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THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

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In the Matter of

ABILITY INSURANCE COMPANY,

An Authorized Insurer and Respondent

Docket Nos. 11-0088 and 11-0089

OIC'S SECOND SUPPLEMENTAL
HEARING BRIEF

Legal Unit, DIC
Patricia D. Petersen
Chief Hearing Officer

Ability Insurance Company's ("Ability" or the "Company") supplemental briefing essentially raises three arguments: (1) it believes that "lapse" is not when the rule says it is, nor when its WAC 284-54-253(1)(a) notice letter was supposed to say it is, nor when its policy says it is; instead, it feels its own interpretation of WAC 284-54-253 is correct as to when the 5-month period starts and started with respect to the insured here (*see* sections "IIIA" and "IIB"), (2) it also belatedly, and for the first time, contends that federal law preempts OIC's authority, particularly with regard to the standard of proof of "cognitive impairment" and "loss of functional capacity" under WAC 284-54-253 (*see* section "IIC"), and (3) it also belatedly, and for the first time, claims that its insured and her designee both failed to timely present enough of a specific kind of evidence the Company contends she needed to present to even qualify for reinstatement, an elevated, more stringent proof of "cognitive impairment" or "loss of functional capacity" (section "IID").

Each of the Company's arguments is incorrect, inconsistent with the facts and the law, or both. The Company miscalculated the 5-month period under WAC 284-54-253(2) by ignoring the rule's language, the language in its insurance policy, and even what its own alleged designee notice said. The Company's acts were also wrongful, as they violated the Insurance Code in numerous regards, culminating in the Company wrongful decision to deny the designee's request to reinstate the insured's policy. The Company's wrongful acts estop it from now asserting its "federal preemption" and other various late, side arguments (which are also wrong), including its argument that the insured supposedly failed to timely present the

1 modicum of proof the Company now asserts she owed to become entitled to reinstate her
2 policy (which argument is also wrong.)

3 **A. By ignoring WAC 284-54-253's language, the Company's policy with its**
4 **insured, and other legal principles the Company cites, the Company**
5 **miscalculates the counting of the five-month reinstatement period.**

6 The Company's supplemental briefing, in some ways, belies its faulty arguments. For
7 example, the Company's brief does correctly cite many of the same Washington principles
8 OIC cites. These rules of construction and interpretation that the Company cites mirror many
9 of the same ones that IOC cited. These include the following:

10 The court's fundamental objective is to ascertain and carry out the Legislature's intent,
11 and if the statute's meaning is plain on its face, the court must give effect to that plain
12 meaning as an expression of legislative intent. [...]

13 [...] The plain meaning of a provision is derived from all that the Legislature has said
14 in the statute and related statutes which disclose legislative intent about the provision
15 in question.

16 [...] A term in a regulation should not be read in isolation but rather within the context
17 of the regulatory and statutory scheme as a whole. We should not construe a
18 regulation in a manner that is strained or leads to absurd results. *Our paramount*
19 *concern is to ensure that the regulation is interpreted in a manner that is consistent*
20 *with the underlying policy of the statute.*

21 (Emphasis added.) See Company supplemental briefing at 4 and 5. The problem is, however,
22 that the Company then goes on to ignore these principles, and then incorrectly argues that
23 "[r]egulatory construction of WAC 284-54-253 is not necessary to determine when a policy
lapses for non-payment of premium." See Ability briefing at p. 2, lines 14-15. Since our task
is to determine the start of the WAC 284-54-253(2) five-month period, the principles the
Company cites need to be followed, not ignored.

For example, our "paramount concern" is to ensure that WAC 284-54-253 is
interpreted in a manner that is consistent with its underlying policy. While Ability's briefing
does not mention what the rule's "underlying policy" is that should receive "paramount"
importance, OIC's supplemental brief did: its policy is to construe WAC 284-54-253 in such a
way so as to "protect insureds from unintentional lapse," including by "liberally constru[ing]

1 WAC 284-54-253] to promote the public interest in protecting purchasers of long term care
2 insurance.” OIC brief at pps.7-8, *citing* RCW 48.84.010 and WAC 284-54-253. This
3 requires us to construe WAC 284-54-253, and to do so “liberally” in a way that favors
4 *insureds*, because, as the Company knows,¹ this rule’s underlying policy is to protect
5 especially vulnerable insureds from inadvertently losing the coverage that they in particular
6 often need the most, yet, are least able to protect against losing. Through this lens, then, the
7 first thing we must do – as the Company notes – is to read the relevant language and give its
8 plain meaning effect. *See, e.g.*, the Company’s supplemental briefing at 4 and 5.

9 There are three sources of language we must read here in order to determine when
10 WAC 284-54-253(2)’s five-month period starts: (1) the language in WAC 284-54-253, (2) the
11 language in the Company’s purported WAC 284-54-253(1)(a) notice, and (3) the language in
12 the Company’s policy with its insured. First is the language of WAC 284-54-253.

13 OIC’s brief has already discussed WAC 284-54-253 and explained that it means what
14 it says. While the Company’s brief fails to discuss this language, the Company does at least
15 (barely) mention it, even if only in passing over it. As the Company notes, WAC 284-54-253
16 states that a designee is “to receive notice of lapse for nonpayment of premiums at least thirty
17 days prior to the termination of coverage,” (emphasis added), and WAC 284-54-253(1)(a)
18 next requires that this notice “shall provide that the contract or certificate will not lapse until
19 at least thirty days after the notice is mailed to the insured’s designee.” (Emphasis added.)
20 *See* Company’s supplemental briefing at page 7 lines 6-14 (*see also* OIC supplemental brief at
21 9.) OIC’s brief pointed out that this language sets forth a mandatory, not discretionary, duty,
22 *see, e.g., Crown Cascade, Inc. v. O’Neal*, 100 Wn.2d 256, 261, 668 P.2d 585 (1983),² and it

21 ¹ As pointed out in footnote 19 of OIC’s supplemental brief, the Company knows that the actual reason why
22 most of its policyholders’ contracts expire is because they do not intend for them to expire.

23 ² Absent persuasive evidence of a contrary intent, the word “shall,” when used in a law or rule, “is imperative
and operates to create a duty rather than to confer discretion.” *Crown Cascade, citing Clark Cy. Sheriff v.*
Department of Social & Health Servs., 95 Wn.2d 445, 448, 626 P.2d 6 (1981).

1 creates requirements which **must** be given meaning and not simply be ignored or rendered
2 superfluous.³ Under the governing principles cited in the Company's brief, "if the statute's
3 meaning is plain on its face, the court must give effect to that plain meaning as an expression
4 of legislative intent. [...] The plain meaning of a provision is derived from **all** that the
5 Legislature has said in the statute and related statutes which disclose legislative intent about
6 the provision in question." See Company supplemental briefing at 4 and 5. Though these
7 rules of construction require us to read this and see what it means, the Company's
8 supplemental briefing demonstrates a curious incuriosity about this language.

9 WAC 284-54-253 *expressly* states what duties the Company needs to carry out to
10 protect its insureds: (1) the Company needs ensure that a designee would "receive notice of
11 lapse for nonpayment of premiums at least thirty days **prior to** the termination of coverage,"
12 and (2) the Company needed to send a notice that "**shall** provide that the contract or
13 certificate will not lapse until at least thirty days **after** the notice is mailed to the insured's
14 designee." (Emphasis added.) See WAC 284-54-253. This plainly means exactly what it
15 says: the Company must send a notice to a designee *in advance of the lapse or termination of*
16 *coverage*, and the notice the Company sends must inform the designee of the date that this
17 lapse or termination event will occur. Equally plain is that the Company breached both of
18 these duties. It claims it didn't *send* a notice in advance (nor does it even try to explain why),
19 nor does it contend the notice it thinks it gave related a *future* lapse or termination date. This
20 awkward inconsistency may explain why the Company basically ignores the meaning of the
21 language of the rule and doesn't apply the rules of construction it claims apply in its briefing,
22 but this isn't the only language the Company ignores.

23 ³ A reviewing court should construe agency rules in "a rational, sensible" manner, giving meaning to the
underlying policy and intent. *Mader v. Health Care Auth.*, 149 Wn.2d 458, 70 P.3d 931 (2003) (citing *Cannon*
v. Dep't. of Licensing, 147 Wn.2d 41, 57, 50 P.3d 627 (2002)). "In construing a statute, we give effect to all its
language so that 'no portion is rendered meaningless or superfluous.'" *Friends of Columbia Gorge, Inc. v.*
Wash. State Forest Practices, 129 Wn. App. 35, 47, 118 P.3d 354 (2005), citing *Muckleshoot Indian Tribe v.*
Dep't of Ecology, 112 Wn. App. 712, 720, 50 P.3d 668 (2002), *review denied*, 150 Wn.2d 1016 (2003).

1 The second source of language we must look at here – which is next ignored by the
2 Company – is the language in the Company’s alleged WAC 284-54-253(1)(a) notice. It
3 provides, in relevant part, that “If the premium is not received within 35 days from the date of
4 this letter, the policy will lapse for nonpayment of premium.” (Emphasis added.) See OIC
5 Exh. 7. Of course, the only way this could comply with what the rule required would be if it
6 related that lapse “will” occur *in the future*.⁴ Yet, Donald Lawler testified that the Company
7 intended for its letter to mean something different – that lapse had *already happened*. Again,
8 this would explain the Company’s reluctance to even begin to try to explain what the plain
9 language means, since the undisputed evidence in this matter shows that the Company didn’t
do what those words required it to do, let alone meet the policy of WAC 284-54-253.

10 The third source of language we must consider is Company’s own policy with its
11 insured. Again, the Company’s supplemental briefing also ignores this, as well as the
12 meaning it was recently given as explained in the recently final, published decision against the
13 Company in the case *Bushnell v. Medico Ins. Co. et al*, 159 Wn. App. 874, 246 P.3d 856
14 (2011), *review denied*, 172 Wn.2d 1005 (2011). As OIC’s supplemental brief pointed out
15 about this policy language, it, too, meant what it said: it could not lapse until at least after the
16 policy’s 31-day grace period had ended. See, e.g., OIC supplemental brief at 20. The
17 *Bushnell* Court agrees. At page 888 of *Bushnell*, the Court rejected the Company’s arguments
18 that lapse happens sooner than the policy’s same “grace period” language provides here.
19 While the Company argued around the grace period language, and pointed at other language it
20 preferred to rely on to leave the insured without coverage, the Court ruled otherwise. It held
21 that the language “unambiguously states that during the grace period, ‘[y]our policy stays in
22 force.’” This, the Court held, means that “coverage d[oes] not lapse until after the grace
23

⁴ Of course, the word “will,” when used in this context as an auxiliary verb, under any dictionary definition, always refers to a future event.

1 period.” *Id.* (Emphasis added.) Under the law, *Bushnell*’s recent finality renders this court
2 decision the conclusive interpretation as to this policy provision’s meaning.⁵ It applies here.

3 Taken together, the language of WAC 284-54-253, the language of the Company’s
4 alleged WAC 284-54-253(1)(a) notice, and the language of the Company’s own policy with
5 its insured all each show that the Company miscalculated WAC 284-54-253(2)’s five-month
6 period. The rule, the March 20, 2009 letter/notice, and the insured’s policy’s language each
7 plainly mean that the policy “lapse” or “termination” date was in the future, at a date after the
8 letter/notice is mailed, and after the policy’s grace period has ended. There is no basis in any
9 of this language to conclude that the lapse or termination date somehow “reverts back,” as the
10 Company has argued – nor has the Company supplied any citation to any law, rule, court
11 decision, or any other authority to support its “reverts back” argument. After WAC 284-54-
12 253 establishes all this, WAC 284-54-253(2) next couples with it to extend the right to
13 reinstatement if requested within “the five months after the policy lapsed or terminated due to
14 the nonpayment of premium.” Thus, under WAC 284-54-253 and the Company’s alleged

14 ⁵ Under the Washington doctrines of collateral estoppel and res judicata, the Company is bound by the *Bushnell*
15 Court’s determination on this point. Collateral estoppel, or issue preclusion, bars relitigation of an issue in a
16 subsequent proceeding involving the same parties. 14A KARL B. TEGLAND, WASHINGTON PRACTICE:
17 CIVIL PROCEDURE § 35.32, at 475 (1st ed. 2003) (hereafter TEGLAND, CIVIL PROCEDURE). Res
18 judicata, or claim preclusion, may also operate here, though it has been said to have been “intended to prevent
19 relitigation of an entire cause of action and collateral estoppel is intended to prevent retrial of one or more of the
20 crucial issues or determinative facts determined in previous litigation.” *Luisi Truck Lines, Inc. v. Wash. Utils. &*
21 *Transp. Comm’n*, 72 Wn.2d 887, 894, 435 P.2d 654 (1967). The term res judicata (“thing decided” or “matter
22 judged” in Latin) has sometimes been used to both issue and claim preclusion. Philip A. Trautman, *Claim and*
23 *Issue Preclusion in Washington*, 60 Wash. L. Rev. 805 (1985). But collateral estoppel is often distinguished
from claim preclusion “in that, instead of preventing a second assertion of the same claim or cause of action, it
prevents a second litigation of issues between the parties, even though a different claim or cause of action is
asserted.” *Rains v. State*, 100 Wn.2d 660, 665, 674 P.2d 165 (1983) (cites omitted); TEGLAND, CIVIL
PROCEDURE § 35.32, at 475. For collateral estoppel to apply, the party seeking application of the doctrine
must establish that (1) the issue decided in the earlier proceeding was identical to the issue presented in the later
proceeding; (2) the earlier proceeding ended in a judgment on the merits; (3) the party against whom collateral
estoppel is asserted was a party to, or in privity with a party to, the earlier proceeding; and (4) application of
collateral estoppel does not work an injustice on the party against whom it is applied. Trautman, *Claim and*
Issue Preclusion, 60 Wash. L. Rev. at 831. Under either collateral estoppel or res judicata, whether the policy’s
“grace period” is an “issue” or a “determinative fact,” the result is the same: *Bushnell*’s conclusion that the
policy’s “grace period” language that “unambiguously states that during the grace period, ‘[y]our policy stays in
force,’” means that “coverage d[oes] not lapse until after the grace period,” governs here.

1 WAC 284-54-253(1)(a) notice, WAC 284-54-253(2)'s five month period commenced well
2 after the date the Company claims it did. While this language should not be read in a way that
3 is "strained or leads to absurd results" (see Company's supplemental briefing at 4-5), that is
4 precisely what the Company's reverts back argument would require.⁶ Likewise, *Bushnell* also
5 makes clear that the Company miscalculated when its policy lapsed based simply on the
6 language of its own policy with its insured. Either way, the conclusion is the same. The
7 Company miscalculated the start of the five months and since the undisputed evidence shows
8 that a claim was made within five months of the correct start date, the Company wrongfully
9 refused to grant reinstatement, which was timely requested under both scenarios.

10 The Company's supplemental briefing next turns to inapplicable and faulty legal
11 arguments to attempt to justify its views. One such faulty argument is the Company's
12 baseless claim that applying the language it ignores will result in untold numbers of insureds
13 "get[ting] to choose, after the fact, to obtain insurance for a past incident," or "simply
14 wait[ing] out each grace period before deciding whether or not to renew the policy." See
15 Ability brief at p. 9 lines 10-11 and 16-18. This argument is not only unsupported by the

15 ⁶ The Company's interpretation requires that the word "lapse" be assigned one meaning in once sentence, which
16 would be directly at odds with its plain meaning in another sentence. For example, WAC 284-54-253 states that
17 the designee will "receive notice of lapse for nonpayment of premiums at least thirty days prior to the
18 termination of coverage." WAC 284-54-253(1)(a) then makes clear that this "notice" referred to earlier "shall
19 provide that the contract or certificate will not lapse until at least thirty days after the notice is mailed to the
20 insured's designee." Plainly, read together, the various parts of the rule treat "termination" and "lapse" as the
21 same event, and they do not equate this event with the due date for the payment of the premium. Yet, the
22 Company wants to interpret them in such a way as to think that "lapse" in WAC 284-54-253(1)(a) means
23 something different – the due date for the payment of premium under the policy. The problem with this is, the
rules use the language "due date for the payment of premiums" elsewhere, like in WAC 284-54-250, and WAC
284-54-253 even discusses "nonpayment of premium" elsewhere, so it is treated as a separate and distinct event
from "lapse." The Company's attempt to conflate them into one meaning flies in the face of rules of
construction. Statutes must be read together "to give each effect and to harmonize each with the other." *Draper
Mach. Works, Inc. v. Department of Natural Resources*, 117 Wn.2d 306, 313, 815 P.2d 770 (1991). There is a
"presumption that the Legislature does not engage in unnecessary or meaningless acts." *Bailey v. Allstate Ins.
Co.*, 73 Wn. App. 442, 446-47, 869 P.2d 1110 (1994), citing *State v. McCullum*, 98 Wn.2d 484, 493, 656 P.2d
1064 (1983). When an agency chooses to create a regulation that is silent as to one term in one part, but uses the
term elsewhere, such choices should be deemed deliberate, and different meanings must not be conflated without
evidence of the same, just as courts do with the laws enacted by the Washington State Legislature. "Where the
Legislature omits language from a statute, intentionally or inadvertently, . . . [a reviewing] court will not read
into the statute the language that it believes was omitted." *State v. Moses*, 145 Wn.2d 370, 37 P.3d 1216 (2002).

1 rules of construction the Company cites, it is also baseless and inconsistent with the
2 “paramount” goals of protecting insureds and construing the rule’s language and policy in
3 favor of insureds. It is also an argument without any rational or factual basis. This
4 argument’s faulty premise is that these insureds are all eagerly awaiting their chance to
5 deliberately game the system by fraudulently obtaining a few weeks of free and undeserved
6 coverage on the back of the Company’s good will. But the truth is, as the Company knows,⁷
7 that since these insureds are among the most vulnerable of virtually all insureds, hobbled with
8 a kind of “cognitive impairment” and “loss of functional capacity” that prevents them from
9 possessing such an insidious sort of *mens rea* to cheat the Company in such a calculated way,
10 that the scenario they imagine defies reality. Both baseless and puzzling, the Company’s
11 argument is utterly meritless. Unfortunately, it isn’t the only such argument the Company
12 makes; the Company also cites a series of cases that are also, at best, unhelpful.

13 One such unhelpful case that the Company cites, at page 5 and 6 of the Company’s
14 supplemental briefing, is the United States Supreme Court case, *General Dynamics v. Cline*.
15 The Company discusses this case in the context of arguing about what WAC 284-54-253’s
16 use of the word “lapse” may mean, contrary to the rules of construction,⁸ but OIC staff
17 respectfully submit that *Cline* does not substantially help address or resolve any issue in this
18 matter. *Cline* involves a different issue, an entirely different context, and it simply has
19 nothing to do with the instant matter, though it does somewhat aptly emphasize something the

20 ⁷ See footnote 19 in the OIC’s supplemental hearing brief, noting that the Company knows that its “[e]xperience
21 shows that most policies expire inadvertently,” while evidence shows that, far and away, most insureds whose
22 policies lapse have the worst physical and mental condition and are most in need of the coverage they lose.

23 ⁸ The Company’s effort to look to caselaw to define the word “lapse” while ignoring the pertinent language is
also inconsistent with the rule of construction that policies are to be construed “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)) “a meaning and construction most
favorable to the insured must be applied, even though the insurer may have intended another meaning,” (*Nichols
v. CNA Ins. Co.*, 57 Wn. App. 397, 400, 788 P.2d 594 (1990), citing *Riley v. Viking Ins. Co.*, 46 Wn. App. 828,
830, 733 P.2d 556 (1987)) and “not [its] technical, legal meaning.” (Cite omitted.) *Allstate Ins. Co. v. Peasley*,
131 Wn.2d 420, 424, 932 P.2d 1244 (1997). This applies whether a word is undefined in a contract or in a statute.
See *Am. Legion Post No. 149 v. Dep’t of Health*, 164 Wn.2d 570, 592 fn. 17, 192 P.3d 306 (2008).

1 parties seems to agree on: that an undefined policy term's meaning is drawn from the
2 dictionary, not technical or legal meanings. *Compare*, Ability's briefing at 6-7 with OIC's
3 brief at 22-24 (both recognizing that Washington courts may choose to consult a dictionary to
4 help determine a word's common and ordinary meaning.) The only other thing in *Cline* of
5 even any remote assistance here is its reminder warning that "disregarding the context of a
6 term must be guarded against." *See* Ability brief at p. 6 lines 19-21. As explained, WAC
7 284-54-253's context shows that it would be absurd to suggest the same words in the same
8 rule in the same regulatory scheme mean two different things in two different subsections.
9 Yet, ignoring the context of WAC 284-54-253 and its use of the word "lapse" is precisely
10 what the Company does here, ironically, immediately after pointing out that *Cline* warns us
11 against doing that here.

12 Another faulty claim in the Company's brief is its erroneous assertion that a 1984
13 Washington Court of Appeals decision's isolated language should be read out of context and
14 relied on here to support its views. The Company argues that the case's sentence, "the
15 general rule is that failure of an insured to pay renewal premium by the due date results in a
16 lapse of coverage as of the last day of the policy period," supposedly "addresse[s] the
17 question at issue here." *See* page 8 of its brief, *citing Safeco Ins. Co. v. Irish*, 37 Wn. App.
18 554, 557, 681 P.2d 1294 (1984). But aside from the fact that looking to *Irish* for the meaning
19 of an undefined word defies the rules of construction that both parties believe should be
20 applied here, actually *Irish* does not address the question at issue here and for several reasons,
21 is inapplicable.

22 First, *Irish* is did not address the question here – whether the Company miscalculated
23 when WAC 284-54-253's five-month reinstatement period commenced. *Irish* was an auto
insurance case whose outcome was based on that case's very specific and different policy
language. *Irish* was not a long-term-care insurance case, and it did not address any of WAC
284-54-253's specific, long-term care unintentional lapse notice requirements that are relevant

1 here, nor any other portions of Chapter 54 of Title 284 WAC. Here, WAC 284-54-253 and
2 the insured's policy include the language that governs. The insured's policy provides that its
3 coverage remains in force until the end of the grace period, and under *Bushnell*, this means
4 lapse cannot happen until the day this grace period ends. Likewise, WAC 284-54-253
5 provides that the policy's lapse or termination date is tied to a specific date when the notice is
6 mailed, and it requires that this notice shall be mailed "prior to the termination of coverage,"
7 and "shall" provide that the date of lapse shall not occur until at least 30 days after the date
8 this notice is mailed. In *Irish*, no such language was at issue. Moreover, whereas in *Irish* the
9 insurer complied with the applicable automatic renewal statute (RCW 48.18.292(1)(b),
10 applicable to auto policies), here Ability failed to comply with Insurance Code obligations
11 that included its obligations under WAC 284-54-253.

12 Second, *Irish* has never been construed in the way the Company argues it should here,
13 as binding precedent in this long-term care, unintentional lapse Model Rule-based
14 reinstatement case. In fact, when other courts were asked to draw the same conclusion Ability
15 urges here, using the same above-quoted language from *Irish*, those other courts rejected
16 those attempts. Rather than simply take one sentence out of context from *Irish*, as Ability
17 urges we do here, courts instead rightly look at whatever relevant policy and law or rule
18 language is actually at issue. In one example, a court did not apply this isolated sentence from
19 *Irish* because it was "simply not applicable" – it recognized that because *Irish* did not deal
20 with the same specific language or the same specific requirements that were before it, its
21 conclusion didn't apply. *Olivine Corp. v. United Capitol Ins. Co.*, 105Wn. App. 194, 201, 19
22 P.3d 1089 (2001). Likewise, in the unpublished case *Sheldon v. Metro. Prop. & Cas. Ins.*
23 *Co.*, 2003 Wash. App. LEXIS 1879, the same division of the Washington Court of Appeals
that penned *Irish* distinguished its old case's quoted language because "[t]he policy in *Irish*
expressly provided for automatic termination, whereas the policy in this case does not." And
again in Washington Court of Appeals Division III's *Whistman v. W. Am. of Ohio Casualty*

1 *Group of Ins. Cos.*, 38 Wn. App. 580, 686 P.2d 1086 (1984), that court too distinguished
2 *Irish*, like the other courts, because *Irish* dealt with an automobile policy with its own certain
3 specific language that was only applicable to that case, while the homeowner policy in its case
4 was simply different. *Id.* at 583, fn. 1. *See also DeTemple v. Southern Ins. Co.*, 154 Ariz. 79,
5 85, 740 P.2d 500 (Ct. App. AZ 1987) (same result.) The same reasoning applies here, where
6 *Irish* does not address the specific scheme and specific requirements in WAC 284-54-253.

7 Third, *Irish* is also inapplicable because it involved very specific and materially
8 different cancellation notice language that is not at all analogous here. In *Irish*, the insurer
9 issued its insured, Mr. Irish, a notice that *specifically* “reminded him that his renewal
10 premium had not been received and that if not received by 12:01 a.m. February 17, 1979, his
11 policy would be “cancelled” at that time.” *Irish* at 556-57. As this shows, the court deemed it
12 dispositive that the insurer’s notice was explicit as to the exact date – and even the exact
13 moment – when the “cancellation” would take effect, right down to the minute. Here, by
14 contrast, the notice allegedly given from Ability to the insured’s designee only said “[i]f the
15 premium is not received within 35 days from the date of this letter, the policy will lapse for
16 nonpayment of premium.” OIC Exh. 7. The Company’s notice said no more about the
17 “lapse” that “will” happen. Nor did *Irish* determine whether this kind of language was
18 compliant with WAC 284-54-253. *Irish* is inapplicable.

19 The Company’s supplemental briefing also cites other inapplicable cases, including
20 *Coventry Assoc. v. Am. States. Ins. Co.*, 136 Wn.2d 269, 961 P.2d 933 (1998) and *Saunders v.*
21 *Lloyd’s of London*, 113 Wn.2d 330, 779 P.2d 249 (1989). The Company also cited these two
22 cases in its motion for stay brief, and each time it did, it did so to support its recurring
23 argument that these two cases somehow prohibit or invalidate OIC’s two orders because they
supposedly wrongfully mandate otherwise prohibited free coverage. But the Company’s
reliance on these cases is misplaced, and a fair reading shows they are inapplicable here.

1 First, as OIC staff pointed out in its response and opposition to the Company's motion
2 for a stay, these two cases are factually not analogous. *Saunders* dealt with property damage
3 from a fallen tree, and claims for coverage under an entirely different kind of policy. The
4 case dealt with legal issues like whether estoppel, waiver, and Consumer Protection Act
5 ("CPA") tort claims were well-founded. *Saunders* dealt with none of the long-term care
6 policy and practice requirements at issue here. *Coventry*, too, addressed whether an insured
7 may bring a bad faith or CPA claim against its insurer when the insurer conducted a bad faith
8 investigation of the insured's claim but the denial of coverage was ultimately determined to
9 be correct. Like *Saunders*, it dealt with no long-term care contract rules or practices, either.
10 As OIC staff pointed out before, the only commonality between any of these cases is that they
11 each involve insurance contracts and they each involve insurance companies. Aside from
12 that, they are otherwise inapposite.

13 Second, the portions of *Coventry* and *Saunders* pointed to by the Company simply do
14 not support the Company's arguments. In fact, the portions the Company cites appear to have
15 been taken out of context. For example, the Company relies on page 480 of *Coventry*, which
16 provides:

17 This is not to say an insurer is required to pay claims which are not covered by the
18 contract or take other actions inconsistent with the contract. Of course, insurance
19 companies, like every other organization, are going to make some mistakes. As long
20 as the insurance company acts with honesty, bases its decision on adequate
21 information, and does not overemphasize its own interests, an insured is not entitled to
22 base a bad faith or CPA claim against its insurer on the basis of a *good* faith mistake.

23 *Coventry* at 480. While this does not seem inconsistent with OIC's position and actions, it *is*
inconsistent with the Company's claim that the case somehow prohibits "free" insurance.
When the above-quoted text is considered, it demonstrates that Ability's stay motion (*see*
page 6, lines 20-21, that "an insurer is [not] required to pay claims which are not covered by
the contract or take other actions inconsistent with the contract") somewhat misrepresents
what the court *really* said. Obviously, the case does not declare any ban on mandating "free"

1 coverage, as the Company suggests. Likewise, the Company relies on page 336 of *Saunders*,
2 which provides:

3 The underlying rationale is that an insurance company should not be required to pay
4 for a loss for which it received no premium. *See Saunders* (quoting *Sullivan v. Great*
5 *Am. Ins. Co.*, 23 Wn. App. 242, 247, 594 P.2d 454 (1979)). That rationale supports
6 precluding waiver or estoppel in situations where the insured attempts to broaden
coverage to protect against risks not stipulated in the policy or expressly disclaimed.
See Carew; *see also* Annot., 1 A.L.R.3d 1139, 1144 (1965). That rationale cannot,
however, support precluding waiver or estoppel where the insurers have previously
accepted premium payments for periods for which they provided *no* coverage.

7 *Saunders* at 336. Again, a reading of this whole case, in context, makes clear that the limited
8 portion of *Saunders* quoted by the Company did not declare any supposed wrongfulness of
9 supposedly “free” insurance (*see* the Company’s motion for stay at page 6 lines 22-24).

10 Reading the *whole* case shows that *Saunders* really dealt with whether waiver and estoppel
11 could apply to insurers’ practices concerning *renewal* premiums – not the Company’s
12 argument here. This is made clearer by looking at the case *Saunders* cited, *Sullivan v. Great*
Am. Ins. Co., 23 Wn. App. 242, 247, 594 P.2d 454 (1979), where the court stated:

13 [...] courts have reasoned that an insurance company should not be required by waiver
14 or estoppel to pay for a loss for which it charged no premium.

15 This language clarifies that these three cases’ concern was with estoppel and waiver regarding
16 the collection of premium, not any supposed concern with or ban on this “free coverage” that
17 the Company keeps talking about here. None of these three cases (*Saunders*, *Coventry*, or
Sullivan) supports Ability’s arguments, nor do they prohibit or undermine the OIC’s orders.

18 Finally, even if, *arguendo*, there were some law or case that did prohibit the allegedly
19 improper requiring of “free coverage,” the Company’s “free coverage” complaint would *still*
20 fail because the Company is the one that created the scenario it now complains about, all by
21 its own wrongdoing and violations of the law. As indicated, WAC 284-54-253 expressly
22 states that the WAC 284-54-253(1)(a) notice is to be mailed at least “thirty days prior to the
23 termination of coverage,” and the rule requires that this notice “shall,” consequently, provide
that the date of lapse shall not occur until at least 30 days after the date the notice was mailed.

1 In this case, the evidence is undisputed that the Company failed to meet these requirements.
2 Instead of doing what the rule required, the Company allegedly chose to wait to allegedly
3 send its WAC 284-54-253 notice. The undisputed evidence shows that the Company does not
4 even allege that it sent this notice until at least a month and a half *after* the date it now claims
5 “lapse” supposedly occurred. If true, the Company’s notice was almost *three months late*. It
6 is unclear why the Company failed to act any sooner than it alleges it did on March 20, 2009,
7 instead of at least thirty days *prior* to termination or lapse as the rule required, but regardless,
8 the Company unilaterally created the allegedly improper “free insurance” scenario it now
9 complains of, and it did so only because it chose to violate the express requirements of WAC
10 284-54-253. The Company cannot now complain about consequences of its own
11 noncompliance and violation of the Insurance Code, or complain that it is somehow OIC’s
12 fault. For this reason, too, the Company’s argument should be rejected.

12 **B. The law estops the Company from now arguing about federal laws,
13 preemption, or the insured’s alleged failure to meet a burden of proof as to
14 medical evidence of cognitive impairment or loss of functional capacity.**

13 The *only* issue properly before this Court is the one this brief just addressed – whether
14 the Company calculated the 5-month period incorrectly, as OIC believes it did. The Company
15 addresses this issue in sections “IIIA” and “IIIB” of its supplemental briefing. This Court
16 should rule on this issue in OIC’s favor.

17 Yet, the Company has also now raised a myriad of other, subsequently developed
18 irrelevant side legal arguments that range from federal preemption to tax law to HIPPA
19 analysis.⁹ Although WAC 284-02-070(1)(b)(ii) requires a hearing demand to “specify the
20 grounds to be relied upon as the basis for the relief sought,” and RCW 48.04.010(2) also
21 requires the demand to “specify in what respects such person is so aggrieved and the grounds

22 ⁹ Section “IIIE” of Ability’s supplemental briefing does also include another, puzzling, new discussion about its
23 claimed “surprise” over the OIC’s actions based, in part, on an OIC document called “News Release
Guidelines.” This seemingly misplaced discussion, though, to the extent it is even relevant to any issue here, is
addressed separately.

1 to be relied upon as basis for the relief to be demanded at the hearing,” the Company’s May 2,
2 2011 hearing demand failed to “specify” – or even allude to – any of the various new side
3 legal arguments included in sections “IIC” and “IID” of its supplemental briefing. And as a
4 consequence, this Court’s June 21, 2011 Notice of Hearing also reflected that the only reasons
5 why the Company demanded a hearing were for those reasons “specified” in the Company’s
6 May 2, 2011 letter. *See* 6/21/11 Notice of Hearing at page 2. THIs violated .¹⁰ Since these
7 new, side legal arguments were not properly raised when they were required to be raised, they
8 are not proper to raise now.

9 Aside from violating WAC 284-02-070(1)(b)(ii) and RCW 48.04.010(2)
10 requirements, however, all of these other arguments in sections “IIC” and “IID” of the
11 Company’s supplemental briefing are also improper because the law estops and forecloses the
12 Company from raising them. These new arguments only arose because of the Company’s
13 change in its position. When the designee asked what she needed to do, the Company did not
14 help or inform the designee to understand what it now claims she needed to do. Its November
15 5, 2009 letter to its insured’s designee only gave one incorrect reason for its reinstatement
16 denial – that she did not request it in time. It said nothing about the supposed inadequacy of
17 what she had provided. But over *a year later* the Company added a new and late reason: it
18 claims the insured’s designee also failed to timely provide enough and the specific kind of
19 “proof” the Company now claims federal laws supposedly require. And consequently, to
20 bolster that after-the-fact reason/excuse, the Company now adds the arguments in sections
21 “IIC” and “IID” of its brief.

22 The problem with the Company’s new arguments is that because the Company not
23 only added a new reason/excuse when it was too late, but also did not comply with its

¹⁰ The requirements under Washington’s Administrative Procedures Act (“APA”) appear to be no different in requiring adequate advance notice of the issues for hearing. “The APA requires that the parties be put on notice of the issues to be litigated.” *Eidson v. Dep’t of Licensing*, 108 Wn. App. 712, 727, 32 P.3d 1039, citing *McDaniel v. Dep’t of Soc. & Health Servs.*, 51 Wn. App. 893, 898, 756 P.2d 143 (1988).

1 obligations under the Insurance Code, including obligations it owed during its original
2 interactions with its insured and its insured's designee, the law estops and forecloses the
3 Company from now raising them. There are several estoppel-type grounds to support this.

4 First is the doctrine of equitable estoppel. "Equitable estoppel may apply in a situation
5 where one party makes an admission, statement, or act, which another party justifiably relies
6 on to its detriment." *Schoonover v. State*, 116 Wn. App. 171, 179, 64 P.3d 677 (2003) (citing
7 *Dep't of Ecology v. Campbell & Gwinn, L.L.C.*, 146 Wn.2d 1, 19, 43 P.3d 4 (2002)).

8 Equitable estoppel has three elements: "(1) an admission, act or statement inconsistent with a
9 later claim; (2) another party's reasonable reliance on the admission, act or statement; and (3)
10 injury to the other party which would result if the first party is allowed to contradict or
11 repudiate the earlier admission, act or statement." *Id.* at 179-180 (quoting *Campbell &*
Gwinn, L.L.C., 146 Wn.2d at 20).

12 Washington also recognizes another kind of estoppel that applies specifically against
13 insurers who vary the reasons for denying claims only to secondarily bolster their positions.
14 "[I]t is the general rule that if an insurer denies liability under the policy for one reason, while
15 having knowledge of other grounds for denying liability, it is estopped from later raising the
16 other grounds in an attempt to escape liability, provided that the insured was prejudiced by the
17 insurer's failure to initially raise the other grounds." *Bosko v. Pitts & Still, Inc.*, 75 Wn.2d
18 856, 864, 454 P.2d 229 (1969), citing *Moore v. National Accident Soc'y*, 38 Wash. 31, 80 P.
19 171 (1905); *D'Aquila Bros. Contracting Co. v. Hartford Accident & Indem. Co.*, 22 Misc. 2d
20 733, 193 N.Y.S.2d 502 (1959), modified on other grounds, 15 App. Div. 2d 509, 222
21 N.Y.S.2d 409 (1961); *Lancon v. Employers Nat'l Life Ins. Co.*, 424 S.W.2d 321 (Tex. Civ.
22 App. 1968); *Middlebrook v. Banker's Life & Cas. Co.*, 126 Vt. 432, 234 A.2d 346 (1967).

23 For example, in *Moore v. National Accident Soc'y*, 38 Wash. 31, 80 P. 171 (1905),
cited in *Bosko, supra*, an insured's accident insurance policy promised to pay \$25 per week in
coverage if the insured was "wholly disqualified from transacting business by any such

1 injury.” *Moore* at 31. Pursuant to a provision “that a failure, on the part of the insured or his
2 beneficiary, to give notice to the company of an injury to the insured, for a period of ten days
3 after the injury occurred, should invalidate the policy,” the insured gave the insurance
4 company notice of his loss and demanded payment. *Moore* at 31-32. But the insured “was
5 met with a refusal on the part of the company on the ground that he had not given notice of
6 his injury within ten days, as provided in the policy.” *Moore* at 31-32. Accordingly, the
7 insured sued the insurer. Before trial, however, the court granted the company’s motion to
8 dismiss the case, which motion was made on the *new* grounds “that the appellant did not
9 furnish proofs of his injury, within the period limited, after giving notice to the company that
10 he had received an injury.” *Moore* at 32. On appeal, the Washington Supreme Court reversed
11 this decision, holding that this new argument was improper to raise because the insurer was
12 “estopped” from raising such new grounds for denial after it had only given one basis for its
13 actions:

14 As the company denied its liability and refused to treat with the insured on the ground
15 of want of timely notice, its action amounted to a waiver of any other objection, and it
16 is not now at liberty to vary its ground and insist that the appellant cannot recover
17 because he failed to comply with some other condition of the policy. *Hennessy v.*
18 *Niagara Fire Ins. Co.* 8 Wash. 91, 35 Pac. 585, 40 Am. St. 892; *Castner v. Farmers’*
19 *Mut. F. Ins. Co.*, 50 Mich. 273, 15 N.W. 452.

20 This same reasoning applied in *Moore* and *Bosko* also applies here. Here, the insurer gave
21 one reason and one reason only for its denial: “the request was too late.” *See* OIC Exh. 15.
22 Just like in *Moore*, the Company waited more than a year to add its new reason, and then, it
23 only did so to OIC, and then, as an apparent afterthought. *See* OIC Exh. 26.

Like the above-stated estoppel rule set forth in cases like *Moore* and *Bosko*, another
doctrine, called the “mend the hold” doctrine, also applies here, also requires the same
outcome, and for the very same reasons. This doctrine “is the name of a common law
doctrine that limits the right of a party to a contract suit to change his litigating position. In
fact the phrase is a nineteenth-century wrestling term, meaning to get a better grip (hold) on

1 your opponent.” *Harbor Ins. Co. v. Continental Bank Corp.*, 922 F.2d 357, 362 (C.A. 7
2 1990). The first case to spell out this doctrine was a United States Supreme Court decision
3 from 1877, where the doctrine precluded an “after thought” argument because

4 [...] where a party gives a reason for his conduct and decision touching any thing
5 involved in a controversy, he cannot, after litigation has begun, change his ground, and
6 put his conduct upon another and a different consideration. He is not permitted thus to
7 mend his hold. He is estopped from doing it by a settled principle of law.

8 *Railway Co. v. McCarthy*, 96 U.S. (6 Otto) 258, 267-68, 24 L. Ed. 693 (1877). While
9 advocates might be tempted to summarily dismiss such an oddly-named, seemingly “quirky,”
10 antiquated doctrine, courts are not. In fact, it actually enjoys fairly widespread contemporary
11 acceptance among a growing numbers of courts – including in Nebraska, Ability’s home state.
12 When the doctrine was used to estop an insurer from raising a later new claim in the relatively
13 recent Illinois case, *Harbor Ins. Co.*, *supra*, Judge Posner refused to reject it simply for being
14 “quirky” and observed that “[t]he persistence of the doctrine, nineteenth-century phraseology
15 and all, is not a peculiarity of Illinois jurisprudence,” given its contemporary acceptance in
16 other states, and “the doctrine itself, appropriately configured [. . .], can be seen as a corollary
17 of the duty of good faith that the law [. . .] imposes on the parties to contracts.” *Harbor Ins.*
18 *Co.* at 363.

19 Moreover, as one commentator observed, “mend the hold” is “especially applicable to
20 insurance coverage.” Robert H. Sitkoff, “*Mend the Hold and Erie: Why an Obscure*
21 *Contracts Doctrine Should Control in Federal Diversity Cases*,” 65 U. Chi. L. Rev. 1059,
22 1069-70. “Mend the hold” has been thought to be particularly applicable to the situation like
23 Ability’s, where an insurer issues a letter declining coverage, setting forth one reason, but
then later, only in an attempt to bolster its earlier asserted grounds for denial, gives yet an
alternative reason why the conclusion to deny should be upheld:

The mend the hold doctrine, in its majority (and most severe) form, limits a party's
defenses for breaking a contract to those based on a prelitigation explanation for
nonperformance given to the other party. The most common justification for the
doctrine is that it allows a contracting party to rely on the given explanation as
exclusive. Thus, if the party willing to perform wishes to save the deal, it may try to

1 obviate the other party's reason for not performing with the assurance that other
2 impediments to performance are not lurking in the background. The mend the hold
3 doctrine, by definition, applies only to contract disputes.

3 [. . .]

4 The comparatively more frequent use of the mend the hold doctrine in insurance cases
5 may stem from insurance companies' practice of writing letters to policyholders to
6 explain their reasons for denying a claim. Certainly at a minimum these letters,
7 typically referred to as "declination letters," ameliorate the problems of proof
8 associated with a verbal refusal to perform.

6 *Id.* at 1062-63 and 1070-71.

7 The "modern majority" applies "mend the hold" to "limit[. . .] a breaching party's
8 defenses to a prelitigation explanation for nonperformance regardless of that party's good
9 faith reasons for changing positions and the other party's ability to cure." *Id.* at 1067. In
10 particular, as one of the states in this majority observed, it works no injustice whatsoever to
11 apply it against Ability here:

12 The rule works no hardship on the insurer. Considerations of public policy require that
13 he shall deal with his individual customer with entire frankness. He may refuse to pay
14 and say nothing as to the basis of his refusal. In that case, all defenses to an action on
15 the policy are available to him. He may refuse to pay on a particular ground reserving
16 the right to defend on other grounds, with the same result. But, when he
17 deliberately puts his refusal to pay on a specified ground, and says no more, he should
18 not be allowed to "mend his hold" by asserting other defenses after the insured has
19 taken him at his word and is attempting to enforce his liability.

15 *Cummings v. Conn. Gen. Life Ins. Co.*, 102 Vt. 351, 361-62, 148 A. 484 (1930). Though
16 written in 1930, this rings true today.

17 Moreover, Professor Appleman's treatise, in discussing how doctrines of waiver and
18 estoppel "are so closely related," included "mend the hold" in its discussion. 1-5 Appleman
19 on Insurance § 5.07. Appleman noted that "mend the hold" is a sort of "quasi-estoppel
20 doctrine" that "is intended to prevent parties from doing so tactically and in bad faith, and so
21 is related to the doctrine that insurers are required to act in good faith and deal fairly with
22 their insureds." *Id.* Since "[c]overage cases raise contract issues, and insurers sometimes take
23 inconsistent positions, [...] the doctrine may be applied in such cases." *Id.*

1 Here, regardless of how the estoppel's principle is named – whether as estoppel,
2 “mend the hold,” equitable estoppel, waiver, or some other variant – the undisputed facts
3 demonstrate that such doctrines *should* be applied here. The facts show that the Company's
4 belated arguments have as their genesis the Company's own late change in position and
5 violations of the law, specifically including the Insurance Code.

6 On August 4, 2009, the insured's designee (who was also her daughter) spoke with
7 “Jerry in the claims department,” reviewed her mother's policy and other information
8 regarding the same with Jerry, and then Jerry told her how to submit a claim to Ability for
9 coverage for a claim under this policy. Two days later, following Jerry's instructions, she
10 submitted a claim. OIC Exh. 8. Following this same procedure, she submitted a second claim
11 about a month later. OIC Exh. 11.

12 On September 11, 2009, after learning the Company denied the claims because it
13 thought the policy had lapsed or expired, the insured's designee/daughter spoke with someone
14 with Ability, “Sharon.” *See* hearing recording at appx. 4:08. The insured's designee
15 explained to Sharon that she had just discovered a letter in her mother's mail about the lapse,
16 and had known nothing about it. *Id.* at 4:09. Sharon explained to that she believed a notice
17 about this had been sent out to her (the insured's daughter), but the insured's daughter told
18 Sharon that she didn't receive anything, she had forward on her mail, and she couldn't believe
19 she didn't get anything. *Id.*¹¹

20 The insured's daughter said to Sharon, “what can we do to reinstate this,” to which
21 Sharon replied “well, if you can get anything that shows her cognitive impairment, just get all
22 this paperwork together and get this to me.” *Id.* at 4:10. The insured's designee did that. *Id.*
23 Sharon said nothing further. Sharon did not mention anything about “loss of functional

¹¹ In fact, the insured's designee later testified in response to questions from the Company's lawyers that she did not experience any other mail not getting to her after this forward. *Id.* at 4:49. As previously indicated, the Company has thus far failed to present adequate proof that it ever really did mail the notice letter date March 20, 2009.

1 capacity.” *Id.* at 4:12. Sharon did not explain what evidence was required. *Id.* at 4:12-4:13.
2 Sharon’s only focus was cognitive impairment, and the insured’s designee sent what Sharon
3 asked for. *Id.* at 4:13. Sharon did not tell the insured’s designee that she needed to provide
4 any particular kind of documentation from a health care provider. *Id.* at 4:14. The insurance
5 company never sent her any information in writing or otherwise telling her what she needed to
6 do. *Id.* The insured’s designee was never explained what medical evidence was needed to
7 satisfy them, not in writing, not by Sharon or anyone else. *Id.* at 4:14-4:15.

8 Ability’s November 5, 2009 letter to its insured (via her designee) reflects the
9 Company’s position on why it denied the two claims and the request to reinstate coverage.
10 The only reason this letter gave for denying reinstatement and coverage, according to this
11 letter, was because reinstatement “is limited to a five month period” which the Company
12 (erroneously) believed “expired in July and we did not receive any contact from you until
13 August.” OIC Exh. 15. Further, as indicated, all that Sharon told the insured’s daughter to
14 provide was “anything that shows her cognitive impairment.” *See* hearing recording at appx.
15 4:08. The facts are undisputed that the insured’s designee provided this, and more. *See, e.g.,*
16 OIC Exh. 14. There is no evidence Sharon or anyone else told the insured’s designee about
17 “loss of functional capacity,” or what specifically she needed to do to prove to the Company’s
18 satisfaction whatever reinstatement standard it believed she had to meet. The Company never
19 offered any assistance, or guidance, and never changed its reasons for denial with its insured
20 or her designee. Not until a year later, in two letters to OIC, did the Company add the new
21 reason that the insured’s designee failed to also provide the proof the Company believes the
22 federal laws require. OIC Exh. 26. As indicated, not even the Company’s May 2, 2011
23 Hearing Demand set forth this new reason.

These facts show that, whether the doctrine is equitable estoppel, estoppel against an
insurer under *Bosko/Moore*, “mend the hold,” or some other, the Company should be
estopped from its new arguments. The Company’s admission, act or statement to its designee

1 by Sharon let the designee on to believe what she needed to do to help get the policy
2 reinstated. What Sharon said was all she was told. Based on that, she did not know of
3 anything else she had to do. She did her best, and did what Sharon told her to do. But then
4 the designee received the November 5, 2009 letter telling her that the only reason the request
5 for reinstatement was denied was because it was too late. Of course, after trying again, and
6 being given the identical reason again (*compare* OIC Exhs. 15 and 17), she naturally did
7 nothing else. After all, all Sharon mentioned was “cognitive impairment,” she only told her to
8 get what she got, and she didn’t know of any more than the proof Sharon told her she needed
9 to submit. Yet, today the Company now claims that way back then, the designee also needed
10 to do more. Worse, this alleged failing is now a new reason why the Company believes the
11 decision it made, as reflected in its November 5, 2009 letter, needs to be upheld.

12 These facts also show that what the Company did – inadequate as it was – also
13 violated numerous bedrock requirements in the Insurance Code, specifically including several
14 unfair claims settlement provisions in WAC 284-30-300 through 284-30-400.¹² For example:

15 ¹² WAC 284-30-310 makes clear that the regulation “applies to all insurers and to all insurance policies and
16 insurance contracts. This regulation is not exclusive, and acts performed, whether or not specified herein, may
17 also be deemed to be violations of specific provisions of the insurance code or other regulations.” Moreover,
18 only one violation constitutes a *per se* unfair trade practice under these rules:

19 The requirement of frequency of violation does not mean that an act is not unfair or deceptive if proven
20 to have been committed against only one insured. The goals served by the Insurance Commissioner’s
21 enforcement of the regulations differ from those served under the CPA. The Insurance Commissioner’s
22 aim is a well regulated insurance industry. *Tank v. State Farm Fire & Cas. Co.*, 105 Wn.2d 381, 395,
23 715 P.2d 1133 (1986). Treating isolated unfair acts differently from frequent violations is consistent
with the Insurance Commissioner’s purpose. On the other hand, the CPA is designed to protect the
public and foster fair and honest competition, and is to be liberally construed to serve that end. RCW
19.86.920. Private disputes are actionable under the CPA. RCW 19.86.090. We conclude an isolated
unfair or deceptive act which meets the description of prohibited conduct as contained in WAC 284-30-
330 constitutes a *per se* unfair trade practice under the rules of *Hangman Ridge*.

Evergreen Int’l, Inc. v. American Cas. Co., 52 Wn. App. 548, 558, 761 P.2d 964 (1988).

1 • An insurer like Ability may not “[m]isrepresent[...] pertinent facts or
2 insurance policy provisions.” WAC 284-30-330(1); *see also* WAC 284-54-800(1) (requiring
3 the same.) Here, if, as Mr. Lawler testified, the Company intended its alleged March 20, 2009
4 letter to “revert back,” the Company misled and intended to mislead its insured’s designee
5 about pertinent facts. It also misled her by failing to mention the need for a “certification” in
6 its November 5, 2009 denial letter, or any subsequent correspondence with either their insured
7 or the insured’s designee. Exacerbating this, of course, is that the Company’s failings
8 precluded the insured’s designee from asking Dr. Mihali for one, but as we now see, he would
9 have provided one, and actually did. Curiously, the Company also decided not to conduct an
10 exam to assist its insured, though the Company had a contractual right to do so, *see* OIC Exh.
11 1 p. 7, separate and apart from other, independent duties to assist first party claimants like the
12 insured and her designee here,¹³ which other independent duties the Company also apparently
13 ignored.

14 • An insurer like Ability may not “fail to fully disclose to first party claimants all
15 pertinent benefits, coverages or other provisions of an insurance policy or insurance contract
16 under which a claim is presented.” WAC 284-30-350(1). The words of Sharon – and later,
17 the letters of Donald Lawler – were the designee’s sole source of information; the Company
18 disclosed nothing else. Sharon only mentioned “cognitive impairment” evidence. She was no
19 more specific and did not say anything about a “certificate,” explain anything further, or even
20 mention “loss of functional capacity,” which is another basis for reinstatement in both the
21 policy and WAC 284-54-253(2). The Company never even bothered to communicate with
22 the insured’s designee or to explain to her what her role was as “designee” (“Advisor,”
23 according to the Company’s March 20, 2009 letter), nor did it bother to inform her whether
her updated address would ever be required, or why. The Company even failed to share a

¹³ “[...A]n insurer has a duty to deal fairly with the insured and to give equal consideration in all matters to the insured’s interests.” *Am. Mfrs. Mut. Ins. v. Osborn*, 104 Wn. App. 686, 697, 17 P.3d 1229 (2001) (*quoting* *Tank v. State Farm*, 105 Wn.2d 381, 386, 715 P.2d 1133 (1986)).

1 copy of the policy with her. The Company never assisted her, OIC, or anyone else – and from
2 the lack of evidence, may not have ever assisted any claimant ever – in explaining the specific
3 proof and procedures the Company believes are required for reinstatement under the Model
4 Rule’s unintentional lapse provisions. The company not only failed to fully disclose what
5 WAC 284-30-350(1) required it to disclose, there is no evidence that the Company was even
6 aware of its obligations in the first instance – though it now seeks to levy blame on the
insured’s designee and OIC.

7 • An insurer like Ability may not: “conceal from first party claimants benefits,
8 coverages or other provisions of any insurance policy or insurance contract when such
9 benefits, coverages or other provisions are pertinent to a claim.” WAC 284-30-350(2). Here,
10 the insurer failed to expose and share with the first party claimant¹⁴ crucial information about
11 a supposed medical “certificate” the Company supposedly felt it needed. Had they asked,
obviously, Dr. Mihali would have provided this.

12 • In addition, an insurer must, “[f]or all other pertinent communications from a
13 claimant reasonably suggesting that a response is expected, an *appropriate* reply must be
14 provided within ten working days for individual insurance policies[...].” (Emphasis added.)
15 WAC 284-30-360(3). Here, the Company failed to do this. No “appropriate” reply to the
16 designee’s questions were ever given, apparently, since the Company felt something more
17 was needed. Worse, now the Company is trying to assign blame to the designee and OIC for
18 it, even as it *now* belatedly and disingenuously claims more reasons to support what it wants
19 us to believe were its supposed position all along. The Company owed more in its reply to its
insured and her designee under his rule.

22 ¹⁴ It is important to note that throughout WAC 284-30-300 through 284-30-400, ““Claimant” means, depending
23 upon the circumstance, either a first party claimant, a third party claimant, or both and includes a claimant's
designated legal representative and a member of the claimant's immediate family designated by the claimant.”
(Emphasis added.) WAC 284-30-320(2); see also WAC 284-30-320(6) (defining “first party claimant.”)

1 • Most important, perhaps, here, was that Ability was obligated, “[u]pon
2 receiving notification of a claim, every insurer must promptly provide necessary claim forms,
3 instructions, and reasonable assistance so that first party claimants can comply with the policy
4 conditions and the insurer's reasonable requirements. Compliance with this paragraph within
5 the time limits specified in subsection (1) of this section constitutes compliance with that
6 subsection.” WAC 284-30-360(4), citing WAC 284-30-360(1) (requiring response in ten
7 days.) As previously explained, Ability utterly failed to do any of this, and worse, it now
8 seeks to blame the insured and her designee for it.

9 • “Within fifteen working days after receipt by the insurer of fully completed
10 and executed proofs of loss, the insurer must notify the first party claimant whether the claim
11 has been accepted or denied. The insurer must not deny a claim on the grounds of a specific
12 policy provision, condition, or exclusion unless reference to the specific provision, condition,
13 or exclusion is included in the denial. The denial must be given to the claimant in writing and
14 the claim file of the insurer must contain a copy of the denial.” WAC 284-30-380(1). Similar
15 is WAC 284-54-800(9), which prohibited Ability from “[f]ailing to promptly provide a
16 reasonable explanation of the basis in the insurance contract in relation to the facts or
17 applicable law for denial of a claim or for the offer of a compromise settlement.” Again,
18 Ability violated both of these provisions.

19 • Outside WAC 284-30-300 through 284-30-400, similarly, “[w]henver an
20 insurer is required by law to give the reason for its canceling, denying, or refusing to renew
21 insurance, as, for example, pursuant to RCW 48.18.291, 48.18.292, or 48.30.320, it shall give
22 the true and actual reason for its action in clear and simple language, so that the insured or
23 applicant will not need to resort to additional research to understand the real reason for the
24 action. It is not sufficient, for example, to state that an insured “does not meet the company's
25 underwriting standards.” The reason why the individual does not meet such underwriting
26 standards is what must be given. If the actual reason relates to medical information, the

1 insurer may make a broad reference thereto and limit specific disclosure of details to the
2 applicant's or insured's physician." WAC 284-30-570. This too was violated. The only
3 "actual reason" the Company gave was that the request was too late. It was required to give
4 its "actual reason," if this was not it, and it failed to do so.

5 The Company cannot so grievously fail in numerous of its obligations, repeatedly
6 violate the Insurance Code, and then later benefit from it by being allowed to for the first time
7 assert new, novel legal arguments to bolster its November 5, 2009 decision. Accordingly, the
8 Company should be estopped from now being able to raise any of the arguments it now raises
9 in sections "IIC" and "IID" of its supplemental briefing. All those arguments are only now
being raised as a result of the Company's own wrongdoing.

10 **C. None of the Company's remaining arguments has any merit.**

11 Ability's supplemental briefing raises several other arguments that are either
12 unfounded, incorrect, or misleading. These are addressed in turn.

13 **1. Insureds' WAC 284-54-253 reinstatement rights are not required to
"mirror" any federal or other law.**

14 The Company erroneously implies that the WAC 284-54-253 reinstatement rights that
15 extend to insureds must "mirror the federal law requirement or it is not a tax-qualified long-
16 term care plan." Such a suggestion would be misleading.

17 First, while for the reasons previously articulated, any foray into argument about
18 whether federal preemption has any place here is one that the Company is and should be held
19 to be estopped from raising, the McCarran-Ferguson Act preserves states' rights to regulate
20 insurance. "No Act of Congress shall be construed to invalidate, impair, or supersede any law
21 enacted by any State for the purpose of regulating the business of insurance . . . unless such
22 Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b). Here, no federal
23 law alleged "specifically relates to the business of insurance," but rather, to tax treatment of
monies that exchange hands between an insurer and an insured. Of course, in this case, no
such payment of benefits is at issue – only the right of reinstatement.

1 While it is true that federal law provides for the tax-favorable “treatment” of such tax-
2 qualified long-term care policies, such “treatment” merely relates to how the Internal Revenue
3 Service treats payments made under the policies, for tax purposes. *See* 26 U.S.C.S. §7702B.
4 In fact, this law only governs “amounts [...] received” under such a policy, not how an insurer
5 transacts insurance, including how it grants “reinstatement” or cancels its insurance policies.
6 26 U.S.C.S. §7702B(a)(2). And while any federal laws can preempt state regulations and can
7 invalidate state regulations under the *Supremacy Clause*, this applies to state regulations
8 which are “inconsistent” with federal laws. *Lewis and Portland Gray Panthers v. Hegstrom*,
9 767 F.2d 1371, 1375 (C.A. 9), *citing Townsend v. Swank*, 404 U.S. 282, 285, 30 L. Ed. 2d
10 448, 92 S. Ct. 502 (1971) and *Carleson v. Remillard*, 406 U.S. 598, 601, 32 L. Ed. 2d 352, 92
11 S. Ct. 1932 (1972).

12 Here, no aspect of WAC 284-54-253 is in any way inconsistent with any federal law,
13 let alone in conflict with any federal law. Indeed, while Ability’s supplemental briefing
14 seems to have somehow overlooked it, OIC’s supplemental brief explained that the federal tax
15 laws Mr. Lawler alluded to in his testimony *explicitly* not just contemplate but allow
16 regulations like WAC 284-54-253. *See* OIC supplemental brief at pps. 27-28 (*citing* IRS
17 Notice 97-31 and excerpts from the Conference Report and Joint Committee on Taxation
18 explanation of HIPPA, that states can impose “more stringent consumer protection
19 provisions”); *see also* 26 USCS 7702B(g)(2)(A)(i)(VI) (specifically identifying a qualified
20 long-term care contract as meeting federal tax requirements if it meets the requirements of the
21 NAIC Model Rule section on unintentional lapse). Obviously, since WAC 284-54-253 was
22 contemplated by and authorized to co-exist with federal laws, WAC 284-54-253 is not
23 inconsistent with any such federal laws. It is simply one such more stringent consumer
protection feature, and it is in no way preempted by federal law.

24 In any event, all arguments about federal preemption or about the adequacy of proof of
25 “cognitive impairment” or “loss of functional capacity” are moot. A certification of Dr.

1 Mihali has been offered into evidence. It proves she met even the higher standards advocated
2 by the Company.

3 **2. The Company presents baseless warnings of consequences and
misrepresents what the law provides.**

4 The Company argues that a variety of severe “consequences” could occur unless the
5 Company gets its way. *See* Company brief at 19. The Company presents no evidence to
6 support its dire warnings – perhaps because it knows of no evidence that any person has ever
7 *really* suffered any such “consequences.” OIC knows of none, either.

8 The Company even warns of even more grave consequences – the probability of
9 imminent “substantial penalties” that are presumably going to be doled out by that famous
10 federal agency, the Internal Revenue Service. Citing a federal law, the Company bellows that
11 “[a]n insurer that fails to ensure that the policies satisfy certain qualification standards may be
12 subject to a penalty tax pursuant to 26 U.S.C § 4980C.” *Id.* The trouble with that, however,
13 is that’s not exactly what the law says. While the law does provide for a penalty if certain
14 requirements of the statute are not met, 26 U.S.C.S. §4980C(b)(1), none of those requirements
15 are at issue here. *See* 26 U.S.C.S. §4980C(c) and (d). Moreover, the Company misleads by
16 omission – as it has before – by not quoting more of this law. The law, in fact, not only
17 requires the Company to comply with the NAIC Model regulation and Model act, 26 U.S.C.S.
18 §4980C(c)(1)(A) and (B), its subsection (f) even provides:

19 Coordination with State requirements. If a State imposes any requirement which is
20 more stringent than the analogous requirement imposed by this section or section
21 7702B(g) [26 USCS § 7702B(g)], the requirement imposed by this section or section
22 7702B(g) [26 USCS § 7702B(g)] shall be treated as met if the more stringent State
23 requirement is met.

26 U.S.C.S. §4980C(f). This makes clear that the Company’s fears are baseless.

3 **3. WAC 284-54-253 follows the NAIC model regulation.**

22 Parroting Mr. Lawler’s declaration, the Company’s supplemental briefing claims
23 “Washington State has not adopted the current NAIC Long-Term Care insurance Model

1 Regulation. Instead, Washington has adopted only portions of a previous version of the
2 model.” See Company supplemental briefing at 19-20. As an initial matter, this is simply
3 wrong – probably because Mr. Lawler apparently simply looked it up on a summary that itself
4 seems out of date. Nor is there any evidence of exactly what versions Mr. Lawler thinks
5 exist. But the evidence shows that WAC 284-54-253 “follows” the NAIC model regulation
6 section on unintentional lapse protection. See OIC Exhs. 35-37. Yet, even if WAC 284-54-
7 253 were not “current” or consistent with whatever the most “current” NAIC model
8 regulation says, if any exists, there is no evidence of what such a supposedly “current” version
9 looks like, or how WAC 284-54-253 differs, if at all, from it, or whether any difference is in
10 any way material here. In any event, as indicated above and in OIC’s supplemental brief,
11 federal law authorized more stringent consumer protections exactly like the ones in WAC
12 284-54-253.

13 **4. Section III E of the Company’s supplemental briefing makes no sense, but**
14 **is misleading.**

15 The Company’s section “III E” seems to complain about “unusual press releases” that
16 were issued, and relies on a “News Release Guidelines” document as proof that the Company
17 was surprised by the issuance of the orders, and the press release. The relevance of this
18 argument – to the extent it is an argument – seems dubious at best. But it discusses that
19 “OIC’s policy is to announce all OIC enforcement actions though [sic] routine news releases,
20 issued every month or two, publicizing several enforcement actions simultaneously.” See
21 Company supplemental briefing at 25. This is inaccurate and misleading.

22 The “guidelines” the Company refers to are that – “guidelines.” The Company
23 suggests no deviation from that practice is appropriate or normal. But the “guidelines” say
“[b]ut there are enforcement actions that merit a separate, more timely, news release.” In fact,
a review from just the past year’s OIC news releases (*see*
<http://www.insurance.wa.gov/news/index.shtml>) shows that this has occurred no less than ten
times already in the past year alone – with individual press releases that were just like the

1 ones in Ability's case. Not that it is relevant or material to any issue in this case, but the
2 Company's argument that the "guidelines" suggest something else, is misleading.

3 **5. WAC 284-54-253(2) does not require proof within 5 months – just a
4 request to reinstate within 5 months.**

5 Finally, the Company contends the proof under WAC 284-54-253(2) needed to be
6 provided before the date it believes the 5-month period ended. *See* Company brief at p. 20.
7 The rule says otherwise: only the request needs to be within the five month window. In the
8 event the language is ambiguous, it must be construed against the insurer and in favor of
9 coverage.

DATED this 28th day of September, 2011.

10 OFFICE OF INSURANCE COMMISSIONER

11 By: 
12 Alan Michael Singer