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IN THE SUPREME COURT

OF THE

STATE OF UTAH

PREPAID DENTAL SERVICES, INC., a Utah Corporation, Plaintiff-Appellant vs. ROGER C. DAY, Commissioner of Insurance of the State of Utah, Defendant-Respondent	)	Case No. 16826

REPLY BRIEF

AN APPEAL FROM THE DECISION AND ORDER OF
THE THIRD JUDICIAL DISTRICT COURT
OF SALT LAKE COUNTY, STATE OF UTAH
THE HONORABLE DEAN E. CONDER, JUDGE, PRESIDING

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FILED

MAR 27 1980

Clerk, Supreme Court, Utah

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I. NATURE OF THE CASE

In this case, Prepaid Dental Services, Inc., Appellant herein, petitioned the court below for a Declaratory Judgment declaring that the Findings and Order of Roger C. Day, Commissioner of Insurance of the State of Utah, herein Respondent, were inconsistent with the definition of "Insurance" as set forth in Section 31-1-7 of the Utah Code Annotated (1953) and the definition of a "Health Maintenance Organization" within the provisions of Title 21, Chapter 42, Utah Code Ann. (1953).

II. DISPOSITION OF THE CASE IN LOWER COURT

The court below issued a Memorandum Opinion which sustained the Findings and Order of the Insurance Department and dismissed Appellant's Petition.

III. NATURE OF RELIEF SOUGHT ON APPEAL

Respondent seeks an affirmation of the decision of the lower court which sustained the Findings and Order of the Insurance Commissioner.

IV. STATEMENT OF FACTS

Appellant and Respondent stipulated to the facts in this case, and the Appellant has set forth in his Statement of Facts the verbatim wording of the stipulation, with which Respondent, of course, agrees. Appellant additionally stated that the trial court took no "additional evidence."

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The trial court did, in fact, admit a certified copy of the Appellant's Articles of Incorporation showing that it was a "for profit" corporation (R.248, Exp. 1P). There is no dispute on this point. Respondent otherwise agrees with the concluding paragraphs of Appellant's Statement of Facts which are not quoted from the stipulation.

The trial court, in its Memorandum Opinion summarized briefly and clearly the undisputed fact situation.

> "The Plaintiff requires the dentists to render "...services described in Exhibit 'A' attached hereto and incorporated herein by reference, at no charge to such Participant or Employer Group other than the monthly charge then in effect..." (Ex. A par. Eighth). Furthermore, the dentists shall provide a "performance bond" such that if the dentist..."fails to perform the required services for any reason, the bonding company will pay such other licensed dentist as may be designated by the Participant to perform the services..." (Ex. A par. Twelfth). The substance of the transaction therefore calls for the employer to pay to the Plaintiff a monthly charge for each participant and in exchange for this the Plaintiff agrees to use its "best efforts" to obtain licensed dentists to render professional services as scheduled. On the other half of the transaction, the Plaintiff enters into a contract with dentists who agree to perform the scheduled services for an agreed monthly sum and to furnish a performance bond to guarantee the participant that if the dentist fails to "...perform the required services for any reason..." the bonding company will pay such other licensed dentists to perform the services as the Participant may designate." (R.251)

V. ARGUMENT

A. THE PLAN PROPOSED IS INSURANCE.

The trial court, in its Memorandum Opinion, stated the issues in this case in clear terms:

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"The question before this court is whether or not the program outlined in the Stipulated Statement of Facts constitutes "insurance" and if it does, then does it qualify under the "Health Maintenance Organization Act." (31-42-1, et seq.)

The basic question is whether or not this program constitutes "insurance." The Defendant contends that when you look at the total program it constitutes a contract whereby "...one undertakes to...allow a... benefit upon determinable risk contingencies." (31-1-7) Plaintiff, on the other hand, claims that the documents attached to the Stipulated Statement of Facts show (1) that the dentists are independent contractors (Ex. D Par. 9.01) and (2) that Plaintiff is only obligated to use its "best efforts" in obtaining and providing dental services (Ex. D Par. 2.02 and 2.03). Exhibit "C" is the Master Contract and except for the "best efforts" provisions it certainly has all the provisions and language of a group insurance policy coverage." (R.250).

1. The obligations of PDS are a "Benefit" under the Statute.

Were it not for the "best efforts" mechanism used by Plaintiff, not even Plaintiff would question that the plan devised by the Plaintiff would be considered insurance under our Insurance Code. Plaintiff admits in its brief that "under the plan proposed by PDS there is a risk" and does not seriously dispute that "there is a distribution of risk under the Prepaid Dental Plan." (Plaintiff's brief p.10,11). Plaintiff's claim is that the "basic insurance equation fails in that PDS does not assume that risk." (Plaintiff's brief p.11). The heart of Plaintiff's defense then, is that the mechanism of "best efforts" negates an "assumption of the risk" by Plaintiff.

The position the Commissioner of Insurance took and that which the trial court took was that the use of "best

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efforts" was a "benefit" which falls squarely within the statutory definition of insurance as a "contract whereby ...one undertakes to...allow a benefit upon determinable risk contingencies." (31-1-7 UCA).

As noted in Utah Funeral Directors & Embalmers v Memorial Gardens, 17 Utah 2d 227, 408 P.2d 190 (1965), after Justice Crockett wrote his opinion in the In re Clark's Estate, 10 Utah 2d 427, 354 P.2d 112 (1960), the Legislature amended the statutory definition of insurance so as to adopt and codify the court's conclusions. The statute now expresses, as clearly and completely as the Legislature is able to do so, the current definition of insurance under Utah law.

It is common knowledge that in many insurance contracts, the assumption of risk by the insurer is not for the total risk exposure of the insured. In a life insurance policy, the insurer assumes a fixed dollar risk which may be as low as a hundred dollars or as high as millions of dollars. The insurer does not agree to equate that which it does in providing a benefit with the total loss to the insured. The insurer simply "allows" the "benefit" contracted under the terms of the policy. Not even Plaintiff would claim that a $100 insurance policy covers the total loss to an insured in a matured life insurance policy. The $100, however, is the "benefit" under the statute that is "allowed upon a determinable risk contingency." The same

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situation applies in an automobile insurance policy. Such a policy may be purchased for a liability coverage of $100 or $100,000,000. There may be deductibles in the policy contract. In any of these cases, it is not necessary that the policy insure the entire risk to which the insured is exposed in order for the policy to be an insurance policy under our Insurance Code definition. It is only necessary that the insurer "undertake to allow a benefit upon a determinable risk contingency." The same categorization also applies to a fire insurance policy or other casualty insurance policy. A building may be insured against fire for much less than its value and a high deductible may be part of the terms of the policy. Whatever the agreed benefit, however, it is triggered upon the happening of the determinable risk contingency, i.e. the occurrence of a fire which does damage to the insured's structure. Further examples could be given from the health insurance field or any other insurance field to show that the benefit does not have to be co-equal with the amount of the damage at risk. Had the legislature intended that the entire damage be covered in order to have such a contract defined as an insurance policy under the statutory definition of insurance, the legislature certainly could have used a word other than "benefit". Webster's Third International Dictionary defines benefit as:

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"3. Whatever promotes welfare; advantage; profit."

The undertaking of the Plaintiff to use its "best efforts" to obtain the services of dentists under contract to Plaintiff to provide the contracted care is certainly a "benefit" as defined by Webster.

The performance bond contracted by PDS to be furnished provides an additional "benefit" to the participant or policy holder. A recitation from page 12 of Plaintiff's brief makes clear what this obligation intends:

> "...the Dental Group must provide a performance bond in an amount equal to the estimated annual payment due from each Employer Group. The terms of such performance bond provide that in the event the Dental Group fails for any reason to perform the required services, the bonding company will pay such other licensed dentist as may be designated by the Participant to perform the specific dental services described in the Dental Group Agreement. Thus, if the Dental Group failed for any reason to perform any of the specified dental services the Participant would rely on the performance bond to have those services performed by another..."

Plaintiff claims because the performance bond is written by a licensed and regulated insurer, that the "risk is assumed" by the dental group's performance bond carrier and not by PDS.

The benefit which PDS provides to the policy holder is the agreement that the performance bond will be provided. PDS binds itself by contract to the dentists to enable PDS to provide the necessary services to the policy holders. PDS then further binds the dentists by contract that the dentists provide a performance bond. The initial performance

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of the "best efforts" of PDS, then of the dentists, and finally of the performance bond, is all triggered by my toothache. The fact that PDS by contract provides that others shall furnish the benefit, does not relieve PDS of providing that which it agrees to do under the contract. The trial court found the contract between PDS and the dentist pool to be a third party beneficiary contract running in favor of the participants. These are the "benefits" that make the contract one of insurance under the statutory definition.

2. Cited cases are not analogous.

The lynch pin of Plaintiff's argument is the more than 40 year old Jordan v Group Health Association case, 107 F.2d 239 (1939) and its progeny. The Jordan case is clearly distinguishable on at least 5 critical points.

(a) Group Health Association was a "not for profit" corporation. Plaintiff obviously understands this critical difference because on page 10 of his brief, he tries unsuccessfully to shoe-horn the PDS fact situation into the Jordan fact situation by categorizing the relationship of the participants in PDS as follows:

> "...however, a more accurate description would be the joining together of a number of persons who will need dental care in order to obtain a discount price for such dental care."

Although the description is close to the fact situation in Jordan, it is not the fact situation of PDS. Jordan dealt with a non-profit consumer cooperative association

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incorporated as a non-profit corporation under Washington, D.C. law. Control of the association was in trustees who served without compensation. The very idea of the consumer cooperative was that the consumers - members of the association - band together for their mutual benefit in obtaining medical services at "wholesale prices." PDS makes no claims to being a not-for-profit corporation or association. It intends to market dental care based on need for a profit. The reasoning of the Jordan case is not applicable in a "for profit" situation because it changes the basic purpose of the association. In Jordan, at least a claim could be made that the dominant feature was a non-profit service contract. This is not true with PDS. The Fishback v Universal Service Agency case, 151 P.768 (Wash. 1915) cited by Plaintiff is also distinguishable on this ground. The distinction is discussed in cases following Jordan.

A plan similar to that proposed by PDS was held to be insurance in McCarty v King County Medical Service Corp., 175 P.2d 653 (Wash. 1946). In this case, the service corporation had contracts with certain physicians and hospitals, by which they agreed to treat all members of the corporation's plan. In holding the plan to be insurance, the court distinguished the plan from similar plans held not to be insurance in Jordan and an earlier Washington case, Fishback, which was relied on in Jordan. Jordan was characterized as a consumer cooperative, not for profit. The McCarty

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plan, on the other hand, was described as a "...private corporation, a distinct entity in the eyes of the law, dealing with employee beneficiaries on the one hand, and with physicians and hospitals on the other." 175 P.2d at 662. The court also pointed out that the service corporation had full authority to determine the eligibility of any employee applicant. In the Jordan plan, the service corporation was characterized as an agent for the physicians, but the court in McCarty declared the service corporation to have such control as to be the moving spirit in the business, and therefore declared the corporation to be the principal.

(b) Jordan Court "over-reached" to find socially desirable result. In analyzing the Jordan case, the eminent insurance authority, Professor Keeton, has commented:

> "Although the arrangement challenged in Jordan was well conceived to minimize or subordinate the elements of risk transference and distribution through the association, it is difficult to escape the conclusion that the decision was influenced by an appraisal of the arrangement as socially useful and as giving rise to less urgent need for public regulation than ordinary insurance arrangements." Insurance Law Basic Text, Keeton, Robert E. (West Pub. 1971 at 547).

In a note in the Harvard Law Review shortly after the Jordan decision was reached, the commentator concluded similarly to Professor Keeton:

> "In the absence of special legislation it would seem wiser to treat the plans as insurance, but of a type not intended to be required by the statutes." 52 Harv. L.R. 809,815.

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As stated in Keeton's Insurance Law Basic Text at 549, the trend today is toward just such special legislation.

(c) Special legislation has met Jordan's socially desirable result. Special regulatory statutes have been enacted for medical and health associations in most states, so as to prevent the courts from having to struggle with whether general insurance statutes are applicable to plans of this type. In Utah, our legislature has established two methods of allowing the results thought socially desirable in Jordan by declaring such a plan insurance but providing for a minimum of regulation. The Non-Profit Service Corporation Act, 31-41-1 et seq. UCA and Health Maintenance Organization Act, 31-42-1 et seq. UCA, specifically allow organizations similar to that proposed by Plaintiff to operate outside the scope of the general insurance laws but still under minimum needed regulation.

If the Plaintiff in this case wants to reincorporate as a non-profit corporation, as was the case in Jordan, and the other cases cited as being controlling by Plaintiff in its brief, it could be granted a Certificate of Authority by the Commissioner under Chapter 37 of the Insurance Code. Several similar dental plans are already operating in the State under the provisions of this Act. Both Blue Cross and Blue Shield operate under the provisions of this Act and it seems obvious that the legislature intended to meet

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the socially desirable goals that the Washington Court met in Jordan, supra, by providing a statutory method for doing so under much less stringent regulations.

(d) Different Statutory Definitions. The Washington D.C. statutory definition of insurance under which the Jordan and Fishback cases were decided, is more limited than the Utah definition of insurance. The Washington statute required "payment of indemnity" (Jordan, supra, page 244). The Utah definition as repeatedly pointed out provides only that a benefit be allowed. (31-1-7 UCA.) This broad difference is crucial.

(e) PDS has created more assumption of risk than Jordan. The trial court in its memorandum decision expresses this distinguishing feature between Jordan and PDS succinctly (R.251).

> "Courts will look to substance rather than form and an obvious examination of this transaction shows that Plaintiff is spreading the risk upon determinable contingencies. Plaintiff cites Jordan v Group Health Association, 107 F.2d 239 (1939) and Fishback v Universal Service Agency, 151 P.758 (Wash. 1915). These cases are distinguishable in that the plaintiff in this case not only says it will use its "best efforts" as set forth in those cases but goes one step further and requires the dentist to file a "performance bond" thus eliminating one element. In Jordan the court said "...insurance also, by the better view, involves distribution of the risk, but distribution without assumption hardly can be held to be insurance." (107 F.2d at 245, emphasis added). Although the plaintiff says it has not directly assumed the risk, it nevertheless has contracted to cover it by Exhibit B and the performance bond. Participants are third party beneficiaries of that contract.

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3. Case Law confirms Plan is Insurance.

In addition to the McCarty case discussed above, the Ohio court and the California court have considered similar plans and determined them to be insurance.

Cleveland Hospital Service Corporation v Ebright, 45 NE 2d 157 (Ohio) affd. 49 NE 929, held such a plan to be insurance because, among other things, although non-profit, they used actuarial data to compute their premium schedule, and therefore were actually insuring the risk rather than providing a service.

People v California Mutual Association, 441 P.2d 97 (Cal. 1068) held a similar plan to be insurance because indemnity was a substantial financial proportion of the business. PDS is basing its premium schedule on actuarial data, and, as has already been discussed, a substantial financial proportion of its business is indemnification of the participants.

B. THE PROPOSED PLAN FALLS UNDER THE HEALTH MAINTENANCE ORGANIZATION ACT.

PDS falls within the scope of the general type of plan intended to be governed by Utah's Health Maintenance Organization Act. All underlining in quoted material is mine.

Sections 31-42-3(4) and (5) state:

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"(4) "Health maintenance organization" means any person:

(a) Who furnishes, either directly or through arrangements with others, health care to an enrolled member in return for periodic payments; the amounts of said payments are agreed upon prior to the time during which the health care may be furnished; and

(b) Who is obligated to the member to arrange for or to directly provide available and accessible health care.

(5) "Health care" means any of the following or any combination thereof; Professional or personal services, facilities, equipment, devices, supplies, medicine, etc. intended for use in the diagnosis, treatment, mitigation or prevention of any human ailment or impairment."

This section declares precisely what PDS proposes to do - arrange for health care to enrolled members in return for periodic payments.

Section 31-42-4 states:

"No person may operate a health maintenance organization within the state of Utah without obtaining a certificate of authority from the Commissioner."

Section 31-42-6(2) sets forth the conditions that must be met in order to qualify for a certificate of authority and subsection (c) thereof states that:

"...the Commissioner must be satisfied that the health care plan constitutes an appropriate mechanism whereby the applicant would effectively provide or arrange for a provision of basic health care services on a prepaid basis, through insurance or otherwise..."

Section 31-42-3(6) defines basic health care as:

"...as a minimum, emergency care, inpatient hospital and physician care, outpatient medical services, and out-of-area coverage."

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PDS does not meet the requirement of providing basic health care.

Section 31-42-2 states as an introduction to the act:

"As a guide to the interpretation and application of this act, the public policy of this state is declared to be as follows: The legislature wishes to eliminate legal barriers to the establishment of health maintenance organizations which provide readily available, accessible and quality comprehensive health care to their members and to encourage their development as an alternative method of health care delivery. The state of Utah must have reasonable assurance that health maintenance organizations offering health plans within this state are financially and administratively sound and that such organizations are in fact able to deliver the benefits which they offer."

PDS is the type of plan intended to be governed by Utah's Health Maintenance Organization Act. However, PDS fails to qualify for a certificate of authority because it does not provide "comprehensive" health care or "basic health care" as defined by Sections 31-42-2 or 31-42-3(6) UCA.

C. INSURANCE COMMISSIONER'S EXPERTISE.

The weight of authority suggests that the reviewing court in deciding questions as to the proper interpretation and application of a statute, may properly attach weight, or great weight, to the decision of such question by an administrative agency having special competence to deal with the subject, in line with the general principle that courts will give great weight to the administrative construction of a statute (2 AmJur 2d 519), Administrative Law, §656). In this case, the Commissioner of Insurance

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initially heard the claim of Plaintiff and thereafter issued comprehensive Findings and an Order which demonstrate the expertise of the Insurance Commissioner in understanding the specific claim of Plaintiff as well as his ability to relate the results of a decision to the possible problems that may flow in its wake. The Commissioner made the following Findings and Order which we submit is an appropriate result for this Court to reach:

> "Findings:
> 1. The Petitioner proposes to contract with "employer groups" to arrange for certain specific services related to dental care to be provided to "participating employees" of employer groups for a set monthly fee per participating employee. Such an arrangement is traditionally thought of as a "direct service" contract financed on a "capitation basis." To arrange for the services to be performed, Petitioner will, in turn, contract with dentists who will receive a set monthly fee for their services. The plan proposed purportedly only obligates Petitioner to use its "best efforts" to arrange for dental services for the participants.
>
> 2. The monthly fee paid to the Petitioner by the employer groups provides for a series of services as needed by the employee members where there is no proportional, direct connection, as there would be if providers were put on a "fee for service basis," between the services and the monthly fee. Depending upon the patient's needs, more or less service may be provided for the same service fee. Under such an arrangement risk related to the cost of providing services is transferred by the terms of the employer contracts to petitioner and may be transferred, in part, by Petitioner to other dentists by provider contracts.
>
> 3. The proposed plan, therefore, includes all of the elements normally present in an insurance transaction viz: (a) an insurable interest, (b) a risk of loss, especially by persons bearing similar risks, (c) an assumption and dispersion of the risk by the Petitioner, (d) a mechanism to distribute and disburse the risk

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of loss, and (4) payment of a permium to the Petitioner for the transfer of the risk from the insured. The mechanism is identical to the risk assumption and dispersion mechanisms contemplated by Chapter 42 of Title 31, Utah Code Ann., as amended, which governs health maintenance organizations.

4. Petitioner argues that his obligation extends only to the use of best efforts by the Petitioner and is not sufficient assumption of risk by the Petitioner to be deemed to be subject to the Utah Insurance Code. This argument is rejected. Instead, the Commissioner finds that the legislature intended precisely that such a plan be deemed to be under the Utah Insurance Code to safeguard the public's interest by assuring that no misrepresentation, failure to perform or deliver, or other public injury occur, either under a traditional indemnity arrangement, or more particularly, under more complex and, therefore, more vulnerable direct health service arrangements. Moreover, if "best efforts" were a meaningless consideration in transferring risk the proposed plan could be a fraud.

5. The proposed plan of Petitioner is an insurance transaction within the definition set out in the Utah Insurance Code Section 31-1-7 and requires, therefore, either the authority of a health service corporation, a health maintenance organization, or a health insurer.

6. The plan as proposed by Petitioner furnishes "health care" to enrolled members within the definition provided in the Health Maintenance Organization Act, Section 31-42-3(5), Utah Code Ann. 1953 as amended.

7. The proposed operating plan falls within the definition of a "health maintenance organization" within the Utah Insurance Code, but does not propose to offer benefits sufficiently broad to meet the "basic health care services" required to qualify to receive a Certificate of Authority therefor.

Order:
1. The Plan proposed by Petitioner is governed by the Utah State Insurance Code and the mode of delivery and payment proposed is subject more particularly to a classification as a "Health Maintenance Organization" under the Utah Insurance Code.

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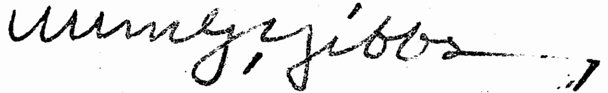
2. The Petitioner cannot operate as proposed without a Certificate of Authority from the Utah Insurance Department and Petitioner would have to expand the proposed services to be offered to meet the basic health services requirement to qualify for licensure as a health maintenance organization."

Dated this 27th day of March, 1980.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that I mailed two copies of the foregoing Reply Brief to Messrs. John Preston Creer and David F. Evans, attorneys for Plaintiff-Appellant at 1100 Beneficial Life Tower, 36 South State Street, Salt Lake City, Utah 84111 this 27th day of March, 1980.

Ruth J Martin

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