Act of 1956 was prospective in its operation, and, therefore, inapplicable to contracts which were in existence at the time of its adoption. This concession would resolve the issue [***3] but for appellant's contention that a new contract arose upon the payment and acceptance of each renewal premium; hence, the quoted provisions of the statute became a part of the policy upon its renewal for an additional term after the approval of the Act on March 31, 1956. This raises the question of whether the insurance in force after the payment and acceptance of each renewal premium was a new and independent contract or an extension or continuation of the original contract. The answer to this question depends upon the intention of the parties as expressed in the writing. Am. Jur., Insurance, Section 357, 44 C.J.S., Insurance, § 283. We think it clear from the terms of the policy that the parties contemplated continuous insurance, rather than successive independent contracts.

The policy acknowledged an "initial payment" of \$ 9.00, which kept the insurance in force for the "initial term" of two months. Thereafter, the "monthly premium" was \$ 1.50, with the privilege of paying "renewal premiums" monthly or quarterly, semi-annually or annually at slightly reduced rates.

The insuring agreement covers only losses resulting from accident or from sickness originating "while [***4] this policy is in force and more than 15 days after the date hereof." As to an [*618] important group of diseases, the policy applies only "if hospital confinement begins after this policy has been in force for six months or more." (Emphasis ours.)

The provisions of the policy as to reinstatement apply "if default be made in the [**928] payment of the agreed premium for this policy." Default occurs if any "premium payment be not received * * * on or before the date when due or within the grace period provided herein." (Emphasis ours.)

Inferentially, the initial payment of \$ 9.00 included \$ 6.00 for the cost of writing and issuing the policy, which could thereafter be kept in force by payment of premiums at the rate of \$ 1.50 per month. This disparity in cost is a strong indication that continuous insurance was contemplated. The references in the policy to agreed premiums, dates when premiums are due, default in payment and reinstatement are inconsistent with the view that the policy terminated on each premium paying date or within fifteen days thereafter.

The exclusion from coverage of a loss resulting from any sickness originating within fifteen [***5] days of the date of the policy, and the exclusion of loss resulting from certain diseases, including any disease of the heart or circulatory system, until the policy has been in force for six months, are even more persuasive of the view which we adopt. Otherwise, an insured might pay premiums over a period of years after purchasing this insurance, yet never become entitled to the full coverage of the insuring

agreement. This would be a harsh result, not required by the provision that the policy was renewable only at the option of the company or by any other language of the contract. The optional renewal provision merely gave the company the right to cancel at the end of the grace period following any premium paying date. It did not affect the continuity of the contract, or the maturity of rights thereunder, so long as premiums were paid and accepted.

Affirmed.

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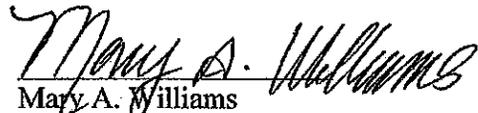
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Tax Treatment Of Long-Term Care Insurance

Stanley I Strouch is Chairman and CEO of **Creative Insurance Planning**, an independent brokerage agency which services the life and health insurance needs of independent agents. Stanley worked in the legal department of New England Life Insurance Company, was its National Director of Advanced Sales, then worked for Aetna and in the mid-'80s as Vice President of Health Operations, was in charge of the development of Aetna's long-term care products.

Stanley authored LISI's Long Term Care – Information EVERY Planner Needs to Know (Estate Planning Newsletter # 1019).

Stanley has prepared for LISI members an extensive special report on the tax treatment of Long-Term Care insurance.

EXECUTIVE SUMMARY:

The 1996 Health Insurance Portability and Accountability ACT, HIPAA, clarified the tax treatment of employer paid LTCI by adding Code Section 7702B to the Internal Revenue Code. This section provides among other things that for purpose of the Internal Revenue Code

- a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,
- amounts received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care as defined in section 213(d),
- any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,
- amounts paid for a qualified long-term care insurance contract shall be treated as payments made for insurance for purposes of section 213(d) (1)(D).

This article examines the relevant tax issues for both tax qualified and non-tax qualified long-term care purchased by individuals and businesses.

FACTS:

TAX TREATMENT FOR INDIVIDUALS

Individuals have two potential income tax deductions for LTCI premiums:

1. the self-employed health insurance deduction under IRC Section 162(l) and
2. itemized medical expense deduction under IRC Section 213.

SELF-EMPLOYED HEALTH INSURANCE DEDUCTION

CODE SECTION:

162(l) permits a self-employed individual to deduct the "applicable percentage" of LTCI premiums for "medical care for the taxpayer, his spouse and dependents."

7702 B (a) (1) states that a qualified LTCI is an accident and health insurance contract.

162(l)(2)(C) states that a qualified LTCI policy is a medical care insurance policy, but that in applying the applicable percentage, "only eligible long term care premiums...shall be taken into account.

162 (l) (1) (B) defined the applicable percentage as 60% in 2001, 70% in year 2002, and 100% in year 2003 and thereafter.

213(d) (10) lists five different age-based eligible long-term care premiums that are subject to annual cost of living adjustments.

Based on Rev. Proc. 2005-50 the eligible premiums for 2006 are:

Age	Amount
40 or Younger	\$280
41 through 50	\$530
51 through 60	\$1,060
61 through 70	\$2,830
71 or older	\$3,530

Example 1 James is 65 and self-employed. His LTCI premium is \$3,740. In 2006, he can claim a self-employed health insurance deduction of \$2,830.

Example 2 Both James and his wife age 59 purchased a qualified LTCI policy. The premium for her policy is \$2,540. James can deduct \$2,830 for his policy and \$1,060 for his wife's policy as a self-employed health insurance deduction.

Recap:

The self-employed health insurance deduction is available for premiums paid for (1) a qualified LTCI policy or policies that insure a self-employed taxpayer,

his or her spouse and dependants, but only for premiums that do not exceed the eligible premium for each person. As noted below, the balance of the eligible premium may be deductible as an itemized medical expense.

The self-employed health insurance deduction is a deduction from gross income in determining the taxpayer's adjusted gross income. This means that a self-employed taxpayer can claim the self-employed health insurance deduction whether he or she itemizes deductions or claims a standard deduction. On the other hand, the medical expense deduction under IRC Section 213 is limited to taxpayers who itemize their deductions.

LIMITATIONS:

The self-employed health insurance deduction is subject to two further limitations.

1. The deduction cannot exceed the taxpayers earned income from the business "with respect to which the plan providing the medical care coverage is established."
2. If the taxpayer is eligible to participate in a subsidized LTCI plan of another employer the deduction is not available.

ITEMIZED MEDICAL EXPENSE DEDUCTION

Code Section 213(a) permits individual taxpayers who itemize their deductions to deduct their, their spouse's and their dependents "medical care" expenses that in total exceed 7 ½% of adjusted gross income.

Code Section 213(d)(1)(D) states that the term "medical care" includes "amounts paid...for any qualified long-term care insurance contract," but limits the deduction to "only eligible long term care premiums".

In the case of a self-employed individual, deductible medical expenses for LTCI premiums are limited to the balance of the eligible premiums that were not deducted as self-employed health insurance. In the case of individuals who are not entitled to any self-employed health insurance deduction, the entire eligible premium constitutes a medical care expense under IRC Section 213(a).

Example: The total premium for James and his wife's policies is \$6,280. In 2006, they can deduct \$3,890 under IRC Section 162(l). If James and his wife itemize their deductions, the balance of the eligible premium, \$2,390, may be deductible if their total medical expenses including the \$2,390 long term care premium exceeds 7 ½% of adjusted gross income.

LTCI PREMIUMS PAID BY BUSINESS

The tax treatment of employer paid long-term care is different for C Corporations, S Corporations, and Partnerships.

There are three tax issues to examine for each type of business entity.

1. Are the premiums deductible by the business entity?
2. Is the premium paid by the entity taxable to the insured?
3. Are the benefits received under the long-term care

contract received tax- free?

C CORPORATIONS

Are the employer's premium payments taxed to employee?

No! IRC Section 106 provides that long- term care premiums paid by the employer are not included in an employee's income. Regulation, 1.106-1, provides that an employee's gross income does not include contributions his employer makes to an "accident or health plan". The regulations provide that the employer may contribute to an accident and health plan by paying the premium or a portion of the premium on a policy of accident or health insurance covering one or more of his employees. Section 7702 B (1) treats employer paid long- term care insurance as medical insurance. As such, the premiums paid by the employer are not included in the employee's income.

Is the employer entitled to deduct the long-term care premium?

Yes! The employer is allowed a deduction for the long-term care premiums paid on behalf of its employees under IRC Section 162(a). The regulations to Section 162 provide, "Amounts paid or accrued within the taxable year for dismissal wages, unemployment benefits, guaranteed annual wages, vacations, or a sickness, accident, hospitalization, medical expense, recreational, welfare or similar benefit plan, are deductible under section 162(a) if they are ordinary and necessary expenses of the trade or business."

Are the benefits received under the long-care contract excluded from income?

Yes! The tax treatment of benefits received under a long-care contract where the premium is paid for the employer is governed by IRC section 105. Section 105 is an inclusion section of the Code. Section 105(a) states that unless otherwise provided in this section, any benefits received by an employee through accident or health insurance for personal injuries or sickness is included in gross income to the extent such amounts are attributable to contributions by the employer that were not includible in the employees gross income. Since the premium that the employer paid for an employee's long-term care contract is not included in the employee's income, it would appear under Section 105(a) that the benefits under the long- term care contract are included in the employee's income.

Section 105(b) however provides that gross income does not include benefits paid to reimburse the taxpayer for expenses incurred by him for the medical care (as defined in section 213(d)). Section 213(d) was amended in 1996 to include benefits and premiums paid for qualified long- term care contracts. Thus, benefits received by the employee under a long- term care contract, where the employer pays the premium, are excluded from income.

Is the tax treatment different if "the plan" only covers highly compensated employees or owner-employees?

Sections 162 and 106 do not have any limitation for plans that only cover highly compensated employees, or owners. Section 105, however, provides there must be a plan and the plan must be for employees. The Regulations in Section 1.105-5 provide that "a plan may cover one or more employees, and there may be different plans for different employees or classes of employees. An accident or health plan may be insured or noninsured, and it is not necessary that the plan be in writing or that the employee's rights to benefits

under the plan be enforceable."

Even though the above stated regulation seems to indicate that the plan need not be in writing, we suggest there be a written plan and also a corporation resolution adopting the plan.

Even if the board adopts a written plan, if the plan only covers stockholder-employees the IRS may challenge the deduction and exclusion from income. The issue is whether the stockholder-employee is covered as an employee or as a stockholder. If the plan is deemed to cover the participants as stockholders then the transaction in all likelihood will be treated as a dividend. This means that the premium is not deductible to the corporation and the premiums or benefits are includible in the gross income of the shareholder.

The courts have approved plans which cover a class of employees that is based on factors other than being a stockholder. The most successful classification is officers of the corporation. *Bogene, Inc v Comm.*, TC Memo 1968-147; *E.B. Smith v Comm.*, TC Memo 1970-243; *Arthur R. Seidel v Comm.*, TC Memo 1971-238; and *Nathan Epstein v Comm.*, TC Memo 1972-53.

If the owners want a plan that covers only employee owners, they must develop a classification that is not based solely on stock ownership. For example, the classification can cover all officers, or all senior officers. A non-owner employee may need to be covered under the classification, but the added cost will assure the desired tax treatment.

PARTNERSHIPS

For employees, other than partners, the tax treatment of partnership paid long term care premiums is the same as for a C corporation. Partners, however, are treated differently. There are really two issues:

1. How does the partner treat the premium paid by the partnership?
2. How is this tax treatment reflected on the individual and partnership return?

Revenue Ruling 91-26 discusses health insurance premiums paid for by partnerships or S corporations. With respect to a partnership there are two ways the partnership can account for the premium payment:

1. The premium is paid for services rendered in the capacity of a partner without regard to partnership income, a guaranteed payment under IRC Section 707(c), or
2. The premium is treated as a reduction of a partner's share of profits.

Where the premium payment is treated as a guaranteed payment it is deductible by the partnership under section 162, and includable in the recipient-partner's gross income under section 61.

The Revenue Ruling also held that the premium is not excludable from the recipient-partner's gross income under section 106, but the partner may deduct the cost of the premiums to the extent provided by section 162(l). The deduction under section 162(l) is equal to the eligible premium.

Another way the partnership can account for the long-term care premiums paid on behalf of a partner is to treat the premium payment as a reduction in distributions to the partner. Under this scenario, the premium is not deductible by the partnership, so distributive shares of partnership income and deduction are not affected by payment of the premium. A partner may deduct the cost of the premium paid his behalf to the extent allowed under section 162(l).

S CORPORATIONS

Code Section 1372 provides that, for purposes of applying the income tax provisions of the Code relating to employee fringe benefits, an S corporation shall be treated as a partnership, and any person who is a "2-percent shareholder" of the S corporation shall be treated like a partner of a partnership.

Under Revenue Ruling 91-26, accident and health insurance premiums (which includes long-term care premiums) paid by an S Corporation on behalf of a two-percent shareholder-employee is treated like guaranteed payments under section 707(c). Therefore, the premiums are deductible by the corporation under section 162 and includable in the recipient-shareholder's gross income under section 61.

Further, the premiums are not excludable from the recipient-shareholders gross income under section 106, but the two-percent shareholder may deduct the premium as a self employed individual as provided in section 162(l).

ERISA CONSIDERATIONS:

I believe that an employer paid long-term care plan is an employee welfare benefit plan and within the scope of the Employee Retirement Income Security Act (ERISA). However, if the business has less than 100 employees, the ERISA are listed below:

The Establishment by Written Plan

Section 402 of ERISA requires that every employee benefit plan be established and maintained pursuant to a written instrument. This written instrument must provide for one or more named fiduciaries that have authority to control and manage the plan. This document should be kept with the records of the company.

Summary Plan Description

The administrator of the plan (usually the employer) must provide a Summary Plan Description to each participant.

Select Group Exemption

Plans maintained by an employer, primarily to provide benefits for a select group of management or highly compensated employees for whom benefits are paid through insurance policies paid for by the employer, are exempt from reporting and disclosure requirements. The plan documents have to be made available to the Secretary of the Labor if they are requested.

Reporting Requirements

Fully insured plans with fewer than 100 participants are exempt from annual

reporting of Form 5500. Plan that cover 100 or more employees come under the full requirements of ERISA.

NON-TAX QUALIFIED LONG TERM CARE INSURANCE CONTRACT

Is a tax-qualified long-term care plan the best plan for your clients? Are you meeting your professional responsibility by only recommending a tax-qualified plan? Have the insurance companies so conditioned us that we automatically believe that a tax qualified plan is a better plan than a non-tax qualified plan?

The primary reason, and perhaps the *only* reason, to recommend a *tax*-qualified long-term care plan is that the benefit payments are guaranteed to be tax-free.

However, the tax status of the benefits is only one of many factors to consider when recommending a long-term care plan, and in fact, is probably one of the least important. The *most* important consideration is how the insured qualifies for benefits. What good is it to have a long term care policy where the benefits are guaranteed to be tax-free, but the insured may not qualify for benefits?

Before 1996, the year HIPPA was passed, there were three ways an insured could qualify for benefits under most long-term care plans.

1. The insured was unable to perform two out of six activities of daily living without human assistance or continual supervision;
2. The insured was "cognitively impaired";
3. The insured's physician certifies that the care or service was medically necessary.

With the passage of HIPPA, Code Section 7702(B) provides that a tax-qualified long-term care insurance policy **must provide "qualified benefits"** for a **chronically ill** individual. A chronically ill individual is defined as:

1. An individual who is unable to perform two out of six daily activities of living for a period of at least ninety days due to a loss of functional capacity, without substantial assistance from another individual, certified by a health practitioner, *or*
2. The insured requires substantial supervision to protect him or her from threats to health and safety due to *severe* cognitive impairment.

The new benefit triggers are substantially more restrictive than the pre-HIPPA benefit triggers.

Why did Congress pass a law that makes it more difficult for an insured to qualify for benefits? Perhaps the insurance companies lobbied Congress. With respect to long-term care, HIPPA was anti-consumer and pro-insurance company. In my opinion, the insurance companies were the primary beneficiaries of the legislation. They can offer for sale a "Congressionally approved" more restrictive long-term care plan, at the same or higher premium than the pre-HIPPA plans.

After HIPPA, all of the long-term care insurance companies introduced a tax-qualified long-term care plan to comply with the new law. Many of the companies said that the tax-qualified policy was the only type of long-term

care policy entitled to the tax breaks, and that the primary reason they introduced the tax-qualified policy was to meet the requirements of the new law. Most of the major companies only sell the tax-qualified plan.

It is my understanding that before HIPPA, many long-term care claims resulted from the medical necessity benefit trigger. HIPPA eliminates the medical necessity benefit trigger and makes it more difficult to qualify under the other two benefit trigger tests. Since it is more difficult to qualify for benefit, you would expect claim experience under the new policies to be much better than under the pre-HIPPA policies. Did the insurance companies reduce the premium? No, and in fact, many companies increased premiums under the guise of new plan benefits. In effect, HIPPA resulted in a substantial rate increase by most companies.

BENEFIT TRIGGERS:

Although everyone likes tax breaks, the most important feature of a long-term care policy is the benefit triggers. The tax issues are discussed below:

Other than the financial strength of the company, why would anyone buy a long-term care policy that pays benefits on a restricted basis?

As discussed above, the non-tax qualified long-term care plan typically has three benefit triggers. However, the benefit triggers may differ by companies, and therefore you should carefully review the policy. There are only five companies that will issue a non-tax qualified long-term care policy: Bankers Life and Casualty, Mutual of Omaha Insurance Company, Penn Treaty Network America, Physicians Mutual Insurance Company and United of Omaha Life Insurance Company.

Some companies have different benefit triggers for Facility Care and Home Care. Some companies have a triple benefit trigger for Facility care and a double benefit trigger for Home Health Care (a double trigger eliminates the medical necessity trigger). ***The preferred non-qualified plan is a plan that offers the three benefit triggers for both Facility Care and Home and Community Based Care.***

TAX-QUALIFIED PLANS ARE MORE RESTRICTIVE:

The first restriction of a tax-qualified plan is that a health provider must certify that the condition resulting in the insured being unable to perform two out of the six activities of daily living will last at least ninety days. This may not be particularly onerous but, nonetheless, this restriction does not exist in the non-qualified plan.

An often-overlooked restriction of the qualified plan is the requirement of SEVERE cognitive impairment versus "cognitive impairment" for the non-tax qualified plan.

The problem is that "severe" is not defined in the policy. Therefore, it is completely discretionary for the insurance company to define when and how coverage will be instituted. Definitions that are unclear or, not defined, may lead to questionable coverage. The issue may become particularly taxing if Alzheimer's or other form of senile dementia affects a loved one. At what point does the individual reach the severe stage?

Finally, and most importantly, under a tax qualified plan the insured must be sicker, (chronically ill) to qualify for benefits. Under a non-tax qualified plan if

the insured's physician using standard medical practices says the insured needs "covered care", the care may be paid for up to the daily benefit. The medically necessary trigger applies even if the insured can perform all the activities of daily living and is not cognitively impaired. ***The medical necessity trigger is essential to provide full and adequate coverage.***

A reasonable expectation of people who buy a long-term care policy is that benefits are paid when they get sick.

However, a tax-qualified plan may not work this way. An insured can be sick enough or be functionally disabled to require care, but not sick enough to satisfy the chronically ill benefit trigger of a tax qualified plan.

For example, as people age they naturally become frail, and although they may be able to do many of the activities of daily living as defined in a tax-qualified policy, they may need help with activities like grocery shopping, cooking, managing medication, etc. Since the insured is not chronically ill, no benefits are paid under a tax-qualified plan. Benefits may, however, be paid under a non-tax qualified policy that has a medical necessity benefit trigger for home and community based care.

Let's look at another situation. Assume an insured, age 72, has a hip replacement. Full recovery is expected within eight weeks. Rarely will a doctor certify that this insured is chronically ill. If, however, the insured's doctor certifies that the insured needs care, under the "medically necessary" trigger, benefits will be paid subject to satisfying the elimination period. If the policy does not have the "medical necessary" benefit trigger no benefits will be paid.

Please note if Medicare provides coverage, even a non-tax qualified plan will not provide benefits because there is no duplication of coverage.

TAX ISSUES:

Many insurance companies and industry commentators have stated that the policy owner will have adverse tax results if the policy is not tax-qualified. There are really three different tax issues:

1. Is the benefit received under a long-term care plan *excluded* from gross income?
2. Is the premium *deductible*?
3. If an employer pays the premium, is that amount *excluded* from the employee's income?

Are long-term care benefits excluded from gross income?

Clearly, if the policy is a tax-qualified plan the benefits are tax-free. ***Benefits received under a non-tax qualified plan should also be received tax-free.*** Many companies and commentators have given different opinions. Although every one is entitled to an opinion, they are wrong. Mary Oppenheimer, the Assistant Chief Counsel in the IRS's Office of Employee Benefits and Exempt Organizations responded to a letter from George R. Nethercutt, a State of Washington congressional representative. Congressman Nethercutt asked several questions about the federal income tax treatment of benefits received from "Non-tax Qualified Long Term Care Policies.

In the response to Nethercutt, Ms. Oppenheimer stated,

"If the insurance contract does not meet the requirements of section 7702B, it is necessary to examine additional Code sections to determine whether the ... benefits may be excluded from income... If an individual, rather than an employer, purchases an A&H policy, section 104(a)(3) excludes from gross income amounts received through the policy." The response goes on to say that "unlike qualified LTC plans, policies that do not meet the requirement of section 7702B are not statutorily defined in the Code and must, therefore meet the requirements of...104(a)(3) in order for the... benefits to be excluded from income. As a general rule, to meet the requirement ...of 104(a)(3) benefits must be received through a plan that constitutes an A&H insurance arrangement and must be payable for personal injuries or sickness. Determining whether a NTQ policy meets the requirements necessitates a detailed analysis of the specific provisions of each insurance policy."

The policies of reputable companies offering a non-qualified plan should qualify as an A&H arrangement.

Although the letter does not directly say all NTQ policies meet the definitions of an A&H policy, the letter is very strong indication that a typical NTQ long-term care policy *will* qualify as an A&H policy under section 104(a)(3), and thus the benefits will be excluded from income.

Additionally, the companies that only issue tax qualified long term care plans say that payments under a NTQ long-term care plan are included in income because the IRS requires the insurance companies to report payments under long term care policies on Form 1099.

This analysis is specious and a scare technique by the companies.

Ms. Oppenheimer states,

"Insurers are required to report all LTC benefits that are paid. This reporting requirement is mandatory under section 6050Q(a) of the Code. However, the fact that all LTC benefits must be reported does not necessarily mean that all LTC benefits are taxable...In addition, LTC benefits from NTQ policies that satisfy the definition of A&H insurance and are amounts received for personal injuries or sickness are also not taxable."

The letter to the Congressman further states, even though the insurance company files the Form 1099-LTC,

"the instructions to the form indicate that the payer, the insurance company, is not required to determine whether any benefits are taxable..."

Rather, the policyholder determines whether to report the amounts that appear on their copy of the Form 1099.

The final question addressed in the letter to the Congressman was

"Does the IRS currently lack clarification from Congress in regard to congressional intent of the tax status of benefits on NTQ LTC insurance plans?"

Ms. Oppenheimer's response was

"In enacting section 7702B, the Congress wanted to provide a safe harbor for qualified LTC insurance contracts so that taxpayers could be sure that the benefits from such contracts are non-taxable. However, the Congress did not specify how NTQ LTC insurance contracts should be treated. Nevertheless as previously discussed, existing Code provision can be used to analyze the taxability of these benefits and to the extent that a taxpayer has difficulty making a determination, a definitive answer is available from the IRS through a private letter ruling process."

The letter from Ms. Oppenheimer is a clear indication that the benefits from a NTQ LTC policy will be *excludable* from income under Section 104(a)(3).

Are the premiums for a non-tax qualified long term care plan deductible if:

1. The employer pays the premium?
2. The individual policy owner pays the premium?

If the employer pays a long-term care premium on a policy for an employee, the premium payment is deductible under IRC Section 162.

The regulations to Section 162 provide:

"Amounts paid or accrued within the taxable year for ... sickness, accident hospitalization, medical expense are deductible under Section 162(a) if they are an ordinary and necessary expense of the trade or business."

It would appear that the business could deduct the premium for both a tax-qualified, and a non-tax-qualified policy.

With respect to self-employed individuals, and more than two-percent owners of pass through entities, no portion of a NTQ long-term care premium is deductible. All of the relevant code sections, IRC 162(l) and 213(d) specifically refer to a long-term care policy as defined in section 7702B. Thus, if the policy is a NTQ policy no deduction is allowed.

Even if the deduction is disallowed for the people referred to in the above paragraph, what is the economic loss? With respect to self-employed and more than 2% owners of pass through entities, the amount of the deduction is the eligible premium.

With respect to an individual that itemizes deductions, the medical expense deduction is limited to total medical expenses that exceed 7.5% of adjusted gross income. In determining medical expenses, a portion of the long-term care premium is an eligible medical expense. When allowable medical expenses including a portion of the long-term care premium exceed 7.5% of adjusted gross income, the excess over 7.5% is deductible.

How many people do you know have medical expenses that exceed 7.5% of adjusted gross income? Since the deductibility issue for most individuals is a non-issue, the decision on whether to purchase a tax-qualified or non-tax-qualified policy should be based on other criteria.

If the employer pays the premium, is the amount of the premium included in the taxpayer's income?

Code Section 106 is the applicable section of the code dealing with this issue.

It provides that gross income does not include amounts paid by his employer to an accident and health plan. Section 7702B treats tax-qualified long-term care insurance as medical insurance. Thus, if the policy is tax-qualified, it is clear that the premium payments by an employer are excluded from gross income.

The answer is unclear for a non-tax qualified plan. The conservative approach is that the premium is included in income, because there is no specific section of the Code that provides for non-recognition of income.

However, it could be argued that an employer sponsored long-term care plan is an "accident and health policy" under IRC Section 106.

Even if the premium is taxable to the employee, it is better than purchasing the policy personally. Let us assume that the premium is \$1,000 and the employee is in a 28% tax bracket. The cost to the employee is \$280. This is a lot better than paying the \$1,000 if he purchased the policy personally. If the employee includes the premium in income, he is deemed to have paid for the policy personally so that the benefits are income tax free under Section 104.

CONCLUSION:

As a professional, you have an obligation to explain the difference between a tax-qualified plan and non-tax qualified plan. Let the client decide which plan he or she wants.

If you agree that the benefits received under a non-tax qualified plan will be excluded from gross income, then you should recommend that your client purchase a non-tax-qualified plan. Even if the entire premium is tax deductible, which is not the current law, the additional benefit triggers under the non-tax qualified policy may more than offset the deductibility of the premium.

Remember, the value of the deduction is based on your income tax bracket. If you are in a 30% tax bracket and the premium is \$3,000, the deduction saves you \$900. Should your client purchase a product with inferior benefit triggers to obtain the small tax savings?

HOPE THIS HELPS YOU HELP OTHERS MAKE A POSITIVE DIFFERENCE!

Stanley Strouch

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