BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of	)	
	)	
C P	)	OAH No. 15-0283-PER
	)	Agency No. PERS 2015-0122

FINAL DECISION

I. INTRODUCTION

C P is a beneficiary of the AlaskaCare Retiree Health Plan ("Plan") medical insurance as a spouse of a Tier 1 retiree. He brought this appeal to contest the determination of the Division of Retirement and Benefits ("DRB" or "Division") to require an annual deductible under the Plan in addition to the annual deductible that Mr. P was required to pay pursuant to his membership in the Medicare Program, part B. After engaging in investigation and discovery, the parties stipulated that the case "may be resolved on dispositive motion practice," without the need for a hearing.[1] They then submitted cross-motions for summary adjudication.

A proposed decision was issued on January 11, 2016; it concluded that the language of the Plan is ambiguous as to whether DRB can require retirees to pay both deductibles sequentially, and therefore it must be construed to meet the insured's reasonable expectation that the deductibles may be satisfied concurrently. DRB submitted a Proposal for Action (PFA), urging that the proposed decision be rejected, and raising certain arguments that were not articulated in its summary adjudication brief, including that the proposed decision will cause "far reaching and potentially devastating results on the resources necessary to sustain the Plan and its coverage,"[2] and that Mr. P's "interpretation [of the Plan] does not reflect the reasonable expectations of an insured member."[3] Because these arguments had not been previously raised, the case was remanded to the ALJ, and Mr. P was given an opportunity to respond to DRB's new arguments. Mr. P filed a short responsive brief on March 8, 2016. DRB requested leave to file a reply to Mr. P's responsive brief, but leave was denied in an order dated March 23, 2016. As further discussed below, DRB's arguments in its PFA are not persuasive. The discussions in DRB's PFA and Mr. P's response, however, have resulted in slight revisions to the decision, to clarify the manner in which DRB should credit a retiree's assessed Medicare deductible towards the Plan deductible.

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1 June 11, 2015 Stipulation for Filing Dispositive Motions.
2 DRB's PFA at 6-7.
3 DRB's PFA at 10-11.

Mr. P's motion for summary adjudication is granted, [4] and DRB's failure to apply the amount of the assessed Medicare deductible to Mr. P's deductible under the Plan is reversed. DRB shall compensate Mr. P in the amount of $44.60, the amount of damages the parties have stipulated to be recoverable by Mr. P under this Decision.

II. BACKGROUND AND FACTS

The terms and conditions of coverage and benefits under the Plan are set out in the Retiree Insurance Information Booklet ("Booklet").[5] Because "there is no other document setting out the contractual obligations of the Plan, this .... Booklet is the insurance contract for Plan members."[6] The Plan requires an annual deductible of $150, and it provides that Plan benefits "become supplemental" to Medicare benefits for persons who are 65 years or older and thus eligible for Medicare.[7] Aetna is the entity that administers the Plan for DRB.

The Plan contains a Coordination of Benefits ("COB") provision[8] authorizing a "right to offset" against benefits paid by Medicare and other sources, designed to protect against retirees duplicating their recovery of medical benefits. Key pertinent provisions of the COB are quoted below:

- The primary plan pays benefits first, without regard to any other plan.
- When the retiree plan is secondary, the amount it will pay will be figured by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the retiree plan on that claim. The plan pays the difference between the amount the other plan paid and 100% of expenses the retiree plan would cover.[9]

Mr. P became a beneficiary of the Retiree Medical Benefits Plan in January 2012, and until March 2014 the Plan was his sole source of medical benefits coverage.[10] During that period his only annual deductible was the $150 deductible required under the Plan. When he turned 65 in March 2014, he enrolled in Medicare Parts A and B. At that time, per the terms of the Plan, Medicare provided his primary health coverage and the Plan's coverage became "supplemental" to Medicare.

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4 Mr. P's motion was granted by order dated December 31, 2015, but the record was kept open to resolve a factual dispute regarding the amount of his damages. The parties subsequently resolved the dispute by stipulating to the amount of damages. *See* 1/6/16 Stipulation Regarding Damages Amount.

5 *In re D.M.*, OAH No. 08-0153-PER (2008), page 2.

6 *In re D.T.*, OAH No. 10-0577-PER (2011), page 2.

7 Agency Record ("AR") 42.

8 AR 43-47.

9 AR 44 (emphasis in original).

10 The factual recitations in this Decision are derived from the parties' respective briefs on summary adjudication, and unless otherwise indicated the facts discussed herein were not disputed.

In April 2014, Mr. P was required to pay the Medicare $147 annual deductible, in connection with receiving two sets of medical services that were deemed "covered services" under the Plan. Medicare assessed the charges from the first set of services as follows: $24.33 to deductible and $5.26 paid to the provider. Charges from the second set were assessed: $122.67 to deductible and $91.34 paid to the provider, leaving $25.17 unpaid. At this time AETNA assessed the full amount of the charge for the first services, $29.59, towards the Plan deductible ($5.26 more than was assessed by Medicare towards its deductible).

Subsequently, in connection with Mr. P receiving other medical services, Aetna charged him additional deductibles in October 2014 ($69.80) and November 2014 ($29.89 and $20.72) totaling $120.41, which when added to the $29.59 previously assessed by Aetna equals the total of the $150 Plan deductible. It should be noted that there appears to have been an "overlap" between the two charged deductibles of $24.33, which is that portion of the $29.59 charge for the first April 2014 medical services that was charged to both the Medicare & the Plan deductibles.

Mr. P asserted in his briefing that this sequence of charges resulted in him being charged a total deductible of $272.67 by Medicare and Aetna (on behalf of the Plan), or $125.67 in excess of the Medicare deductible.[11] In its brief, DRB disputed the amount of out-of-pocket expense actually paid by Mr. P, asserting that in fact he was only required to pay a total of $44.60 for his 2014 medical expenses.[12] The parties have subsequently stipulated that $44.60 is the correct amount.[13]

III. DISCUSSION

A. The Plan's Provisions Regarding Deductibles

Mr. P argues that assessing him for both the Medicare and the Plan deductibles violates the Plan provisions which allow only a single annual deductible to be charged to members. To evaluate his argument, we start with two basic premises. First, because there is no document other than the Booklet that sets out the contractual obligations of the Plan to its members, the Booklet constitutes the insurance contract for Plan members. Second, under Alaska law, interpretation of insurance contracts is governed by the premise that they "are considered contracts of adhesion that must be construed to provide the coverage 'a layperson would have

[11] P's Motion for Summary Adjudication ("Motion") at 5.
[12] DRB's Opposition & Cross-Motion for Summary Adjudication ("Opp.") at 3, fn. 4.
[13] 1/6/16 Stipulation Regarding Damages Amount.

reasonably expected from a lay interpretation of the policy terms.'"[14] Insurance "coverage provisions are interpreted broadly, while exclusions are viewed narrowly."[15] The doctrine of interpretation in favor of an insured's reasonable expectations "is not dependent on there being any ambiguity in the contract language."[16] However, if the contract language is ambiguous and susceptible to more than one interpretation, "the interpretation that favors the insured is followed."[17]

As already noted above, the terms of the Plan require that the Plan's coverage is "supplemental" or "secondary" to Medicare after a retiree reaches 65 years of age. The COB, which is an integral part of the insurance contract, accomplishes the coordination between the Plan and Medicare by noting that Medicare first pays benefits without regard to the Plan.[18] The amount the Plan will then pay is calculated "by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the [Plan] on that claim."[19] As stated in the COB, the Plan "pays the difference between the amount the other plan paid and 100% of expenses the [Plan] would cover."[20]

Mr. P contends that this language clearly defines what the Plan will pay when it is supplemental to Medicare – the Plan's payment is calculated by simply subtracting the benefits payable by Medicare "from 100% of expenses covered" by the Plan. He points out that the Booklet provides for a single, annual deductible, and it does not mention or refer to an additional deductible that must be paid when Medicare becomes the member's primary coverage. Nor can any such mention be found in relevant statutes or regulations. He concludes, therefore, that in the absence of an explicit, unambiguous Plan provision for two deductibles, only a single annual deductible can be charged to a member. He further argues that the net result of DRB's practice of requiring two separate deductibles is that a retiree member is penalized upon reaching age 65, as occurred in this case where Mr. P's effective, total annual deductible increased from $150 to $272.67. Such a result, he argues, is contrary to the provision that the Plan is intended to

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[14] *In re D.T.*, OAH No. 10-0577-PER (2011), at 2, *quoting Whispering Creek Condominium Owner Association v. Alaska National Insurance Company*¸ 774 P.2d 176, 177–178 (Alaska 1989).
[15] *Id.*
[16] *In re D.T.*, OAH No. 10-0577-PER, *citing Bering Strait School District v. RLI Insurance Company*, 373 P.2d 1292, 1295 (Alaska 1994).
[17] *Id.*
[18] AR 44.
[19] *Id.* (emphasis in original).
[20] *Id.*

"supplement" Medicare, because the concept of supplementation does not encompass increasing a member's out-of-pocket costs.

DRB argues in response that "[a] retiree cannot satisfy the Plan's deductible by satisfying the Medicare ... deductible... ."[21] But this argument is presented as a conclusion without any persuasive analysis, and without tying it to the actual Plan provisions set forth in the Booklet. Instead, it is supported only by an affidavit of a DRB manager[22] and by reference to documents that are extrinsic to the Booklet and thus are not part of the Plan itself.[23]

DRB's argument begs the question of how to properly interpret the Plan, because it fails to address the actual language of the Plan. The language of the COB states that the Plan's payment on a claim is calculated "by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the [Plan] on that claim."[24] The failure to mention the assessment of the Plan deductible in that context, when contrasted with other Plan language generally requiring assessment of the Plan's deductible against members, results in the Plan being, at best, ambiguous as to whether both deductibles can be assessed against a retiree member or, stated differently, whether the expenses left unreimbursed by Medicare can be deemed ineligible to satisfy the Plan deductible. We must construe the Plan, as a contract of adhesion, in favor of the insured's reasonable expectations, that he or she not be charged a higher total of deductibles as a result of having reached age 65. Construing the Plan in this manner, a retiree can satisfy virtually all of the Plan deductible by satisfying the Medicare deductible. The expenses that Medicare did not pay are expenses borne by Mr. P, and there is no discernible reason not to treat them as the first $147 of member-borne expenses needed to satisfy the Plan's $150 deductible. Aetna, therefore, must credit Mr. P for the $147 Medicare deductible in its assessment of the Plan's $150 deductible.

As mentioned above, DRB raised an issue of fact regarding the damages Mr. P can claim in terms of the amount of out-of-pocket expenses he has incurred. Mr. P argued in his Motion that he is entitled to recover the $125.67 additional deductible assessed by Aetna and DRB.[25]

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[21] DRB's Opp. at 5.

[22] Affidavit of Michele Michaud, Chief Health Official for DRB (Ms. Michaud essentially offers an unsupported opinion as to the proper interpretation of the Plan: "a retiree who is eligible for medical services covered under both the Plan and Medicare must satisfy the Plan's annual $150 deductible").

[23] *See, e.g.,* guidelines of Nat'l Assn. of Insur. Commissioners, excerpted in exh. 3 to DRB's Opp.

[24] AR 44 (emphasis in original).

[25] P's Motion at 9.

DRB countered that Mr. P "only paid a total of $44.60 out-of-pocket for his 2014 claims."[26] Mr. P then responded in a reply brief that he should be entitled to recover both the $125.67 and the $44.60 in out-of-pocket expense.[27] The parties have now resolved this factual dispute by stipulating that $44.60 is the correct amount of damages.

B. DRB's Proposal for Action

DRB's PFA primarily reiterates arguments that it raised in its motion for summary adjudication. These arguments are no more persuasive than when they were first presented and do not compel a rejection of the proposed decision. As previously mentioned, the PFA also asserts two arguments not previously raised in DRB's summary adjudication filings: (1) the proposed decision will cause "far reaching and potentially devastating results on the resources necessary to sustain the Plan and its coverage;"[28] and (2) Mr. P's "interpretation [of the Plan] does not reflect the reasonable expectations of an insured member."[29]

As an initial matter, DRB should have raised these arguments before issuance of the proposed decision. By stipulating that the matter could be decided on summary adjudication briefs, and then omitting any substantive discussion of these issues in its brief, DRB waived the opportunity to raise them. Nonetheless, these issues merit a brief discussion.

First, DRB has failed to set forth any admissible facts regarding its allegation as to the alleged impacts on Plan resources that will result from this decision. In any event, Mr. P's appeal is focused on the proper interpretation of Plan language and whether DRB's practices comport with that interpretation. Impacts on Plan resources that may or may not flow from this decision are policy matters that should have no bearing, one way or the other, on the proper interpretation and implementation of the Plan as written.

Second, DRB argues that Mr. P's expectation of paying only one deductible is unreasonable, contending that "[a] member receiving the benefit of coverage from two health care plans can reasonably expect to pay separate, independent deductibles pursuant to the independent terms of those two ... plans."[30] But this conclusory statement is presented without any factual support, and it ignores the language of the Plan itself. As discussed above, the Plan plainly states that it "becomes supplemental to ... Medicare coverage," and it then pays the

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[26] DRB Opp. at 3, fn. 4.
[27] P's 7/17/15 Reply at 3.
[28] DRB's PFA at 6-7.
[29] DRB's PFA at 10-11.
[30] DRB's PFA at 10.

difference between the amount [Medicare] paid and 100% of expenses the [Plan] would cover." These statements are made without any mention of the member being required to pay the Plan deductible in addition to the Medicare deductible; stated differently, the Plan makes no mention of the expenses left unreimbursed by Medicare being ineligible to satisfy the Plan deductible. Given this language of the Plan, Mr. P's expectation of paying only one concurrent deductible is objectively reasonable, especially in the absence of **any** evidence to the contrary.[31]

IV. CONCLUSION

Mr. P's motion for summary adjudication is granted, and DRB's failure to apply the amount of the assessed Medicare deductible to Mr. P's deductible under the Plan is reversed. DRB shall compensate Mr. P in the amount of $44.60, representing his out-of-pocket expenses incurred due to having both deductibles assessed against him sequentially.

This Decision is issued under the authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060, adopts this Decision as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 13th day of April, 2016.

Signed
Andrew M. Lebo
Administrative Law Judge

[This document has been modified to conform to the technical standards for publication.]

[31] DRB also contends in its PFA that Mr. P failed to "provide any support for his assertion that his coverage, as coordinated under the Plan, resulted in an increase in his overall retiree medical costs." DRB's PFA at 10-11. This contention is not accurate; DRB has **stipulated** that Mr. P incurred $44.60 in out-of-pocket expenses as damages in this case.