

No. 74448-8

IN THE COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

LEXINE OTEY, et al.,

Appellant,

v.

GROUP HEALTH COOPERATIVE,

Respondent.

FILED
COURT OF APPEALS DIV I
STATE OF WASHINGTON
2016 JUN -6 PM 4:51

BRIEF OF RESPONDENT

KARR TUTTLE CAMPBELL

Medora A. Marisseau, WSBA #23114
Stephanie R. Lakinski, WSBA #46391
701 Fifth Avenue, Suite 3300
Seattle, WA 98101
P: (206) 223-1313
F: (206) 682-7100

Attorneys for Defendant/Respondent

TABLE OF CONTENTS

I. Introduction1

II. Statement of Issues.....2

III. Statement of the Case.....3

 A. Procedural History3

 B. Facts of the Case3

 C. The Language of the Agreement.....4

 B. Financial Responsibilities for Covered Services.....5

 D. Summary Judgment Motion and Order.....7

IV. Argument9

 A. Standard of Review9

 B. The trial court correctly ruled the defined terms “Cost Share” and “Copayment” unambiguously describe the Member’s financial obligations, not GHC’s.10

 1. The trial court correctly applied the Agreement’s definitions.11

 2. GHC’s interpretation of “Cost Share” and “Copayment” is consistent with Washington law.13

 3. Otey’s interpretation of “Copayment,” and “Cost Share” is unreasonable.16

 4. Otey’s definition of “actual charge” is not a reasonable interpretation of the Agreement.19

 C. There is no phantom exclusion for inexpensive prescription drugs.....24

 D. The trial court correctly dismissed Otey’s Consumer Protection Act claim.....25

V. Conclusion27

TABLE OF AUTHORITIES

Cases

Allstate Ins. Co. v. Peasley, 131 Wn.2d 420, 932 P.2d 1244 (1997).....11

American Star Ins. Co. v. Grice, 121 Wn.2d 874, 854 P.2d 622
(1993).....12

Baldwin v. Silver, 165 Wn. App. 463, 269 P.3d 284 (2011)12

Boeing Co. v. Aetna Cas. & Sur. Co., 113 Wn.2d 869, 784 P.2d
507 (1990).....11

Celotex Corp. v. Catrett, 477 U.S. 317, 106 S. Ct. 2548, 91 L. Ed.
2d 265 (1986).....10

Coventry Assocs. v. Am. States Ins. Co., 136 Wn.2d 269, 279, 961
P.2d 933 (1998)27, 28

Eurick v. Pemco Ins. Co., 108 Wn.2d 338, 738 P.2d 251 (1987).....21

Fidelity & Deposit Co. of Md. v. Dally, 148 Wn. App. 739, 201
P.3d 1040 (2009)12

Int’l Marine Underwriters v. ABCD Marine, LLC, 179 Wn.2d 274,
313 P.3d 395 (2013)9

Kitsap Cty. v. Allstate Ins. Co., 136 Wn.2d 567, 964 P.2d 1173
(1998).....11, 17, 21

LaPlante v. State, 85 Wn.2d 154, 531 P.2d 299 (1975)9

Michak v. Transnation Title Ins. Co., 148 Wn.2d 788, 64 P.3d 22
(2003).....9

Moeller v. Farmers Ins. Co. of Wash., 173 Wn.2d 264, 267 P.3d
998 (2011).....21

Regence Blueshield v. Ins. Comm’r, 131 Wn. App. 639, 128 P.3d
640 (2006).....19

Stewart v. Chevron Chem. Co., 111 Wn.2d 609, 762 P.2d 1143
(1988).....11

Transcon. Ins. Co. v. Wash. Pub. Utils. Districts’ Util. Sys., 111
Wn.2d 452, 760 P.2d 337 (1988).....11

Ward v. Dixie Nat’l Life Ins. Co., Nos. 06-2022, 06-2054, 257 Fed.
Appx. 620, 2007 U.S. App. LEXIS 27699 (4th Cir. Nov. 29,
2007).....24, 25

Young v. Key Pharm., Inc., 112 Wn. 2d 216, 770 P.2d 182, 187
(1989).....10

Statutes

RCW 18.64.011(23).....7, 21

RCW 19.86	25
RCW 48.01.030	25
RCW 48.46.020(13).....	15

Regulations

WAC 284-30-320(8).....	26
WAC 284-30-330(1).....	26
WAC 284-30-350(1).....	26
WAC 284-30-350(2).....	26
WAC 284-43-0110	14
WAC 284-43-0120	8, 14
WAC 284-43-0160	8
WAC 284-43-0160(14).....	14
WAC 284-43-0160(8).....	14
WAC 284-43-130	8
WAC 284-43-5110(1).....	14

I. INTRODUCTION

This case involves the interpretation of a contract—the Medical Coverage Agreement (“Agreement”)—between Group Health Cooperative (“GHC”) and Issaquah School District. Lexine Otey (“Otey”) is a covered “Member” under the Agreement. Under the Agreement’s terms, Otey is required to pay a \$15 Copayment for preferred generic prescription drugs, or the actual charge, whichever is less, until she reaches her Out-of-pocket Limit.¹

Otey incurred pharmacy charges for various prescription drugs, ranging from \$13.30 to \$14.75. Otey alleges that when a pharmacy charges her less than her \$15 Copayment for a prescription medication, GHC must contribute toward that charge. She further alleges that in this context, the charge to her cannot exceed the amount of the wholesale drug expense incurred by the pharmacy to purchase the drug. She contends GHC’s failure to apply this theory violated the Agreement’s “Cost Share” provision and also violated the Consumer Protection Act.

The trial court correctly ruled that the Agreement unambiguously did not require GHC to contribute toward Otey’s prescription drug charges when they are less than her Copayment and her Out-of-pocket Limit had

¹ A Member’s financial responsibility is limited to \$2,000 per year for an individual or \$4,000 per family per year. It is undisputed that Otey did not reach this Out-of-pocket Limit in this case.

not been reached. The defined terms “Copayment” and “Cost Share” appear in the Financial Responsibilities for Covered Services provision of the Agreement. That provision unambiguously applies to and describes the Member’s financial responsibilities under the Agreement, not GHC’s. There is no ambiguity in the Agreement, the facts are undisputed, and GHC did not breach any duty owed to Otey. The trial court properly granted summary judgment in favor of GHC dismissing all of Otey’s claims.

II. STATEMENT OF ISSUES

1. Should the trial court’s interpretation of the Agreement be affirmed where: (a) the court applied the defined contract terms “Cost Share” and “Copayment”; and (b) the court found the Financial Responsibilities section unambiguous? (Yes.)

2. Should the trial court’s dismissal of the Consumer Protection Act claim² be upheld where the claim was premised on Otey’s breach of contract argument? (Yes.)

² Although Appellant’s brief references a “bad faith claim,” no independent claim was pled. *See* CP 1-16. Rather, Appellant asserted GHC’s failure to “contribute toward a copayment or cost share” was bad faith, which in turn was the premise for her Consumer Protection Act claim. CP 9-13.

III. STATEMENT OF THE CASE

A. Procedural History

On September 11, 2015, Otey filed a putative class action lawsuit against GHC, alleging breach of contract and violation of the CPA. *See* CP 1-16. On November 6, 2015, GHC filed a motion for summary judgment, asking the trial court to dismiss all of Otey's claims. *See* CP 25-38. On December 4, 2015, the Honorable Bruce Heller heard argument of counsel and granted GHC's motion for summary judgment, finding there were no genuine issues of material fact. CP 82. This appeal followed. CP 79.

B. Facts of the Case

The facts of the case are undisputed. GHC is a non-profit Health Maintenance Organization ("HMO") that provides coverage for health and prescription drug services to its subscribers and their enrolled dependents. *See* CP 88, CP 195. Otey is both an enrolled Subscriber and Member (hereinafter either "Subscriber" or "Member") under the Agreement. *See* CP 88-193.³ Otey purchased certain outpatient prescription drugs, including Methocarbamol, Prednisone, and Azithromycin, CP 4-5, which

³ The Medical Coverage Agreement effective November 1, 2015, begins at CP 88 and continues through CP 141. The Medical Coverage Agreement effective November 1, 2014, begins at CP 142 and continues through CP 193. There are no material differences between these agreements for purposes of this appeal. All citations are to the Agreement effective November 1, 2015.

are preferred generic drugs and described in the Agreement as Tier 1 drugs, CP 107. Prescriptions for the above medications are “Covered Services” under the Agreement. CP 107-108, 138. The Agreement states the “Member pays \$15 Copayment” for Tier 1 drugs. CP 107. Otey alleged that when she purchased the above prescriptions from the GHC pharmacy she was charged between \$13.30 and \$14.75 for the prescriptions. CP 4-5. Otey further alleged that the wholesale expense that the pharmacy paid to a drug supplier for the above medications was less than the amount the pharmacy charged her. *Id.* For purposes of the summary judgment motion, GHC stipulated that the GHC pharmacy’s wholesale drug expenses for Otey’s prescriptions identified in the Complaint were less than the amounts she was charged for those prescriptions. CP 48. Under the Agreement, a Member must obtain covered prescriptions from “Group Health-designated pharmacies,” which are pharmacies in the Group Health Provider Directory and include pharmacies that are not owned or operated by GHC. CP 108.

C. The Language of the Agreement

The Agreement sets forth the terms under which health care coverage will be provided to Members, including the benefits to which those enrolled under the Agreement are entitled, which are described in the Benefits Booklet. CP 88-141. “The provisions of the Benefits Booklet

must be considered together to fully understand the benefits available under the Benefits Booklet. Words with special meaning are capitalized and are defined in Section XII.” CP 97. An abridged version of the Benefits Booklet containing relevant language is provided as Appendix A.

“Covered Services” are “[t]he services for which a Member is entitled to coverage in the Benefits Booklet.” CP 138. The Benefits Booklet includes a number of Covered Services, from Acupuncture to Urgent Care, CP 103-124, and includes “Drugs – Outpatient Prescription,” CP 107-109. There is no dispute that the prescription drugs purchased by Otey that are the subject of this lawsuit are “Covered Services.”

The Agreement also sets forth Otey’s “Financial Responsibilities” for Covered Services:

III. FINANCIAL RESPONSIBILITIES

...

B. Financial Responsibilities for Covered Services.

The Subscriber is liable for payment of the following Cost Shares for Covered Services provided to the Subscriber and his/her Dependents. Payment of an amount billed must be received within 30 days of the billing date. Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.

1. Annual Deductible.

Covered Services may be subject to an annual Deductible. Charges subject to the annual Deductible shall be borne by the Subscriber during each year until the annual Deductible is met....

3. Copayments.

Members shall be required to pay applicable Copayments at the time of service....

4. Out-of-pocket Limit.

Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV. Total Out-of-pocket Expenses incurred during the same calendar year shall not exceed the Out-of-pocket Limit.

CP 100.⁴

The Agreement specifically defines a “Cost Share” as “[t]he portion of the cost of Covered Services for which the Member is liable. Cost Share includes Copayments, coinsurances and Deductibles.” CP 138.

The Agreement defines “Deductible” as “[a] specific amount a Member is required to pay for certain Covered Services before benefits are payable.” *Id.* The Agreement also expressly defines “Copayment” as “[t]he specific dollar amount a Member is required to pay at the time of service for certain Covered Services.” *Id.*

The benefits section of the Agreement describes the Copayments for “Drugs – Outpatient Prescription” as follows:

Preferred generic drugs (Tier 1): Member pays \$15 Copayment

Preferred brand name drugs (Tier 2): Member pays \$30 Copayment

⁴ Otey largely fails to cite to relevant language in the Financial Responsibilities section in her briefing.

Non-Preferred generic and brand name drugs (Tier 3):

Not covered; Member pays 100% of all charges

CP 107-108. With respect to prescription drugs “Cost Shares are payable at the time of delivery.” CP 108.

Included in the “Covered Services” for “Drugs – Outpatient Prescription” are “pharmacy services.” See CP 109 (“The Member’s Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services....”). State law regulates pharmacists and defines the “Practice of pharmacy” to include:

the practice and responsibility for: Interpreting prescription orders; the compounding, dispensing, labeling, administering, and distributing of drugs and devices; ... the proper and safe storing and distributing of drugs and devices and maintenance of proper records thereof; the providing of information on legend drugs which may include...the advising of therapeutic values, hazards, and the uses of drugs and devices.

RCW 18.64.011(23).

D. Summary Judgment Motion and Order

GHC asked the trial court to dismiss Otey’s claims for breach of contract and violation of the Consumer Protection Act, which were based on Otey’s misinterpretation of the Agreement and on regulatory provisions that are inapplicable to GHC. The trial court agreed, ruling:

Well, the first issue is whether or not the agreement is ambiguous, and let me go to the actual provisions at issue here. We have a copayment definition that says, “The specific amount a Member is required to pay at the time of services for certain covered services.”

And then we have a broader concept that is called “cost shares” which includes copayments, but it also includes things like coinsurance and deductibles. Deductibles are paid entirely by the Members. Even though it’s called a cost share, there’s no sharing of the deductible. That’s an amount that is owed by the Member.

The Court thinks that there’s only one reasonable interpretation of the term “copayment,” which is a subset of cost share, and that is the amount that is owing by the Member. And that is consistent with the definitions in the WACs, and that’s WAC 284-43-120 and also 284-43-130A(8).⁵

There’s nothing in the contract that I think can reasonably be interpreted to say that a cost share or a copayment requires Group Health to share the cost for a particular bottle of pills....

So I don’t find that the terms are ambiguous. And I find that the financial responsibilities section is quite clear in saying charges will be for the lesser of cost shares – in other words, the Member’s payment – for covered services or the actual charge for that service. So in the context of this case, if somebody’s getting a generic drug they normally have to pay \$15 or the actual charge, which is what the pharmacy is charging....

But there is nothing in any of these definitions that reasonably suggests to the Court an ambiguity or at least a possibility, a reasonable possibility, that the Insurer, Group Health, is required to share in the cost of a particular service. I just don’t see it and, therefore, I am going to grant summary judgment for Group Health in the matter.

⁵ WAC 284-43-120 has since been recodified as WAC 284-43-0120; WAC 284-43-130 was recodified at WAC 284-43-0160.

RP 32-34.

The trial court also agreed that because the Agreement was “clear and unambiguous” and because GHC “followed the terms of the contract,” “that would dispose of the Consumer Protection claim.” RP 34. This appeal followed.

IV. ARGUMENT

A. Standard of Review

Appellate courts review summary judgment decisions de novo, engaging in the same inquiry as the trial court. *Michak v. Transnation Title Ins. Co.*, 148 Wn.2d 788, 794-95, 64 P.3d 22 (2003). Summary judgment is proper only where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Int’l Marine Underwriters v. ABCD Marine, LLC*, 179 Wn.2d 274, 281, 313 P.3d 395 (2013); CR 56(c).

In a summary judgment motion, the moving party bears the initial burden of showing the absence of an issue of material fact. *See LaPlante v. State*, 85 Wn.2d 154, 158, 531 P.2d 299 (1975). If the moving party is a defendant and meets this initial showing, then the inquiry shifts to the party with the burden of proof at trial, the plaintiff. *Young v. Key Pharm., Inc.*, 112 Wn. 2d 216, 225, 770 P.2d 182, 187 (1989). “If, at this point, the plaintiff ‘fails to make a showing sufficient to establish the existence of an

element essential to that party's case, and on which that party will bear the burden of proof at trial', then the trial court should grant the motion." *Id.* (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986)). "In *Celotex*, the United States Supreme Court explained this result: 'In such a situation, there can be no genuine issue as to any material fact,' since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial.'" *Id.* (citing *Celotex*, 477 U.S. at 322-23).

B. The trial court correctly ruled the defined terms "Cost Share" and "Copayment" unambiguously describe the Member's financial obligations, not GHC's.

The interpretation of the Agreement, i.e., a contract, is a question of law for the court. *See Stewart v. Chevron Chem. Co.*, 111 Wn.2d 609, 613, 762 P.2d 1143, 1145 (1988). "A[n insurance] policy is considered as a whole so that the court can give effect to every clause in the policy." *Kitsap Cty. v. Allstate Ins. Co.*, 136 Wn.2d 567, 575, 964 P.2d 1173 (1998). "If terms are defined in a policy, then the term should be interpreted in accordance with that policy definition." *Id.* at 576. If terms are not defined, then they are to be given their "plain, ordinary, and popular meaning." *Id.* (quoting *Boeing Co. v. Aetna Cas. & Sur. Co.*, 113 Wn.2d 869, 877, 784 P.2d 507 (1990)). "Overall, a policy should be given a practical and reasonable interpretation rather than a strained or forced

construction that leads to an absurd conclusion, or that renders the policy nonsensical or ineffective.” *Transcon. Ins. Co. v. Wash. Pub. Utils. Districts’ Util. Sys.*, 111 Wn.2d 452, 457, 760 P.2d 337 (1988). Further, when construing a contract, the court should attempt to give effect to each provision in the contract. *Allstate Ins. Co. v. Peasley*, 131 Wn.2d 420, 424, 932 P.2d 1244 (1997). If policy language is clear and unambiguous, a court may not modify the insurance contract or create an ambiguity. *American Star Ins. Co. v. Grice*, 121 Wn.2d 869, 874, 854 P.2d 622 (1993). An ambiguity in an insurance policy is present only if the language used is fairly susceptible to two different *reasonable* interpretations. *Id.*

In order to prevail on a breach of contract claim, the plaintiff has the burden to prove four elements: duty, breach, causation, and damages. *Baldwin v. Silver*, 165 Wn. App. 463, 473, 269 P.3d 284 (2011). If the duty allegedly breached is not in the agreement, there can be no breach and no damages. *Fidelity & Deposit Co. of Md. v. Dally*, 148 Wn. App. 739, 745, 201 P.3d 1040 (2009).

1. The trial court correctly applied the Agreement’s definitions.

Otey argues that the terms “Copayment” and “Cost Share” require that GHC share in paying for inexpensive prescription drugs that retail for

less than Otey's \$15 Copayment. This is directly contrary to how these terms are defined in the Agreement. Otey's argument ignores the Agreement's definitions as well as the entire "Financial Responsibilities for Covered Services" provision. CP 100-101.

The Agreement is clear. In order to receive Covered Services, which include everything from acupuncture to prescription drugs and urgent care, the Member or Subscriber must comply with the Financial Responsibilities for Covered Services. See CP 100. The Agreement defines "Cost Share" as the "portion of the Covered Services for which the *Member is liable*. Cost Share includes Copayments ... and Deductibles." CP 138 (emphasis added). This clearly provides that the *Member* — and not GHC — must pay the "Cost Share." The Financial Responsibilities section further provides that the "*Subscriber is liable* for payment of the following Cost Shares for Covered Services" as follows:

1. Annual Deductible...
2. Plan Coinsurance...
3. Copayments... [and]
4. Out-of-pocket- Limit.

CP 100 (emphasis added).

Under the Agreement, "Copayment" and "Deductible" are each a type of Cost Share and each is expressly defined in the Agreement. CP 138. Copayment is the "amount *a Member is required to pay* at the time

of service.” CP 138 (emphasis added). “Deductible” is the “specific amount *a Member is required to pay* for certain Covered Services before benefits are payable.” CP 138 (emphasis added). All Cost Shares, including Copayments and Deductibles, are defined as the Subscriber/Member’s financial responsibility; the definitions expressly do not require GHC to pay any “Cost Share.” *See* CP 100, 138.

A Member’s overall financial responsibility per year is limited. Once a Member has met her “Out-of-pocket Limit,” in this case \$2,000 per Member or \$4,000 per Family, then the Member has no further obligation to Cost Share for that year. CP 102; *see also* CP 140 (defining “Out-of-pocket Expense” and “Out-of-pocket Limit”). Before the Limit is reached, GHC provides Covered Services subject to the Financial Responsibilities of the Member.

In sum, the Agreement’s Financial Responsibilities section, CP 100-101, clearly sets forth Otey’s financial obligations, not GHC’s. These terms are clearly defined, and the trial court correctly applied the definitions set forth in the Agreement.

2. *GHC’s interpretation of “Cost Share” and “Copayment” is consistent with Washington law.*

GHC’s interpretation of the Agreement is also supported by the Washington Administrative Code, which regulates health carriers and

creates minimum standards for health plans in Washington, including acceptable charges for health plans. WAC 284-43-0110; *see also* WAC 284-43-0120.⁶ HMOs such as GHC are health carriers for purposes of these regulations. *See* WAC 284-43-0160(14). The regulations provide the following definition for “cost-sharing”:

...“[C]ost-sharing” means amounts paid to health carriers directly providing services, health care providers, or health care facilities *by enrollees* and may include copayments, coinsurance, or deductibles.

WAC 284-43-0160(8) (emphasis added).

With regard to prescription drugs specifically, the “Cost sharing for prescription drugs” regulation states that “[c]ost-sharing means amounts paid directly to a provider or pharmacy *by an enrollee* for services received under the health benefit plan, and includes copayment, coinsurance, or deductible amounts.” WAC 284-43-5110(1) (emphasis added). The definition of “cost-sharing” under the regulations relates only to the enrollee’s (or Member’s) financial responsibility and is completely consistent with the Financial Responsibilities provision of the Agreement providing that the Subscriber is liable for payment of Cost Shares.

⁶ Otey excludes any discussion of the Washington Administrative Code in her brief.

Further, the statutory definition of an HMO specifically provides that health care services to enrolled participants of such organization are covered:

on a group practice per capita prepayment basis or on a prepaid individual practice plan, *except for an enrolled participant's responsibility for copayments and/or deductibles*, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040.

RCW 48.46.020(13) (emphasis added). GHC is an HMO, *see* CP 195, and consistent with the Agreement, copayments are solely the responsibility of the Member.

Although the Court need not rely on these statutory and regulatory definitions to interpret the Agreement's already clear terms, these definitions demonstrate that GHC did not draft the definitions of Copayment and Cost Share in a manner that would mislead its Members to believe that GHC would share in the cost of every single bottle of pills. Rather, these terms are well-defined and widely understood. GHC incorporated these terms into the Agreement and then clearly defined them in line with their regulatory meaning.

3. *Otey's interpretation of "Copayment," and "Cost Share" is unreasonable.*

Because Otey's arguments depend upon ignoring the Agreement's definitions of Cost Share and Copayment, as well as the Financial Responsibilities provision, her arguments are unreasonable as a matter of law. Despite the Agreement's clear contractual definitions, which are also mirrored by applicable regulations, Otey urges this Court to read selectively from the Agreement — rather than interpret the document as a whole — and adopt “dictionary definitions to ascertain [the] common meaning” of *already defined terms*. Appellant Br. at 13. Otey suggests alternative definitions for “cost share,” *id.* at 13-14, and “copayment,” *id.* at 14, from Dictionary.com and *Mosby's Medical Dictionary* to argue that GHC was contractually required to share in the cost of every bottle of pills along with Otey, including those costing less than the amount of her Copayment. *Id.* at 13-14; *see also* CP 13-14. This is an absurd reading of the Agreement.

There is no support for such a premise in Washington law. If terms are defined in a policy, then the terms must be interpreted in accordance with the policy definitions. *Kitsap Cty.*, 136 Wn.2d at 576. This Court cannot adopt the definitions proposed by Otey because they contradict the Agreement. For example, Otey asserts Copayment means

“both parties are sharing the cost of the drug,” Appellant Br. at 14, but the Agreement defines Copayment as “the specific dollar amount *a Member* is required to pay....” CP 138 (emphasis added). Whether an average consumer may have a different lay understanding of copayment, when not defined, such an understanding is irrelevant because the definition in the Agreement controls. Otey’s argument also ignores and contradicts the Financial Responsibilities provision, which — as noted above — provides that “the Subscriber is liable for payment of the [listed] Cost Shares for Covered Services....” CP 100.

Otey’s interpretation of Cost Share also is unreasonable. Otey asserts that the phrase “portion of the cost” included in the Cost Share definition⁷ requires GHC to contribute to the cost of every prescription. However, reading the Agreement as a whole, the only reasonable interpretation is that a Member’s “portion” of the cost for an outpatient prescription medication is the Copayment⁸ and Deductible⁹ if the Out-of-pocket Limit has not been satisfied. The Member’s “portion” of the cost after the Out-of-pocket Limit is met is zero.

⁷ The definition of “Cost Share” is “[t]he portion of the cost of Covered Services for which the Member is liable. Cost Share includes Copayments, coinsurances, and Deductibles.” CP 138.

⁸ If the actual charge for the prescription is less than the Copayment amount then the Member’s Cost Share is the actual charge. CP 100.

⁹ While the amount of the Deductible in the Agreement is zero, CP 102, there is no exception for applying deductibles to outpatient prescription drugs, as Otey now asserts. Appellant Br. at 21.

Otey's interpretation also is unreasonable because it would require the Court to ignore the Financial Responsibilities provision which unambiguously provides that Subscribers/Members are solely responsible for Cost Shares: "The Subscriber is liable for payment of the following Cost Shares...." CP 100. Her interpretation would also read out of the Agreement the definitions of Copayment and Deductible, a subset of Cost Share, so that GHC would be required to contribute toward payment of the Deductible and Copayment in direct contradiction of the Agreement.

Another unreasonable interpretation of the Agreement in Otey's argument is her assertion that GHC's alleged payment obligation applies to an individual bottle of pills, rather than to "Covered Services," as required by the Agreement. This is what Otey calls "aggregate" cost sharing. Her argument is also contrary to the case cited by Otey, *Regence Blueshield v. Ins. Comm'r*, 131 Wn. App. 639, 650, 128 P.3d 640 (2006), which states that cost-sharing in the form of copayments and coinsurance "assure that the subscriber and the insurance company share in all *annual* pharmacy expenditures...." *Id.* (emphasis added). See Appellant Br. at 20. Otey provides no basis for her argument.

Otey's proposed interpretation also provides no clear method under the Agreement to determine what GHC's purported share should be for a prescription medication that retails for less than the Copayment. Otey

does not ever propose an answer. In oral argument, the trial court asked how much GHC should have paid for the prescription drugs at issue under Otey's interpretation of the Agreement. Appellant could provide no answer:

Mr. Houck: ...All we're saying is that they have to share in the cost of these drugs. So however they want to share, you know, if it's 50/50, that \$13.75 that they charge her for the prescription drug, they just have to share somehow in that cost and can't charge her the whole \$13.75 or whatever they made it....

The Court: ...So if I accept your argument that there's a cost share for each bottle of pills, how do we determine what the cost share is?

Mr. Houck: Well, that's for damages; but what we're saying is that you can't grant summary judgment. They've breached the contract. They have not shared in the cost of the drug.

RP 19-20.

Otey's proposed reading of the Agreement conflicts with the contract terms and leads to "nonsensical" results. Her interpretation is unreasonable.

4. Otey's definition of "actual charge" is not a reasonable interpretation of the Agreement.

A corollary to Otey's contention that GHC must contribute to the Member's Cost Share, is her argument that the undefined phrase "actual charge" as found in the Financial Responsibilities provision is ambiguous and should limit her Cost Share to GHC's wholesale drug expense.

An axiomatic canon of contract law is that the court must look to the entire contract to determine whether a particular phrase is ambiguous. *Moeller v. Farmers Ins. Co. of Wash.*, 173 Wn.2d 264, 271-72, 267 P.3d 998 (2011). An ambiguity in an insurance policy is only present “if the language used is fairly susceptible to two different reasonable interpretations.” *Kitsap Cty.*, 136 Wn.2d at 576. A contract should be given a “practical and reasonable rather than a literal interpretation, and not a strained or forced construction leading to absurd results.” *Eurick v. Pemco Ins. Co.*, 108 Wn.2d 338, 341, 738 P.2d 251 (1987) (citations omitted).

Otey argues that “actual charge” is ambiguous, but does not interpret the phrase in the context of the Agreement or show that her interpretation is reasonable. The relevant section of the Agreement states:

The Subscriber is liable for payment of the following Cost Shares for Covered Services provided to the Subscriber and his/her Dependents.... **Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.**

CP 100.

Otey argues “actual charge” means the drug supplier’s wholesale charge to the pharmacy for a prescription drug. Under this reading, Otey claims she should only have been charged the wholesale cost for her

prescription for Methocarbamol, and not the retail cost of \$13.60. Appellant Br. at 6-11.

The trial court properly rejected this argument. The only reasonable interpretation of “actual charge” in the provision describing the Subscriber’s Financial Responsibilities is the actual charge to a Member by a provider of Covered Services. Since the Subscriber’s payment of the Cost Share for prescriptions is due at the time of service, the “actual charge” can only mean the charge (or the Copayment, whichever is less) by the pharmacy to the Subscriber. Appellant concedes that this interpretation is reasonable. *See* Appellant Br. at 7.

The phrase at issue is “**the actual charge for that service.**” CP 100. Otey’s interpretation ignores that the service for which the actual charge is incurred includes more than the pills themselves, but also “pharmacy services,” CP 109, which includes the compounding, dispensing, safe storage and distribution of a prescription drug at a pharmacy by a licensed pharmacist, RCW 18.64.011(23).

Further, a Member may obtain covered prescriptions from pharmacies that are not owned or operated by GHC, such as a Rite-Aid. CP 108. In that case, GHC is not charged anything by a drug supplier, and does not know what Rite-Aid’s wholesale cost would be. Otey admits

there is no way to determine what the “actual charge” to the Member should be in that case:

The Court: ... Let’s say that a Group Health member purchases a generic drug at Rite Aid. I don’t know if Rite Aid is one of the authorized pharmacies. Let’s just say it is. How would one determine, under your interpretation of the contract, what the member pays at Rite Aid? Would it be the same as that she pays at the Group Health Pharmacy? Would it be different? How would you determine that?

Mr. Houck: Well, the thing is is that’s not a consideration; those are damages....

The Court: Well, the reason I think it is legitimate to ask these questions is that under the Hornbook law in determining whether something is ambiguous or not, the Court has to give reasonable interpretations to the contract provisions. So if interpreting it one way leads to completely unworkable situations then I think that’s relevant, not for damages, but for interpreting the contract? Don’t you think?

Mr. Houck: No....

RP 25-26.

Otey’s proposed definition of “actual charge” is also unworkable when applied to “Covered Services” as required under the Agreement. CP 100. For example, it is impossible to determine the provider’s wholesale cost for Covered Services such as “Newborn Services,” CP 116, “Urgent Care,” which covers non-GHC providers, CP 124, and “Hearing Examinations and Hearing Aids,” CP 110. Otey’s interpretation is unreasonable.

Finally, Otey argues that the phrase “actual charge” is ambiguous based on a string of nine federal cases that are irrelevant to interpreting this Agreement. Appellant Br. at 7-8. All of those cases addressed supplemental cancer benefit insurance policies which paid benefits based on the “actual charge” for various cancer treatments. None of the policies involved the member’s or subscriber’s financial responsibility for Cost Shares. *See, e.g., Ward v. Dixie Nat’l Life Ins. Co.*, Nos. 06-2022, 06-2054, 257 Fed. Appx. 620, 625-27, 2007 U.S. App. LEXIS 27699 (4th Cir. Nov. 29, 2007) (unpublished).

The policy language in *Ward* stated: “We will pay the actual charges for [various cancer treatments.]” *Ward*, 257 Fed. Appx. at 623. Although the phrase was used repeatedly throughout the policy, no definition for “actual charges” was provided. *Id.* For many years, the insurer calculated benefits based on the amounts billed to patients by their medical providers, even though providers often had agreements with certain insurers to accept as payment-in-full an amount less than that reflected on the patient’s bills. *Id.* The insurer later changed its policy and began calculating benefits based on the pre-negotiated discount rate for cancer treatments, which was substantially less than the charge billed to patients. *Id.* at 623-24. The insured sued arguing the phrase “actual charge” was ambiguous. The court ruled the term as used in the

supplemental cancer policy could reasonably be interpreted to mean either the full amount billed to the patient, or a lesser amount accepted as payment-in-full by the provider. *Id.* at 627. The other federal cases cited by Otey address this same issue. *See* Appellant Br. at 7-9. These cases have no application here.

C. There is no phantom exclusion for inexpensive prescription drugs.

There is no dispute that Otey's prescription drugs are Covered Services. *See* Appellant Br. at 15. Nonetheless, Otey claims that GHC has created a "phantom exclusion" limiting the prescription benefit because GHC is not responsible for any payment when the retail price of a prescription is less than the Member's Copayment and the Member has not met her Out-of-pocket Limit. *See id.* at 16. However, this is exactly what is provided for in the Agreement. When the Financial Responsibilities provision, CP 100-101, is read in conjunction with the prescription drug benefit, CP 107-109, as the Court must do, Otey's argument clearly fails.

Under the Financial Responsibilities provision, a Member must pay her applicable Cost Share, and once a Member has paid her Out-of-pocket Limit each year — \$2,000 in the case of an individual Member or \$4,000 per Family Unit, CP 102 — the Member is no longer subject to a

Cost Share. *See* CP 100, 102. Otey acknowledges this. *See* Appellant Br. at 21-22. If Otey had reached her Out-of-pocket Limit for the years in question, then she would have paid nothing for her prescription drugs after that point. At the time she filled her prescriptions, however, Otey had not met her Out-of-pocket Limit and still had outstanding financial responsibilities under the Agreement; that is why she was required to pay the lesser of the Copayment or the “actual charge” for her prescription drugs. CP 100. There is no “phantom” exclusion.

D. The trial court correctly dismissed Otey’s Consumer Protection Act claim.

Otey alleges that GHC violated the Consumer Protection Act (“CPA”), RCW 19.86, based on an asserted violation of the Agreement. *See* CP 9-13. As briefed above, GHC did not violate the Agreement. Because Otey’s CPA claim was premised on a breach of the Agreement, summary judgment dismissal was proper.

Otey contends that she has an independent claim for a bad faith claim and CPA violation that should be allowed to proceed to trial.¹⁰ *See* Appellant Br. at 23 (citing to *Coventry Assocs. v. Am. States Ins. Co.*, 136 Wn.2d 269, 279, 961 P.2d 933 (1998)). Otey misapplies *Coventry* to the facts of this case. In *Coventry*, the insurer correctly denied a claim that

¹⁰ Otey’s CPA claim is premised on an insurance “bad faith” claim. *See* RCW 48.01.030. There is no stand-alone bad faith claim. *See* CP 9-15.

was excluded by the insurance policy, but in doing so it engaged in a bad faith investigation. *Id.* at 276-77. The court held that even though the insurer was ultimately correct in determining coverage did not exist, there was still a separate duty to investigate the claim in good faith, and the insured was harmed by the insurer's breach of this duty. *Id.* at 279. In other words, the duty and facts supporting the insurer's bad faith and CPA claims in *Coventry* were entirely separate and independent from the insurer's coverage determination.

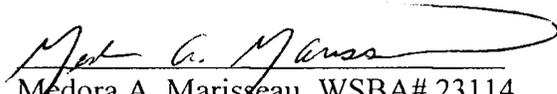
This case involves a situation far different from *Coventry*. Here, Otey alleges a CPA violation based on the very same facts and legal duties that she alleges in support of her breach of contract claim. Otey admits this. In her Complaint, Otey claims that GHC violated the CPA by acting in bad faith,¹¹ which was in turn based on an alleged violation of the Agreement. *See* CP 9-13. Because the only alleged violation here regards what GHC charged Otey under the Agreement, there is no independent CPA claim that should proceed to trial. *Coventry* is inapplicable.

¹¹ As part of her bad faith sub-claim, Otey alleges that GHC violated the Unfair Claims Settlement Practices regulations, WAC 284-30-330(1) and 350(1), (2). CP 10-11. These regulations do not apply to GHC because it is an HMO and therefore not an "insurer" as defined by the regulations. *See* WAC 284-30-320(8) (defining "Insurer"). Even if the regulations did apply to GHC, Otey still bases her claim on an alleged breach of the Agreement.

V. CONCLUSION

The trial court correctly found that GHC followed the unambiguous language of the Agreement, and there was no breach of contract or violation of the CPA. For all the foregoing reasons, the Court should affirm the trial court's summary judgment dismissal of Otey's claims.

DATED this 6th day of June, 2016.

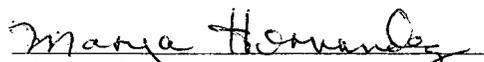

Medora A. Marisseau, WSBA# 23114
Stephanie R. Lakinski, WSBA #46391
KARR TUTTLE CAMPBELL
701 Fifth Avenue, Suite 3300
Seattle, WA 98104
Telephone: 206-223-1313
Facsimile: 206-682-7100
Email: mmarisseau@karrtuttle.com
Email: slakinski@karrtuttle.com
Attorneys for Group Health Cooperative

CERTIFICATE OF SERVICE

I, Marya Hernandez, affirm and state that I am employed by Karr Tuttle Campbell in King County, in the State of Washington. I am over the age of 18 and not a party to the within action. My business address is: 701 Fifth Ave., Suite 3300, Seattle, WA 98104. On this day, I caused to be filed with Washington State Court of Appeals a true and correct copy of RESPONDENT'S BRIEF. I caused the same to be served on the parties listed below in the manner indicated.

William Houck, WSBA #13324	<input type="checkbox"/>	Via U.S. Mail
Houck Law Firm, PS	<input type="checkbox"/>	Via Hand Delivery
4045 262 nd Ave. SE	<input checked="" type="checkbox"/>	Via Electronic Mail
Issaquah, WA 98029	<input type="checkbox"/>	Via Overnight Mail
425-392-7118	<input type="checkbox"/>	Via E-Service Court's Website
houck@houcklaw.com		
Robert B. Kornfeld, WSBA #10669	<input type="checkbox"/>	Via U.S. Mail
Kornfeld, Trudell, Bowen & Lingenbrink, PLLC	<input type="checkbox"/>	Via Hand Delivery
3724 Lake Washington Blvd. NE	<input checked="" type="checkbox"/>	Via Electronic Mail
Kirkland, WA 98033	<input type="checkbox"/>	Via Overnight Mail
425-893-8989	<input type="checkbox"/>	Via E-Service Court's Website
rob@kornfeldlaw.com		

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct, to the best of my knowledge. Executed on this 6th day of June, 2016, at Seattle, Washington.


Marya Hernandez
Assistant to Medora A. Marisseau

Appendix A

Relevant Provisions of the Group Medical Coverage Agreement and Benefits Booklet

XII. DEFINITIONS [See CP 138, 140]

Copayment	The specific dollar amount a Member is required to pay at the time of service for certain Covered Services.
Cost Share	The portion of the cost of Covered Services for which the Member is liable. Cost Share includes Copayments, coinsurances and Deductibles.
Covered Services	The services for which a Member is entitled to coverage in the Benefits Booklet. [See Benefits Booklet at CP 92-141]
Deductible	A specific amount a Member is required to pay for certain Covered Services before benefits are payable.
...	...
Out-of-pocket Expenses	Those Cost Shares paid by the Subscriber or Member for Covered Services which are applied to the Out-of-pocket Limit.
Out-of-pocket Limit	The maximum amount of Out-of-pocket Expenses incurred and paid during the calendar year for Covered Services received by the Subscriber and his/her Dependents within the same calendar year. The Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV [CP 102].

III. FINANCIAL RESPONSIBILITIES [CP 100]

...

B. Financial Responsibilities for Covered Services.

The Subscriber is liable for payment of the following Cost Shares for Covered Services provided to the Subscriber and his/her Dependents. Payment of an amount billed must be received within 30 days of the billing date. Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.

1. Annual Deductible.

Covered Services may be subject to an annual Deductible. Charges subject to the annual Deductible shall be borne by the Subscriber during each year until the annual Deductible is met....

2. Plan Coinsurance

...

3. Copayments.

Members shall be required to pay applicable Copayments at the time of service. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service or if other Cost Shares apply.

4. Out-of-pocket Limit.

Out-of-pocket Expenses which apply toward the Out-of-Pocket Limit are set forth in Section IV [CP 102]. Total Out-of-pocket Expenses incurred during the same calendar year shall not exceed the Out-of-pocket Limit...

IV. BENEFITS DETAILS

[CP 102]

Benefits are subject to all provisions of the Benefits Booklet. Members are entitled only to receive benefits and services that are Medically Necessary and clinically appropriate...

Annual Deductible	Member pays \$0 per Member per calendar year or \$0 per Family Unit per calendar year
...	...
Out-of-pocket Limit	Limited to a maximum of \$2,000 per Member or \$4,000 per Family Unit per calendar year
	The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: All Cost Shares for Covered Services
	The following expenses do not apply to the Out-of-pocket Limit: Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services
...	...

...

[CP 107-109]

Drugs – Outpatient Prescription	
Prescription drugs, supplies and devices for a supply of 30 days or less ...	Preferred generic drugs (Tier 1): Member pays \$15 Copayment

<p>All drugs, supplies and devices must be obtained at a Group Health-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside the Group Health Service Area. Information regarding Group Health-designated pharmacies is reflected in the Group Health Provider Directory, or can be obtained by contacting the Group Health Customer Service Center.</p> <p>Prescription drug Cost Shares are payable at the time of delivery...</p> <p>...</p>	<p>Preferred brand name drugs (Tier 2): Member pays \$30 Copayment</p> <p>Non-Preferred generic and brand name drugs (Tier 3): Not covered; Member pays 100% of all charges</p>
<p>...Prescription drugs are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order...</p>	
<p>The Member's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Members' right to know what drugs are covered and the coverage limitations. Members who would like more information about the drug coverage policies, or have a question or concern about their pharmacy benefit, may contact Group Health...</p> <p>Members who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the Benefits Booklet, may contact the Washington State Office of Insurance Commissioner... Members who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health...</p> <p>...</p>	
<p>Exclusions: Over-the-counter drugs, supplies and devices not requiring a prescription under state law or regulations, including most prescription vitamins, except as recommended by the U.S. Preventative Services Task Force (USPSTF); drugs and injections for anticipated illness while traveling; drugs and injections for cosmetic purposes; replacement of lost or stolen drugs or devices; administration of excluded drugs and injectables; drugs used in the treatment of sexual dysfunction orders</p>	

FILED
 COURT OF APPEALS
 STATE OF WASHINGTON
 2016 JUN -6 PM 1:51