

STATE OF WASHINGTON
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE OFFICE OF INSURANCE COMMISSIONER

FILED

IN THE MATTER OF:

United HealthCare Insurance Company,

An Authorized Insurer

Docket No. 2007-INS-0003

2008 JAN -2 A 10: 13

ORDER GRANTING OIC'S
MOTION FOR PARTIAL
SUMMARY JUDGMENT

Hearings Unit, DIC
Patricia D. Petersen
Chief Hearing Officer

AND

DENYING UNITED HEALTHCARE
INSURANCE COMPANY'S CROSS
MOTION FOR SUMMARY
JUDGMENT

I. Introduction and Procedural Background

1. This matter is an adjudicative proceeding pursuant to the Administrative Procedure Act to review action the Office of the Insurance Commissioner ("OIC") undertook against United HealthCare Insurance Company ("the Appellant"). OIC issued a Notice of Intent to Request Imposition of a Fine on July 18, 2007 ("the Notice of Intent"). In the Notice of Intent, OIC advised of its intention to fine the Appellant "less than \$10,000 per violation or \$150,000 . . . in lieu of suspension or revocation of United's certificate of authority." OIC alleged the Appellant had illegally denied coverage to certain persons under its Medicare Supplement Insurance program.

2. The Appellant filed a timely appeal of the Notice of Intent and requested assignment of an administrative law judge, which prompted this administrative proceeding before the Office of Administrative Hearings. The issue in this appeal is whether OIC's intended action is proper under Washington State's regulatory insurance law.

3. After an initial prehearing conference, OIC filed a timely Motion for Partial Summary Judgment. The motion was supported by one affidavit and motion exhibits A - G. OIC requests entry of an order affirming its interpretation of RCW 48.66.045(1). Specifically, OIC requests an order holding that the guaranteed issue requirement of RCW 48.66.045 applies when a Medicare eligible applicant for Medicare Supplement Insurance plan is replacing other more comprehensive coverage including Medicaid,

employer-sponsored medical coverage or a health insurance purchased in Washington's individual insurance market.

4. The Appellant filed a combined Response to OIC's Motion and Cross Motion for Summary Judgment. The Appellant's Response and Cross Motion were accompanied by four affidavits and Motion Exhibits A - H. The Appellant requests a summary judgment order holding that the guaranteed issue requirement of RCW 48.66.045(1) applies only when a Medicare eligible applicant for Medicare Supplement Insurance plan is replacing another Medicare Supplement Plan or another more comprehensive Medicare Supplement Plan. The Appellant also requests a summary judgment order holding that OIC is estopped from fining the Appellant, that OIC is barred by the statute of limitations from fining the Appellant, and that the fine sought by OIC is arbitrary and capricious.

5. *Leave to File Reply Brief:* Because the briefing schedule did not provide for the Appellant to reply in support of its cross motion, the Appellant filed a Motion for Leave to File Reply in Support of Cross Motion and Motion to Strike OIC's characterization that the Appellant was seeking to gain a competitive advantage in the insurance industry.

6. OIC filed a Memorandum in Response to Appellant's Motion for Partial Summary Judgment and a Motion to Strike. OIC also filed an additional supporting affidavit, and an additional Exhibit deemed Exhibit A to OIC's Memorandum in Response.

7. *Motion to Strike:* At hearing, I orally granted the Appellant's motion for leave to file a reply. I did so in the interest of fairness. Significantly, I did not expect a cross motion reply in support of a cross motion at the time I issued the prehearing order and schedule.

8. I denied the Appellant's motion to strike. I consider OIC's statement in this regard to be a characterization of the facts, and will not take the statement in itself as proof of the Appellant's intent.

9. Neither party raised further objections to the motion exhibits and motion affidavits. The exhibits and affidavits are deemed authentic and admitted as summary judgment evidence in this matter.

10. I heard oral argument on the above motions by telephone on November 5, 2007.

11. Jeffrey Gingold of Lane Powell PC represented the Appellant.

12. Charles D. Brown, OIC staff attorney, represented OIC.
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II. Uncontested Facts

1. United Healthcare Insurance Company ("the Appellant") is a registered Washington Insurer that offers Medicare Supplement Insurance coverage to Washington residents.
2. The Appellant has offered Medicare Supplement plans to under age 65 disabled Washington residents since January 1, 1998, when the Appellant took over as underwriter of the Association for the Advancement of Retired Persons' ("AARP") Healthcare Options Insurance Program.
3. On or about August 27, 2002, an OIC policy and compliance analyst, Marjean Holland, asked the Appellant to advise as to how it treats Washington State residents between the ages of 50 and 64 who "are replacing" Medicaid coverage with the Appellant's Medicare supplement plan coverage.
4. On September 20, 2002, the Appellant's senior compliance consultant advised OIC's policy and compliance analyst in writing of the Appellant's policy: The Appellant did not provide guaranteed issuance of Medicare supplement coverage to Washington State residents between the ages of 50 and 64 who sought to "replace" Medicaid coverage with an AARP Medicare supplement plan provided by the Appellant. That is, the Appellant required evidence of insurability in such circumstances.
5. OIC next advised the Appellant that it could not legally deny Medicare supplement coverage to persons "replacing" Medicaid coverage with an AARP Medicare supplement plan while allowing Medicare supplement coverage to persons replacing employer coverage as "other more comprehensive coverage." OIC advised that to do so discriminated against Medicaid recipients.
6. Next, the Appellant changed its enrollment procedures and at some point began requiring evidence of insurability for anyone seeking to "replace" either Medicaid or employer-provided health insurance coverage. The Appellant at this point took the view that the phrase "other more comprehensive coverage" in RCW 48.66.045(1) meant "more comprehensive *pre-standardized Medicare supplement* coverage."
7. During the period of 2002 - 2005, the Appellant denied Medicare supplement

coverage to certain persons who sought to replace Medicaid, non-Medicare supplement individual health insurance policies and employer health insurance policies with Medicare supplement coverage.

8. On May 18, 2004, the Appellant notified an OIC employee that the Appellant took the view that the guaranteed issuance clause (RCW 48.66.045(1)) did not apply to an individual who sought to "replace" a Secure Horizons Medicare+ Choice plan because the Secure Horizons Medicare+ Choice plan was not a pre-standardized Medicare supplement plan.

9. On September 3, 2005, OIC received a complaint from a Washington resident who was eligible to receive Medicare. The person sought to replace a comprehensive individual health insurance policy purchased from Regence Blue Shield with one of the Appellant's Medicare supplement plans. The Appellant denied coverage to the complainant.

10. In early September 2005, an OIC Insurance Policy and Compliance Analyst, Wendy Conway, wrote to the Appellant and forwarded a copy of the September 3, 2005 complaint.

11. The Appellant responded by letter dated September 19, 2005. The Appellant explained it denied the application because it believed the consumer was not eligible for guaranteed issuance of a Medicare Supplement plan under RCW 48.66.045(1) because the consumer was not replacing another standardized Medicare Supplement plan.

12. On September 19, 2005, the Appellant wrote to an OIC insurance policy and compliance analyst, Wendy Conway, that the Appellant did not believe guaranteed issuance was required for an under 65 disabled person who sought to replace her individual coverage through Regence Blue Shield Selections with one of the Appellant's Medicare supplement plans.

13. On September 21, 2005, Conway wrote to the Appellant and indicated that Regence Blue Shield Selections qualified as "other more comprehensive coverage" under RCW 48.66.045(1).

14. On September 30, 2005, the Appellant wrote back to Conway that the Appellant believed the guaranteed issuance clause (RCW 48.66.045(1)) applied only when a person sought to replace "pre-standardized Medicare supplement coverage."

15. On November 3, 2005, Conway (of the OIC) wrote to the Appellant. Conway indicated OIC disagreed with the Appellant's interpretation of RCW 48.66.045(1).

16. On November 14, 2005, the Appellant, through Ms. Theresa Luecke, wrote to Conway that OIC had received and approved the Appellant's enrollment applications and noted that the Appellant's Medicare Supplement Plan enrollment application "specifically asks if the applicant intends to replace current Medicare Supplement Plan A, B, C, D, E, F, or G or more comprehensive pre-standardized Medicare Supplement coverage."

17. Next, OIC decided that the Appellant had wrongfully denied coverage to approximately 80 Washington consumers in violation of RCW 48.66.045(1). OIC issued a Notice of Intent to Request Imposition of a Fine issued by OIC on July 18, 2007 ("the Notice of Intent"). In the Notice of Intent, OIC advised of its intention to impose a fine on the Appellant of "less than \$10,000 per violation or \$150,000 . . . in lieu of suspension or revocation of United's certificate of authority."

III. Issues Presented

1. Is there a genuine issue of material fact as to whether the guaranteed issue requirement of RCW 48.66.045 applies when a Medicare eligible applicant for Medicare Supplement Insurance plan is replacing other more comprehensive coverage including Medicaid, employer sponsored medical coverage, or a health insurance purchased in Washington's individual insurance market?

2. Is there a genuine issue of material fact as to whether the affirmative defense of equitable estoppel prohibits the Department from levying a fine against the Appellant for refusing Medicare supplement plan coverage to persons seeking to replace non-Medicare supplement plan individual health plans and employer health plans during the period of 2003 through 2005?

3. Is there a genuine issue of material fact as to whether RCW 4.16.100 (statute of limitations) prohibits the Department from levying a fine against the Appellant for refusing Medicare supplement plan coverage to persons seeking to replace non-Medicare supplement plans during the period of 2003 through 2005?

4. Is there a genuine issue of material fact as to whether the fine sought by OIC in this matter is arbitrary and capricious?

III. Analysis

A. Legal Standard

1. *Legal Standard:* A motion for summary judgment or partial summary judgment may be granted and an order issued if the written record shows that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law on a particular legal issue. WAC 10-08-135.

B. The Meaning of RCW 48.66.045(1)

2. The statutory subsection at issue in this case is found in the Medicare Supplemental Health Insurance Act, RCW 48.66.045(1):

Every issuer of a medicare supplement insurance policy or certificate providing coverage to a resident of this state issued on or after January 1, 1996, shall: (1) Unless otherwise provided for in RCW 48.66.055, issue coverage under its standardized benefit plans B, C, D, E, F, G, K, and L without evidence of insurability to any resident of this state who is eligible for both medicare hospital and physician services by reason of age or by reason of disability or end-stage renal disease, if the medicare supplement policy replaces another medicare supplement standardized benefit plan policy or certificate B, C, D, E, F, G, K, or L, or other more comprehensive coverage than the replacing policy;

3. The Appellant and the OIC argue for different interpretations of RCW 48.66.045(1). OIC argues the legislature provided Medicare eligible individuals the right to guaranteed issuance of Medicare supplement policies if such individuals replaced another Medicare supplement plan *or* any other plan that provides for more comprehensive coverage, including employer health plans, Medicaid plans, or health plans purchased on the individual health insurance market. The Appellant argues, on the other hand, that the legislature meant to provide the right to guaranteed issuance of Medicare supplement coverage only if an individual sought to replace another Medicare supplement plan.

4. OIC correctly argues that courts (and also independent administrative tribunals

such as OAH by extension) should defer to OIC's interpretation of insurance statutes. *Bailey v. Allstate Ins. Co.*, 73 Wn. App. 442, 447, 869 P.2d 1110 (1994). However, deference is not afforded when the statute in question is unambiguous. *Densley v. Dep't of Ret. Sys.*, 2007 Wash. LEXIS 867 (Wash. 2007)(citing *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984) and *Port of Seattle v. Pollution Control Hearings Bd.*, 151 Wn.2d 568, 593, 90 P.3d 659 (2004)); *Bostain v. Food Express Inc.*, 159 Wn.2d 700, 716, 153 P.3d 846 (2007). Only ambiguous statutes require judicial construction and when the language of a statute is plain and unambiguous, a court must give effect to that language as the expression of what the legislature intended. *State v. J.P.*, 149 Wn.2d 444, 450, 69 P.3d 318 (2003).

5. In view of the above, the first issue is whether RCW 48.66.045(1) is ambiguous. Statutes are "not ambiguous simply because different interpretations are conceivable." *Bailey*, 73 Wn. App. 442 at 447, (citing *State v. Keller*, 143 Wn.2d 267, 277, 19 P.3d 1030 (2001)).

6. I conclude that the language of RCW 48.66.045(1) is unambiguous. The plain language of RCW 48.66.045(1) means that an insurance company providing Medicare supplement plan coverage must provide such coverage to any person who is medicare eligible and who is replacing either a Medicare supplement plan policy or other more comprehensive policy. I must give effect to every part of the text of a statute, rendering no portion meaningless or superfluous. *Shannon v. State*, 110 Wn. App. 366, 369 (2002). If the legislature had meant to limit the guaranteed issuance of Medicare supplement plan policies to only those circumstances where an individual was replacing a Medicare supplement plan policy, it would have not included the "other more comprehensive coverage language." If "other more comprehensive coverage" merely meant "other Medicare Supplemental Insurance," the statute's clause would absurdly read, "if the medicare supplement policy replaces another medicare supplement standardized benefit plan policy or certificate B, C, D, E, F, G, K, or L, or other more comprehensive [medicare supplement] coverage than the replacing policy." I note that two times in this statutory subsection the legislature meant medicare supplement coverage, it wrote "medicare supplement." Interpreting "other more comprehensive coverage" to mean "other more comprehensive [medicare supplement] coverage" would render the "other more comprehensive coverage" language meaningless.

7. Having carefully considered the motion evidence and arguments, I conclude there is no genuine issue of material fact as to whether RCW 48.66.045(1) applies when an applicant for medicare supplement policy is replacing any other health insurance policy that provides more comprehensive coverage including private plans, employer plans, or Medicaid plans, if such plans provide other more comprehensive coverage than Medicare supplement plan sought. Based on the plain language of RCW

48.66.045(1), every issuer of a medicare supplement insurance policy must issue coverage under its standardized benefit plans B, C, D, E, F, G, K, and L without evidence of insurability to any resident of Washington who is eligible for both medicare hospital and physician services by reason of age or by reason of disability or end-stage renal disease, if the medicare supplement policy replaces another medicare supplement standardized benefit plan policy or certificate B, C, D, E, F, G, K, or L, or other more comprehensive health insurance coverage than the replacing policy, including employer health plans, Medicaid plans, or health plans purchased on the individual health insurance market

8. In view of the above, OIC's Motion for Partial Summary Judgment should be granted, and the Appellant's Cross Motion for Summary Judgment should be denied on this statutory interpretation issue. I note in passing that I make no ruling on the factual issue of whether the particular plans held by persons applying for Medicare supplement plan coverage in this particular case was "more comprehensive coverage" than the Medicare supplement coverage sought. This fact issue would have to be developed at a full hearing if disputed.

C. Equitable Estoppel

9. In the Cross Motion, the Appellant requests an order of summary judgment holding that the doctrine of equitable estoppel prohibits OIC from penalizing the Appellant as it seeks to do in the Notice of Intent. Specifically, the issue raised by the Appellant is whether OIC changed its communicated application or interpretation of RCW 48.66.045(1) in such a way as to estop it from retroactively fining the Appellant. A party asserting equitable estoppel against a government agency must prove each element of estoppel with clear, cogent and convincing evidence. *Kramerevcky v. Department of Social and Health Services*, 122 Wn.2d 738, 744, 863 P.2d 535 (1993). The affidavits produced by the Appellant and OIC show that though a level of OIC inaction occurred there is a genuine issue of material fact as to whether clear, cogent and convincing evidence shows OIC staff made a sufficient representation such as to prohibit the Department from fining the Appellant as it seeks to do in the Notice of Intent. There are issues of material fact regarding all four elements of equitable estoppel that can be decided only after a full hearing. Significant is the dispute over whether an agent of OIC made an admission, statement, or act inconsistent with the subsequent Notice of Intent. I will need to hear testimony about the oral conversations between the parties to decide whether clear, cogent, and convincing evidence proves the several elements required to estop a governmental entity from levying a fine.

10. Because genuine issues of material fact exist regarding the Appellant's estoppel claim, the Appellant's Cross Motion for Summary Judgment is denied in this regard.

This matter should proceed to hearing on the issue of whether the equitable estoppel bars OIC from fining the Appellant as it seeks to do in the Notice of Intent.

D. The Statute of Limitations

11. The Appellant also requests an order of summary judgment holding that the statute of limitations found at RCW 4.16.100 prohibits OIC from penalizing the Appellant as it seeks to do in the Notice of Intent.

12. An "action upon a statute for a forfeiture or penalty to the state" must be brought "within two years." RCW 4.16.100.

13. The summary judgment evidence shows OIC first discovered the Appellant's *intent* to not comply with RCW 48.66.045(1) in September 2002. However, the evidence also shows that some of the alleged violations of RCW 48.66.045(1) likely occurred within two years of OIC's issuance of the Notice of Intent. Whether violations occurred within two years of the Notice of Intent will have to be shown at hearing. Significantly, legal questions regarding the Appellant's arguments also remain, such as whether the discovery rule applies and when OIC's cause of action first accrued.

14. Because genuine issues of material fact and law exist regarding the Appellant's statute of limitations defense, the Appellant's Cross Motion for Summary Judgment is denied in this regard. This matter should proceed to hearing on the issue of whether RCW 48.66.045(1) bars OIC from fining the Appellant as it seeks to do in the Notice of Intent.

E. Is the Fine Sought Arbitrary and Capricious?

15. The Appellant also requests an order of summary judgment holding that the fine sought by OIC is arbitrary and capricious. The summary judgment evidence shows the fine intended in this case is greater than the fine OIC agreed to in a previous OIC enforcement action against another company, Standard Life and Accident Insurance Company. The Appellant notes that the Standard Life enforcement action also involved alleged violations of RCW 48.66.045(1), but that Standard Life agents lied to OIC at one point during OIC's investigation – something not alleged in this case.

16. In its response, OIC argues the fine sought is proper as it has statutory authority to fine insurance companies up to \$10,000 per violation under RCW 48.05.185.

17. Given the limited evidence offered on this issue at this stage of the proceeding, I will await further development of the fact issues underlying this claim before

considering this issue.

F. Conclusion

18. Since significant factual disputes on the merits of the Appellant's defenses remain, I find that there are triable issues of material fact in this matter, and the Appellant's Cross Motion for Summary Judgment of Dismissal should be denied on all points.

19. This matter should proceed to a full hearing.

V. Order

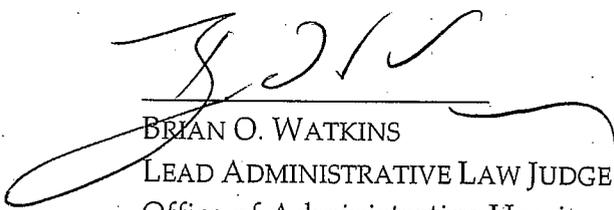
IT IS HEREBY ORDERED,

The Commissioner's Motion for Partial Summary Judgment is **GRANTED**.

The Appellant's Cross Motion for Summary Judgment is **DENIED**.

This matter will proceed to a hearing on the merits of OIC's Notice of Intent to Request Imposition of a Fine and on the merits of the Appellant's defenses.

Dated and Mailed at Olympia, Washington this 19th day of December 2007.



BRIAN O. WATKINS

LEAD ADMINISTRATIVE LAW JUDGE

Office of Administrative Hearings

2420 Bristol Court SW

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Olympia, WA 98507-9046

Certificate of Service

I assert that true and exact copies of the Order Granting OIC's Motion for Partial Summary Judgment and Denying United Healthcare Insurance Company's Motion for Summary Judgment were mailed to the following parties on the 19th day of December

2007.


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Legal Secretary

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