Circuit Court for Montgomery County
Case No. 410852-V

UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 1228

September Term, 2016

TARA HUBER, *et al.*

v.

MONTGOMERY COUNTY

Meredith,
Berger,
Friedman,
JJ.

Opinion by Friedman, J.

Filed: January 26, 2018

The sole question in this case concerns the meaning of the phrase "cost of the premium" in a series of resolutions of the Montgomery County Council memorializing contractual agreements between Montgomery County and its employees. If "cost of the premium" means an actuarial estimate made *before* the policy year of what the claims are anticipated to cost, used as the basis to determine the price of an insurance policy, then the County has accounted for the money properly and it was correctly granted summary judgment. If, however, the phrase "cost of the premium" means an insured's total share of the actual claims paid *after* the policy year, then summary judgment was improper and the employees are owed a refund. Because "cost of the premium" is a clear and unambiguous term that denotes an actuarial estimate and price determined *before* the policy year, we affirm the circuit court's grant of summary judgment.

BACKGROUND

In Fiscal Years 2013 through 2015, Montgomery County offered its employees four types of health benefit plans: two HMOs and two self-insurance plans. Annually, the County Council adopted a resolution memorializing an agreement with the unions[1] representing county employees requiring the County to pay 80% of the "cost of premiums" for the HMO plans and 75% of the "cost of premiums" for the self-insurance plans. The employee contributions (20% and 25%, respectively, depending on the plan selected) were then withheld from the employees' paychecks.

[1] Although the agreement for the County to offer cost-sharing in health benefits plans was won by the union through collective bargaining, the County makes these insurance plans available to all employees, unionized or not.

As best as we can understand it, the County established a single fund, known as the Employee Health Benefits Self-Insurance Fund, into which it appropriated roughly $200 Million annually. This amount included appropriations to pay for employee dental, vision, and life insurance, as well as the health insurance plans at issue. Although the record is silent as to this point, we understand that withholdings for employee contributions to their health insurance were also added into this Fund, although it is unclear whether that amount was included in the annual appropriation. It was from this Fund that the County paid premiums to the HMOs and claims made against the self-insurance plans. It appears that in each year the Fund ran a surplus of approximately $70 Million. And, critically for our purposes, the Fund annually reverted roughly $10 Million to the County's General Fund, which we are told (but cannot independently verify), represents a portion of the year-end surplus of the Health Benefits Fund.[2]

Huber and several of her fellow employees, on behalf of a proposed class of all county employees, filed suit in the Circuit Court for Montgomery County, arguing that the transfers to the General Fund constituted a breach of contract by decreasing the effective percentage of the "cost of the premiums" paid by the County. After minimal discovery, the parties filed cross-motions for summary judgment. The circuit court granted the County's motion and denied Huber's. This timely appeal followed.

[2] Although we do not reach it, we observe that this is a big problem for Huber's case. Had the employees succeeded in demonstrating an entitlement to the excess transferred funds, they would have been unable, on this record, to prove their damages with anything approaching the necessary specificity. *See Dynacorp Ltd. v. Aramtel Ltd.*, 208 Md. App. 403, 494 (2012) (holding that damages in a breach of contract case must be proved with specificity).

ANALYSIS

At bottom, this is a breach of contract lawsuit.[3] We apply an objective theory of contracts and ask what the parties reasonably intended by the words of their contract. *Myers v. Kayhoe*, 391 Md. 188, 198 (2006). That the contract here takes the form of a resolution of the County Council does not change this mode of analysis—we still look to see what the parties reasonably intended by the words of the contract. *See, e.g.*, *City of Frederick v. Brosius Homes Corp.*, 247 Md. 88, 92 (1967) (construing an agreement that incorporated a city resolution as a contract and applying standard principles of contractual construction). Thus, as we would in any breach of contract suit, we review, without deference, the trial court's interpretation of the meaning of the contract. *Myers*, 391 Md. at 198. Moreover, we review the circuit court's grant of summary judgment without any deference as well. *Windesheim v. Larocca*, 443 Md. 312, 326 (2015).

[3] Huber frames her claim as seeking compensation for the diminution of benefits to public employees in violation of the rules laid out in *City of Frederick v. Quinn*, 35 Md. App. 626 (1977) (holding that municipal employees' benefits were quasi-contractual in nature, not gratuities, and setting strict rules on their diminution). That analysis, however, presupposes a diminution in benefits; that is, a breach of the quasi-contractual promise. As we discuss above, we find there was none here. There is a second problem with Huber's *City of Frederick* theory. The transfers of money from the Health Benefit Fund to the General Fund were annual, which we think puts the employees on notice of the County's interpretation of its obligations after the first year (and thus precludes recovery, at least in subsequent years).

The County's alternative frame is equally unavailing. The County makes much of the fact that unions representing some county employees sought a similar benefit in the latest round of collective bargaining, but that they did not win this benefit. While perhaps interesting, both union and non-union employees used these health insurance plans. Moreover, we see no reason to punish the employees for trying to obtain peacefully through negotiation what they were also trying to obtain through litigation.

The word "premium" means the cost of insurance. For example, the New Oxford American Dictionary defines premium (among other definitions) as "an amount to be paid for an insurance policy." NEW OXFORD AMERICAN DICTIONARY (3d. ed. 2010). Webster's defines premium in the insurance context as "the amount paid or to be paid by the policyholder for coverage under the contract, usually in periodic installments." WEBSTER'S NEW UNIVERSAL UNABRIDGED DICTIONARY (2003). Merriam-Webster's Collegiate defines premium as "the consideration paid for a contract of insurance." MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY (11th ed. 2014). Black's Law Dictionary defines premium as "[t]he amount paid at designated intervals for insurance." BLACK'S LAW DICTIONARY (Deluxe 10th ed. 2014). Similarly, Maryland law defines "premium" as "consideration for insurance." Md. Code Insurance ("IN") §1-101(ff). "Insurance" in turn is defined as "a contract to indemnify or to pay or provide a specified or determinable amount or benefit on the occurrence of a determinable contingency." IN § 1-101(s). And in the realm of insurance law generally, "[a]n insurance premium is what the insured pays the insurer to assume the risk. The premium is the consideration the insured provides in return for the insurer's promise to indemnify the insured for a loss." Robert H. Jerry, III & Douglas R. Richmond, INSURANCE LAW 555 (5th ed. 2012). Each of these definitions treat "premium" as the amount paid for the purchase of insurance, *i.e.*, the right to have an insurer pay claims on behalf of the insured. Whatever differences exist among these definitions, none include the idea of a post-claim reconciliation.

These definitions explain the common meaning of the word "premium" but don't explain the phrase "*cost of the* premium." Given these definitions, the phrase sounds

redundant: the cost of the cost of insurance. "[A]n overly broad interpretation of [a] term render[ing] the … language … redundant" is discouraged because "if reasonably possible, effect must be given to each clause or phrase." *Bausch & Lomb Inc. v. Utica Mut. Ins. Co.*, 330 Md. 758, 782 (1993). We think, however, that this phrase is best understood by the fact that it is the County itself that it is paying the premium (at least to the HMOs), and the employees' share is calculated based on that *cost* to the county. Under that understanding, the employees' withholding is not the premium itself, but rather is calculated based on the premium, hence their share is calculated based on the "cost of the premium" to the County.

The premiums charged for the two HMO plans that the County offered its employees are regulated by the Maryland Insurance Administration ("MIA"). HMO annual rates, that is, the premiums that the HMOs charge members, must be submitted to and approved by the Commissioner of the MIA. Md. Code Health-General ("HG") §§ 19-705(a)(2); 19-713. An HMO "may not charge a premium to a[n] … individual covered under a health benefit plan before the applicable premium rate is filed with and approved by the Commissioner." IN § 11-603(a) (2017). HMOs are required to have their plans annually approved by the Commissioner. COMAR 31.12.02.07. "The [submission] … shall be accompanied by the … rates charged for it, together with detailed supporting actuarial data." COMAR 31.12.02.08. HMOs may not charge or make changes to premiums that have not been approved by the MIA. COMAR 31.12.02.03; IN § 11-603(a)-(b).

Therefore, in the HMO plans, the HMOs use actuarial data to determine the price at which they will offer insurance plans. That price, along with the actuarial data, is submitted

to the MIA, which must approve the price. That approved price, the premium, is communicated to the County, which offers it to its employees at a discount, paying 80% of the costs of the premiums and passing 20% of the costs to the employees.[4]

The other two plans offered by Montgomery County were self-insurance plans, in which the County is, itself, the insurer:

> A self-insured group health plan (or a 'self-funded' plan as it is also called) is one in which the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for each out of pocket claim as they are incurred.

Self-Insured Group Health Plans, SELF-INSURANCE INSTITUTE OF AMERICA, https://perma.cc/68CG-LNHB. In this model, the risk pool formed by the group of some or all employees is directly insured by the employer. The employer thus assumes liability for the employees' health costs.

We conclude that the "cost of the premium" in these plans is simply the amount withheld from the paychecks of employees who participate. There is little information in the record about how Montgomery County determines the premiums for self-insurance. As a public employer, Montgomery County's self-insurance plans are exempted from the federal self-insurance regulatory scheme. 29 U.S.C. § 1003(b)(1) (2015). Municipal government self-insurance plans are subject to a variety of federal laws, such as the Patient Protection and Affordable Care Act (the ACA or Obamacare), the Health Insurance

[4] Huber argues, however, that the County charged its employees amounts different than those rates that were pre-approved by the MIA. There is no support in the record for this assertion. In the absence of any such support, Huber's bare assertion does not create the genuine dispute of material fact necessary to defeat summary judgment.

Portability and Accountability Act (HIPAA), and the Public Health Service Act, which regulate, among other things, the benefits, administration, and disclosures of self-insurance plans. *See* 42 U.S.C. § 300gg *et seq.* There is no federal regulation, however, of the premiums charged under these plans. *See* Self-Funded, Non-Federal Governmental Plans, CENTERS FOR MEDICARE AND MEDICAID SERVICES, https://perma.cc/ARN5-XRRJ. Moreover, we can find no state-level regulation of these types of self-insurance plans. The uncontradicted evidence of the County's annual financial statement, however, is that "charges to participants are based on actuarial estimates." That is, as we were told at oral argument, Montgomery County hires an actuary to compute the premiums it charges. Thus, in the self-insurance plans, the County, in consultation with actuaries, determines a price at which it will offer insurance. There is also, we assume, a significant reserve built in in case of catastrophic loses. The County then reduces that price by 75% and offers the plans to its employees.

In all four plans an actuarial estimate is made before the policy year of what the anticipated costs will be. There is no end of the year reconciliation and no reimbursement for excess payment is made. The transfers made between the Health Benefits Fund and the General Fund at the end of the year cannot, then, be a diminution of promised benefits, because the benefit to employees is based on the cost of the premiums at the beginning of the plan year, not on the amount remaining in the Health Benefits Fund at the end of the year.

CONCLUSION

The circuit court properly interpreted the phrase "cost of the premium" to mean an actuarial estimate *before* claims are paid rather than a reconciliation *after* claims are paid. As a result, it properly granted summary judgment and we affirm.

JUDGMENT OF THE CIRCUIT COURT FOR MONTGOMERY COUNTY AFFIRMED. COSTS TO BE PAID BY APPPELLANTS.