SUPREME COURT OF LOUISIANA

No. 98-C-3034

IN RE: THE MATTER OF LOUISIANA HEALTH SERVICE AND INDEMNITY COMPANY D/B/A BLUE CROSS BLUE SHIELD OF LOUISIANA

ON WRIT OF CERTIORARI TO THE COURT OF APPEAL, FIRST CIRCUIT, PARISH OF EAST BATON ROUGE

Calogero, C. J.[*]

The issue presented in this case is whether La. R.S. 22:215.12, which restricts a health insurer's ability to exclude coverage for losses incurred due to pre-existing condition limitations in health insurance policies, is applicable to individuals who enroll in group plans on or after January 1, 1993, when the group master policy was issued prior to January 1, 1993. La. R.S. 22:215.12, which was adopted in 1992, provides in pertinent part:

> Any hospital, health, or medical expense insurance policy, . . . health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan . . . ,which is . . . issued . . . in this state on or after January 1, 1993, shall not deny, exclude, or limit benefits for a covered individual for losses due to a pre-existing condition incurred more than twelve months following the effective date of the individual's coverage.

La. R.S. 22:215.12 (emphasis added).

For policies that fit within the parameters set-out above, the statute also prohibits the insurer from including a more restrictive definition for a pre-existing condition than the following:

> (1) A condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the twelve months immediately preceding the effective date of coverage.

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[*] Kimball, J., not on panel, recused. Rule IV, Part 2, § 3.

> (2) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage.[1]

Id.

La. R.S. 22:215.12 thus limits an insurer's ability to deny an insured coverage for losses incurred due to a pre-existing condition. The statute accomplishes this in two ways: (1) by defining a pre-existing condition as one "for which medical advice, diagnosis, care or treatment" was received or recommended, or for which an ordinary prudent person would have sought advice, diagnosis, or treatment during the twelve-month period immediately preceding his effective date of coverage, and (2) by limiting the time period during which an insurer can deny coverage for losses even for a condition properly characterized as pre-existing, to the twelve-month period immediately following the insured's effective date of coverage. As to both of these restrictions, the policy can contain provisions more favorable to the insured, but not more onerous.

After reviewing the record and the applicable law, we reverse the ruling of the court of appeal and find that La. R.S. 22:215.12 does apply to new enrollees under group health insurance policies issued prior to January 1, 1993, when the effective date of coverage, as evidenced by their individual certificates of insurance, is on or after January 1, 1993.

FACTS AND PROCEDURAL HISTORY

In the course of handling two consumer complaints involving persons insured by Blue Cross/Blue Shield of Louisiana ("Blue Cross"), the Louisiana Department of Insurance ("the Department") discovered that the pre-existing condition exclusion

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[1] Section 215.12 was repealed in 1997 when the Louisiana version of the federal "HIPPA" law was enacted. *See* Acts 1997, No. 1138, eff. July 14, 1997 enacting La. R.S. 22:250.1 through 22:250.16.

in Blue Cross's policies was at variance with La. R.S. 22:215.12.[2] A letter was sent to Blue Cross on February 17, 1995, directing Blue Cross to (1) correct the policy language, and (2) re-adjudicate any claims that may have been erroneously denied under the policy language that was at variance with La. R.S. 22:215.12. In response, Blue Cross asserted that section 215.12 was not applicable to group master policies that had been issued before January 1, 1993. Therefore, Blue Cross maintained that it would neither revise the certificates of insurance issued to individual enrollees enrolling in group health plans on or after January 1, 1993, nor re-assess any claims that had been denied because of the policies' pre-existing condition limitation not in conformance with La. R.S. 22:215.12.

Following further correspondence and meetings, Blue Cross agreed to amend all group policies issued prior to January 1, 1993 to conform to the requirements of section 215.12, but only as to losses incurred on and after March 9, 1995.[3] However, for certificates of insurance issued between January 1, 1993 and March 9, 1995, Blue Cross refused to apply section 215.12 and requested a hearing before the Commissioner of Insurance. Thus, the only time period at issue in this case is between January 1, 1993, and March 9, 1995.

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[2] Blue Cross's policies defined a "pre-existing condition" as one which manifests itself at any time prior to the effective date of the policy. Under La. R.S. 22:215.12, a condition must manifest itself within the twelve-month period immediately preceding the effective date of coverage in order for it to be classified as a pre-existing condition. *See* La. R.S. 22:215.12(1), (2).

[3] Although Blue Cross did finally agree to apply the Department's interpretation of La. R.S. 22:215.12 prospectively from March 9, 1995, this concession was in actuality no concession at all. Blue Cross acknowledged during oral argument that the statutory requirements of La. R.S. 22:215.12 would apply to all individuals covered under group master policies on the first renewal date of the policies after January 1, 1993. Counsel also noted that most group master policies issued by Blue Cross are issued for a one-year term. Thus, by March 9, 1995, most group master policies issued by Blue Cross prior to January 1, 1993, even those with a twenty-four month term, had been reissued, and thus necessarily had to comply with La. R.S. 22:215.12. Even if Blue Cross had not agreed in March 1995 to comply with the Department's interpretation of the statute, the significant periods at issue would have remained the one-year period following January 1, 1993 (for group master policies with one-year terms issued prior to January 1, 1993), and the two-year period following January 1, 1993 (for group master policies with two-year terms).

The parties submitted a joint stipulation of evidence and of facts and sought a declaratory ruling on "the applicability of La. R.S. 22:215.12 to new enrollees under a group policy whose effective date of coverage, pursuant to their certificate of coverage is subsequent to January 1, 1993."

A declaratory ruling was issued on October 6, 1995, by the Insurance Department's Administrative Law Judge ("the Law Judge"), acting on behalf of the Commissioner of Insurance. The Law Judge concluded that "La. R.S. 22:215.12 is applicable to new enrollees whose effective date of coverage is on or after January 1, 1993 even under group master policies issued and delivered before January 1, 1993." In reaching this conclusion, the Law Judge construed the term "policy" in section 22:215.12 to encompass the "certificate of insurance" issued to new enrollees under group master policies. The Law Judge also rejected Blue Cross's argument that the above conclusion would result in a violation of the Insurance Code's anti-discrimination provisions.[4]

On review in the Nineteenth Judicial District Court, the trial court found that regardless of "whether [it utilized] an appellate review or a de novo review, . . . the term policy, plan, or contract indicated in [the] statute includes the certificate of insurance," and therefore, upheld the Law Judge's determination.

The court of appeal reversed, and using a de novo standard of review, found that the term "policy" means the "group master policy" and not the "certificate of insurance" issued to the individual insured. *In re: The Matter of La. Health Serv.*

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[4] La. R.S. 22:652 provides:

> No insurer shall make or permit any unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance having substantially like insuring risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor, or in the benefits payable or in any other rights or privileges accruing thereunder. This provision shall not prohibit fair discrimination by a life insurer as between individuals having unequal life expectancies.

Indem. Co. d/b/a Blue Cross Blue Shield of La., 97-2176 (La. App. 1st Cir. 11/6/98), 723 So. 2d 997. The court of appeal expressly refused to apply the principle of statutory construction known as the "doctrine of contemporaneous construction" on the grounds that the agency's construction of the law had not been held for a sufficiently long period of time, and the statute was not ambiguous. *Id.*, p. 6, 723 So. 2d at 1000. We granted the Department's writ application to determine whether the court of appeal correctly interpreted La. R.S. 22:215.12 when it reversed the judgment of the district court and the ruling of the Law Judge. *In re: The Matter of La. Health Serv. & Indem. Co. d/b/a Blue Cross Blue Shield of La.*, 98-3034 (La. 2/5/99), -- So. 2d --.

DISCUSSION

The primary issue in this case is whether the term "policy" found in La. R.S. 22:215.12, which refers to "[a]ny hospital, health, or medical insurance policy . . . , which is delivered or issued for delivery in this state on or after January 1, 1993," includes the individual certificate of insurance issued to the employee under an employer's group policy. The statutory interpretation of this term is purely a matter of law.

The Law Judge found that the term "policy" encompassed the certificate of insurance. "Judicial review of an adjudication by an administrative governmental agency is a limited review which is governed generally by La. R.S. 49:964(G) of the Louisiana Administrative Procedure Act."[5] *Hay v. South Cent. Bell Tel. Co.*, 475

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[5] La. R.S. 49:964(G), as amended by Acts 1997, No. 128, provides in pertinent part:

> G. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:
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> (1) In violation of constitutional or statutory provisions;

So. 2d 1052, 1055 (La. 1985). We have held that this Court "retains its traditional primacy in interpreting constitutional or statutory provisions and in enforcing correct procedures." *Hay*, 475 So. 2d at 1055 (citing *Save Ourselves, Inc. v. Louisiana Envtl. Control Comm'n*, 452 So. 2d 1152 (La. 1984)). The parties in this case have stipulated to all of the applicable facts and thus our de novo review is directed to the Law Judge's legal finding.

A group insurance policy is a contract between an insurer and a central entity, *e.g.*, an employer, for the benefit of a group of people that has some relationship to the central entity, *e.g.*, the employees. *See* Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* § 7:1, at 7-5 (3d ed. 1998). By its nature, group insurance is a three-party relationship inserting the employer or some other central entity between the insurer and the insured. *Id.* at 7-7. Members of a group insurance plan are generally not supplied with a complete copy of the master policy either before or after enrollment, but are instead given a certificate of insurance that describes the master policy. *Id.* § 8:16, at 8-36. This relieves the employer of the obligation of providing the entire policy to each employee. *Leonard, Tutrix of Bland v. Continental Assurance. Co.*, 457 So. 2d 751, 754 (La. App. 1st Cir.), *writ denied*, 460 So. 2d 1047 (La. 1984). Nevertheless, the relationship between the insurer and the employee is contractual in nature. *See Couch*, § 8.18, at 8-41.

Some authorities consider the certificate of insurance part of the contract

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(2) In excess of the statutory authority of the agency;

(3) Made upon unlawful procedure;

(4) Affected by other error of law;

(5) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion; or

(6) Not supported and sustainable by a preponderance of evidence as determined by the reviewing court . . . .

formed between the insured employee and the insurer. *See, e.g., Couch* § 8.18, at 8-41. Thus, the group policy issued to the employer and the certificate issued to the employee, together, would constitute the contract of insurance between the parties. *See id.* Furthermore, many courts view the certificate as part of the contract. *See id.* at 8-40.

The general statute in Louisiana describing group health and accident insurance is La. R.S. 22:215. Section 22:215(A)(1) describes group health and accident insurance as "any policy of health and accident insurance covering more than one person" and provides that "[t]he policy shall be issued to an employer or association . . . who shall be deemed the policy holder, covering one or more employees of such employer . . . or . . . association . . . for the benefit of persons other than the employer, or the association." That section further provides that "[t]he insurer shall issue to the employer or association for delivery to each employee or member insured under such group policy, an individual certificate containing a statement as to the insurance protection to which he is entitled and to whom payable." La. R.S. 22:215(A)(1)(v). Thus, this statute delineates the differences between a group policy and an individual certificate issued thereunder and clarifies that the two have distinct meanings in our Insurance Code.

Nevertheless, when interpreting provisions of our Insurance Code, Louisiana courts have often construed the terms "policy" and "contract of insurance" to include the certificate of insurance issued to the individual under a group policy. *See Smith v. North Am. Co. for Life, Accident, & Health Ins.*, 306 So. 2d 751, 755 (La. 1975) (construing the term "policy" as used in La. R.S. 22:618(A) to include the individual's certificate of coverage issued under a group plan), *overruled in part by Borer's Estate v. Louisiana Health Serv. & Indem. Co.*, 398 So. 2d 1124 (La.

1981); *Pugh v. Prudential Ins. Co. of Am.*, 546 So. 2d 335, 337 (La. App. 3d Cir. 1989); *Casey v. Prudential Ins. Co. of Am.*, 360 So. 2d 1386, 1390 (La. App. 3d Cir.) (construing the term "insurance contract" as used in La. R.S. 22:269 to include the individual's certificate of insurance), *writ denied*, 363 So. 2d 536 (La. 1978); *Johnson v. Nationwide Life Ins. Co*, 388 So. 2d 464, 466 (La. App. 2d Cir. 1980); *Velez v. Sentry Ins. Co.*, 446 So. 2d 408, 410-11 (La. App. 4th Cir. 1984); *see also Shrader v. Life Gen. Sec. Ins. Co.*, 588 So. 2d 1309, 1313 (La. App. 2d Cir. 1991) (rejecting the insurer's assertion that La. R.S. 22:215.6 did not apply because that statute refers to a replacement "policy" and the insured actually received a certificate of insurance), *writ denied*, 592 So. 2d 1317 (La. 1992).

In *Smith*, we construed the term "policy" to include the individual certificate of insurance under a group health plan. We concluded that the lower courts erred in admitting the insured's application for insurance into evidence where the application was not attached to the certificate of insurance under La. R.S. 22:618(A).[6] We held that "[t]he certificate of insurance issued and delivered to Smith is the 'policy' as that word is used in the statute (La. R.S. 22:618 subd. A)" because to hold otherwise would have defeated the purpose of section 22:618(A). *Smith*, 306 So. 2d at 755.

Blue Cross argues that *Smith* and the other appellate cases cited above are not applicable to the instant case because the issues in those cases pertained to choice of law provisions and rules of evidence as opposed to coverage. Blue Cross argues that *Loubat v. Audubon Life Ins. Co.*, 177 So. 2d 281 (La. 1965), is the only

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[6] When *Smith* was decided, La. R.S. 22:618(A) provided in pertinent part:

> No application for the issuance of any insurance policy or contract shall be admissible in evidence in any action relative to such policy or contract, unless a correct copy of the application was attached to or otherwise made a part of the policy, or contract when issued and delivered.

controlling case on the issue before us because *Loubat* demonstrates that for purposes of determining an individual's coverage under a group health plan, the provisions in the policy govern, rather than those in the certificate of insurance. Thus, for purposes of determining coverage, the term "policy" does not include the individual's certificate of insurance issued under a group plan.

Blue Cross's reliance on *Loubat* is misplaced. The *Loubat* court stated that "the 'Statement of Insurance Protection' sent to [decedent] did not constitute a contract of insurance between him and the insurer, and that it in no manner modified any portion of the [group] master policy." *Loubat*, 177 So. 2d at 284. However, the *Loubat* court was simply stating the obvious based on the facts in that case. Decedent was not covered under the group plan, and thus had no contractual relationship whatsoever with the insurer. Therefore, when the insurer erroneously listed decedent on the Statement of Insurance Protection as the insured, the court simply refused to create an obligation, based on a scrivener's error, where none had been intended by the parties. Furthermore, the Statement of Insurance Protection at issue in *Loubat* was not a certificate of insurance. Rather, it was a courtesy document intended for information purposes only.

As to the applicability of *Smith* and the other appellate cases to the instant case, we are unpersuaded by Blue Cross's argument that they are inapplicable because they do not address coverage issues. Although the issue at the forefront of those cases might have been one of choice of law or evidence, the ultimate issue was always one of coverage. *See, e.g.*, *Pugh*, 546 So. 2d at 337; *Velez*, 446 So. 2d at 410-11. Furthermore, we do not cite those cases for the broad proposition that the terms "policy" or "other contract of insurance," when used in our Insurance Code, always include a certificate of insurance issued under a group policy. Rather,

Smith and the other cases demonstrate that, when interpreting statutes written to apply to both individual and group plans, terms such as "policy" and "contract of insurance," will sometimes be construed to include a certificate of insurance when to do otherwise would completely thwart the legislature's purpose in enacting the statute. *See Smith*, 306 So. 2d at 754-55.

We note, however, that legislative intent is not the appropriate starting point for statutory interpretation. *See Touchard v. Williams*, 617 So. 2d 885, 888 (La. 1993) (quoting *Zerinque v. State, Dep't of Pub. Safety*, 467 So. 2d 1358 (La. App. 5th Cir. 1985)). Rather the appropriate starting point is the language of the statute itself. *Id.* When a statute is clear and unambiguous and its application does not lead to absurd consequences, the statute is applied as written, and no further interpretation may be made in search of legislative intent. *See* La. Civ. Code art. 9. However, when the language of a statute is susceptible of different meanings, it must be interpreted as having the meaning that best conforms to the purpose of the law, and the meaning of ambiguous words must be sought by examining the context in which they occur and the text of the law as a whole. *See* La. Civ. Code arts. 10, 12. Where a statute is ambiguous or susceptible of two reasonable interpretations, statutory interpretation is necessary. *Touchard*, 617 So. 2d at 887. The construction to be given to legislative acts rests with the judicial branch of government. *Touchard*, 617 So. 2d at 885 (citing *State v. Sissons*, 292 So. 2d 523 (La. 1974); *Ethyl Corp. v. Collector of Revenue*, 351 So. 2d 1290 (La. App. 1st Cir. 1977)).

Blue Cross argues that La. R.S. 22:215.12 is not ambiguous because a simple reading of the statute demonstrates that it applies only to policies, plans, and contracts rather than to certificates of insurance. We disagree. We conclude that in

the context of group health insurance plans, La. R.S. 22:215.22 is ambiguous. The statute expressly states that group insurance plans are included in the provisions of the statute. *See* La. R.S. 22:215.12 (stating that the statute applies to "any other insurance contract of this type, including a group insurance plan"). However, the statute does not state whether it is the group master policy issued to the employer or the certificate of insurance issued to the individual insured, when issued on or after January 1, 1993, that triggers the mandates of La. R.S. 22:215.12. The statute refers only to the "insurance policy" and "other insurance contract[s] of this type." Nowhere in the text of the statute does one find legislative clarification that "insurance policy" refers only to the "group master policy" held by the employer, as opposed to the certificate of insurance issued to the individual insured. Moreover, the statute's reference to "other insurance contracts of this type" is ambiguous in the context of group health plans. The ambiguity present is further compounded in that the legislature must have known that various Louisiana courts, including this Court, have at times considered a certificate of insurance to be "the policy" in a group health plan. *See, e.g., Smith,* 306 So. 2d at 755. Thus, it is not clear at all that the legislature intended to exclude from La. R.S. 22:215.12 those individuals who, on or after January 1, 1993, enroll in a group plan whose master policy was issued before January 1, 1993. Accordingly, having concluded that this statute is ambiguous as applied to group health plans, an examination of the legislative intent behind La. R.S. 22:215.12 is appropriate.

La. R.S. 22:215.12 limits an insurer's ability to deny coverage to an insured because of a pre-existing condition limitation in the policy. Specifically, the statute prohibits the insurer from denying coverage for losses resulting from a pre-existing condition when those losses are incurred more than twelve months after the effective

date of the individual's coverage. The statute also defines a "pre-existing condition" and then prevents the insurer from using a stricter definition in its policy. Thus, La. R.S. 22:215.12 benefits the insured by limiting those conditions that the insurer can classify as "pre-existing" and then, assuming a condition is properly classified as "pre-existing," by limiting the time period that the insurer can deny coverage to the twelve-month period immediately following the individual's effective date of coverage. Surely, the purpose of this statute is to protect the insured and to fill-in gaps in insurance coverage that previously existed because of broad exclusions for pre-existing conditions. Thus, the benefits conferred by this statute are significant.

Given that the legislature's intent was to minimize the gaps in coverage that were created by broad pre-existing limitations, we conclude that the term "policy" or "other contract of insurance" includes the certificate of insurance issued to the individual when used in the context of a group health plan. Thus, the provisions of La. R.S. 22:215.12 apply to individual enrollees issued certificates of insurance on or after January 1, 1993, even when the group policy was issued before January 1, 1993. To hold otherwise would frustrate the legislature's clear intent in enacting the statute. Further, this would allow employers and insurers to circumvent the mandates of La. R.S. 22:215.12 as to newly-enrolled and certificated employees, as long as the pre-January 1, 1993 master policy was in effect. This certainly could not be what the legislature intended.

In support of this conclusion, we note that in La. R.S. 22:215.12, the legislature principally focused on the <u>individual</u> insured's coverage as opposed to the group's coverage under the master policy. The statute reads in pertinent part:

> Any . . . policy . . . or any other insurance contract of this type . . . delivered or issued . . . on or after January 1, 1993, shall not deny,

> exclude, or limit benefits for a covered individual for losses due to a preexisting condition incurred more than twelve months following the effective date of the individual's coverage.

La. R.S. 22:215.12 (emphasis added).

The statute's text demonstrates that the protections afforded by this statute were aimed at the individual insured regardless of whether that individual was covered by a group plan or an individual plan. Thus, in the context of a group plan, the individual that the statute aims to protect is the certificated enrollee who obtains coverage on or after January 1, 1993. The legislature surely intended that all insureds receiving individual coverage under a group insurance plan on or after January 1, 1993, be covered by the provisions of La. R.S. 22:215.12, notwithstanding that the group policy was issued before January 1, 1993. Because an individual's effective date of coverage in a group plan is commemorated by the issuance of a "certificate of insurance," that term must have been included in the terms "policy" or "other insurance contract of this type." To hold otherwise, would ignore the clear intent of the statute.

Blue Cross argues that this result will force it to violate the anti-discrimination provisions of the Insurance Code because similarly situated individuals working for the same employer and insured under the same group policy will have two different levels of coverage.[7] An insured who obtains coverage on December 31, 1992, under a group master policy issued before January 1, 1993, would not be entitled to the provisions of La. R.S. 22:215.12 as would an insured under the same plan who enrolls on or after

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[7] La. R.S. 22:652 provides:

> No insurer shall make or permit any unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance having substantially like insuring risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor, or in the benefits payable or in any other rights or privileges accruing thereunder. This provision shall not prohibit fair discrimination by a life insurer as between individuals having unequal life expectancies.

January 1, 1993. Blue Cross argues that there is no evidence that the legislature intended to foster such disparate treatment among insureds under the same group master policy.

This argument is not persuasive given the overwhelming indication of the legislature's intent that this statute apply to new enrollees under group master plans when those enrollees obtain coverage on or after January 1, 1993. We also note that the Insurance Code's anti-discrimination statute, La. R.S. 22:652, has never been applied so as to strike coverage provisions that are mandated by statute. *See Jenkins v. CNA Ins. Co.*, 98-0022 (La. App. 1st Cir. 12/28/98), 726 So. 2d 71; *Clay v. Argonaut-Southwest Ins. Co.*, 435 So. 2d 525 (La. App. 5th Cir. 1983).

For the foregoing reasons, we believe that the most reasonable construction of the statute, in light of its legislative purpose and ambiguous wording, is that the terms "policy" or "any other insurance contract of this type" include certificates of insurance issued under group master policies. To hold otherwise defeats the intent of the legislature.

To reach this conclusion, there is no need to give any deference to the Law Judge's or the Department's interpretation of the statute. Therefore, we find it unnecessary to discuss the doctrine of contemporaneous construction.

CONCLUSION

For group health and accident insurance policies issued by Blue Cross prior to January 1, 1993, the provisions of La. R.S. 22:215.12 apply to new enrollees whose effective date of coverage, pursuant to their individual certificates of insurance, is on or after January 1, 1993.

DECREE

For the reasons stated above, the judgment of the court of appeal is reversed; the

judgment of the district court is reinstated.

REVERSED