UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 00124

September Term, 2015

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SETH B. MILLER

v.

MARYLAND HEALTH INSURANCE PLAN ET AL.

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Wright,
Graeff,
Raker, Irma S.
(Retired, Specially Assigned),

JJ.

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Opinion by Wright, J.

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Filed: July 21, 2016

This appeal arises from a dispute regarding a change in the definition of household income for eligibility purposes of a Maryland health plan. The Circuit Court for Montgomery County upheld a decision by the Associate Deputy Commissioner ("Commissioner") of the Maryland Insurance Administration ("MIA") in which the Commissioner affirmed a prior ruling of the MIA against the appellant, Seth Miller.

In 2013, Miller filed an administrative complaint with MIA against the Maryland Health Insurance Plan ("the Plan"),[1] appellee, after he was denied enrollment into the Plan's subsidized health plan because he failed to submit a completed household income form which was required for the Plan's determination of applicant eligibility.

MIA concluded that the Plan did not violate the insurance laws and that it lacked the authority to determine how the Plan chose to modify its definition of household income for eligibility purposes. On administrative appeal, the Commissioner granted summary judgment in favor of the Plan, citing a lack of authority to regulate how the Plan modified its definition of household income.

In 2015, Miller appealed to the circuit court, which affirmed the Commissioner's decision. Miller filed a timely appeal. For purposes of clarity, we shall rephrase the questions posed by Miller:[2]

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[1] The Maryland Health Insurance Plan was an independent State agency that administered a health care plan with the same name, referred to as MHIP, and a subsidized version of the same plan known as MHIP+.

[2] Miller presented the following questions:

> I. Does the commissioner have jurisdiction to regulate the method and procedures the board used to adopt the definition of household income and

I. Whether the Commissioner may regulate the Plan's Board's modification of the definition of household income used to determine MHIP+ eligibility.

II. Whether the Commissioner may award restitution for the Plan's Board's alleged modification error.

III. Whether collateral estoppel is applicable after the Plan told Miller that eligibility for the MHIP+ health plan was not based on household income.

For the reasons discussed below, we affirm the circuit court's decision.

## BACKGROUND

The Plan was an independent Maryland agency which provides health insurance to otherwise uninsurable Maryland residents.[3] The Plan administered the Maryland Health Insurance Plan ("MHIP") and its subsidized alternative, MHIP+. Miller is a Maryland resident who enrolled in and was receiving coverage under a health care plan offered by the Plan from 2011-2014. Section 14-502 of Md. Code (1995, 2011 Repl. Vol.),

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the method and procedures used to adopt criteria for proof of income used to determine eligibility for the MHIP+ subsidized health plan?

II. Does the commissioner have jurisdiction to award restitution because the board failed to proceed by regulation as required by law to adopt proof of income criteria for the MHIP+ subsidized plan?

III. Is the board estopped from raising the regulation stating the membership eligibility for the MHIP+ subsidized health plan is based on family income because MHIP's attorney told Appellant in an email in the record and record extract that there was no regulation basing eligibility for the MHIP+ subsidy on family income when there is in fact such a regulation?

[3] On May 10, 2016, Governor Hogan signed into law House Bill No. 489, 2016 Md. HB 489. This legislation terminated the MHIP program. MHIP was no longer necessary because individuals are now eligible for insurance under the Affordable Care Act. This recent legislation does not affect the holding reached by this Court.

Insurance Article ("Ins."), stated that the purpose of the Plan was "to decrease uncompensated care costs by providing access to affordable, comprehensive health benefits for medically uninsurable residents of the State [.]" Ins. § 14-502. MHIP+ was a subsidized version of the health care plan provided by the Plan and was used to reduce the additional health costs of those who qualified. Ins. §14-506(e) permitted the Plan to contract with third-parties to administer its unsubsidized plan and MHIP+. At the time of the purported coverage, CareFirst BlueCross BlueShield was under contract to administer the health plan. MHIP+ was terminated in May 2014 but was in use during the time Miller applied for coverage.

Ins. § 14-503 established that the health plans administered by the Plan would be overseen by a Board of Directors ("Board") that consisted of ten members. Ins. § 14-503(c). The Board was tasked with adopting the Plan's operation plans, which is the governing document that includes the "articles, bylaws, and operating rules and procedures." Ins. § 14-503(i). Any plan of operation, or subsequent amendments, must have been submitted to the Commissioner of the MIA for approval. Ins. § 14-503(i)(2). Although the Plan was an independent state agency, the MIA maintained authority over any changes to the standard benefits package of any health plan administered by the Plan.

The Board was also required to "adopt regulations necessary to operate and administer the Plan." Ins. § 14-503(k). These adopted regulations included: (i) residency requirements for the Plan's enrollees; (ii) the Plan's enrollment procedures; and (iii) any other Plan requirements as determined by the Board. *Id*. Ins. § 14-503(k) stated that these regulations do not have to be approved by the Commissioner.

Ins. § 14-505 mandated that the Board establish a standard benefit package. The standard benefit package was determined by the master plan document developed by the Board. Ins. § 14-505(b)(1). The master plan set forth all the terms and conditions of the standard benefit package. *Id*. One of the eligibility requirements for an individual to obtain coverage under the Plan was to live in a household with an annual income at or below 300% of the federal poverty guidelines. Ins. § 14-510. As stated in MHIP's recertification forms, for the 2012-2013 plan year, the household income definition adopted by the Board mirrored the U.S. Census Bureau's definition of household income. This definition of household income included:

> The sum of income received in a calendar year by all household members age fifteen (15) years and older, including household members not related to the householder.

The Plan's 2013/2014 Enrollment Guide, used by its prospective applicants and published by CareFirst BlueCross BlueShield, listed a revised definition for household income. For the 2013-2014 plan year, this altered definition of household income became more favorable to applicants. The Board determined that the Plan should consider only the income of other household members of an individual applicant, who are related by birth, marriage, or adoption, not the more all-encompassing, "including household members not related to the householder." This narrower definition stated:

> Household Income is the sum of income received in the calendar year by all household members who are fifteen (15) years of age and older. A household is defined as all people occupying a housing unit who are related to the householder by birth, marriage, or adoption.

Notably, under either definition, eligibility for MHIP+ required the submission of income records of any parent living with the applicant.

Miller lived with his parents for the health plan years at issue. Miller received coverage under MHIP+ for the 2011-2012 and 2012-2013 plan years even though Miller failed to return a completed form detailing his household income from all individuals living with him for the 2012-2013 year.

As the administrator of MHIP and MHIP+, CareFirst BlueCross BlueShield routinely mailed its members notices which required MHIP+ members to recertify his or her eligibility each year to remain eligible for the health plan. In May 2012, Miller went to the local CareFirst office and attempted to recertify for MHIP+ coverage for the 2013-2014 year. Miller stated that he lived at home with his parents, but failed to bring proof of his father's income and later stated that his father would not give him permission to use his tax returns for his MHIP+ application. CareFirst employees told Miller that his father's tax returns were necessary to determine MHIP+ eligibility. Miller was not enrolled in MHIP+ for 2013-2014 because he failed to provide his father's tax returns, and Miller elected to be enrolled in the unsubsidized MHIP plan instead. Although the definition for household income changed between the 2012-2013 and 2013-2014 plan years, Miller was required to provide his parents' tax returns under both definitions, as their income was to be included as applicable household income, and Miller continued to reside with his parents.

## STANDARD OF REVIEW

On appellate review of an administrative agency decision, "we take the same posture as the circuit court or the intermediate appellate court, and limit our review to the agency's decision." *Anderson v. Gen. Cas. Ins., Co.*, 402 Md. 236, 244 (2007) (citation omitted); s*ee Md. Ins., Comm'r v. Cent. Acceptance Corp.*, 424 Md. 1, 14 (2011). Generally, "review of administrative decisions is narrow." *Id*. (citation omitted). Such scope is "limited to determining if there is substantial evidence in the record as a whole to support the agency's findings and conclusions" and whether or not "the administrative decision is premised upon an erroneous conclusion of law." *United Parcel Serv., Inc. v. People's Counsel for Baltimore Cnty.*, 336 Md. 569, 577 (1994) (citations omitted). Moreover, "a final order by the Commissioner must be upheld on judicial review if it is legally correct and reasonably supported by the evidentiary record." *Ins., Comm'r for the State v. Engelman*, 345 Md. 402, 411 (1997) (citations omitted).

## DISCUSSION

### I. Commissioner's Ability to Regulate Plan Definition Modifications

On appeal, Miller argues that the Commissioner has jurisdiction and authority to regulate the Board's procedural mechanisms to change its eligibility criteria for MHIP+, and failed to do so. He further contends that a change in the definition of household income constituted a change to the standard benefits package offered by MHIP+ and must be made pursuant to the steps as outlined in Ins. § 14-505(d).

Miller's argument has no merit. The Commissioner lacks the authority to regulate the Plan's internal regulations related to eligibility requirements because it is not a

change to the standard benefits package. Therefore, no statutory restrictions or mandates exist describing how the Plan's Board should determine its eligibility requirements for its health plans, including MHIP+. Ins. § 14-501 - 14-509. The Plan's Board was required to create its own bylaws and procedures for operating the Plan and its health plans, which included the ability to adopt any regulations necessary to operate and administer MHIP. Ins. §§ 14-501, 14-503(i)(1). The Plan's Board has extensive internal authority to adopt any requirements for MHIP and MHIP+ that are deemed necessary by the Board to fulfill its master plan. Ins. § 14-503(k)(1).

The regulations utilized by the Board to administer its health plans are codified within the Code of Maryland Regulations. *See* COMAR 31.17.03.01 - 31.17.03.19. The Board retained the right to determine eligibility requirements for its subsidy. COMAR 31.17.03.10-1(D). The Board has the power to determine income eligibility requirements by altering the total percentage requirement of the federal poverty level that an applicant's annual *household* income must meet or fall below. COMAR 31.17.03.10-1(A)(2) (emphasis added). The regulation states that the Board utilizes household, not individual income, when determining an applicant's eligibility for MHIP+. *Id.*

Alternatively, Miller contends such a definition change is a change to the standard benefits package and triggers required statutory procedures that permit the Commissioner limited jurisdiction and authority over MHIP. This argument is also misplaced. A change in the definition of income for an eligibility requirement is not the same as a substantive change to the standard benefits package. The "standard benefits package" is defined by statute to include: the benefits included in the plan, any exclusions from

coverage, conditions requiring pre-authorizations, or utilization review, limits or conditions in selecting primary and specialty care provider, and cost-sharing requirements, such as premiums, deductibles or copayments that members of the MHIP plan have to pay. Ins. § 14-505(b)(1).

MHIP+ is not part of the standard benefits package, as it is a subsidized version of MHIP. MHIP+ is not mentioned within the Insurance Article that contains steps to implement the master plan, including the standard benefits package; at most it states that the Board *may* subsidize a member's health plan. Ins. § 14-505(i)(4) ("The Board may subsidize premiums, deductibles, and other policy expenses, based on a member's income."). The MHIP Board has discretion as to when and how it implements MHIP+, which excludes MHIP+ from the standard benefits package. Because of this exclusion, the procedural requirements to institute any change to the standard benefits package and Miller's corresponding issues raised under Ins. § 14-505(d) are not one and the same.

The Commissioner's applicable authority exists in the initial approval of the Plan's plan of operation, not the authority to regulate the way the Plan modifies its definition of household income. The Plan was given a statutory mandate to promulgate regulations necessary to enact its health plans while allowing for discretion as to specific internal procedures required to implement its subsidized or unsubsidized health plans. The Court of Appeals has stated that when an administrative agency is given "broad power . . . to adopt legislative rules or regulations in a particular area," the agency's regulations will be upheld so long as they do not "contradict the language or purpose of the statute." *Christ v. Md. Dep't of Natural Res.*, 335 Md. 427, 437-38 (1994).

Here, the Plan was given broad powers to adopt "regulations necessary to operate and administer the Plan . . . and any other Plan requirements as determined by the Board." Ins. §§ 14-503(k)(1), 14-503(k)(2)(iii). The decision to modify the definition of household income used for an applicant's MHIP+ eligibility does not contradict the purpose of the legislature's insurance statute. The modification makes it easier for health plan applicants to fall below the household income level bar compared to MHIP's prior definition. When the definition of household income is limited to only relatives living in an applicant's household, it does nothing but help widen the scope of uninsured Marylanders eligible for MHIP+.

The Commissioner does not have the authority to regulate or force a change in eligibility requirements for MHIP+, as they do not result in a "coverage decision" under the Insurance Article, contrary to Miller's contention. Ins. § 15-10d-01. Here, after Miller was denied enrollment in MHIP+, he was enrolled in the unsubsidized MHIP. His health plan coverage remained the same under both MHIP and MHIP+. His inability to qualify for MHIP+ was as a result of his failure to supply his father's tax returns used to assess applicant eligibility. This was a decision regarding eligibility, not of coverage.

Miller contends that the phrase "a determination by a carrier that an individual is not eligible for coverage under the carrier's health benefit plan" under Ins. § 15-10d-01 qualifies the Plan's actions as a coverage decision. On the contrary, the Plan's decision to reject Miller's enrollment into MHIP+ was because of his failure to submit a completed application containing a necessary element to assess his income--his father's

tax returns. Miller was always eligible for health plan coverage, as evidenced by his ability to maintain coverage throughout the plan years in question. The Plan's change in the definition of household income it used was not a decision altering its member's coverage but one altering eligibility requirements for its health plans. The change in the Board's definition of household income (and the Board's definition prior to the change) barred Miller's eligibility for MHIP+ but not to MHIP, thereby maintaining an umbrella of coverage for Miller under the Plan's overall health plan.

## II. Commissioner's Authority to Award Restitution

Miller is not entitled to restitution in this case. The Commissioner may only require MHIP to pay restitution to a health plan member if the member in question suffered "actual economic damages" as a result of MHIP violating Ins. § 14-509. Ins. §14-509(e)(2).[4]

Here, Miller did not suffer actual economic damages as a result of MHIP altering its definition of household income which resulted in the denial of Miller's application for MHIP+ for the years 2013-2014. Miller never properly qualified for recertification of MHIP+, which he argues is the basis for his request. For the 2012-2013 health plan year, Miller received MHIP+ coverage even though he failed to return a completed form detailing his household income from all individuals living with him for that plan year.

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[4] Ins. § 14-509(e)(2) states:

> If the Commissioner finds that the Plan has violated a provision of this subtitle, the Commissioner may require the Plan to make restitution to each claimant who has suffered actual economic damages because of the violation.

Pursuant to the applicable regulation, Miller should have been denied MHIP+ coverage for that year because he failed to submit his father's tax returns. He was not given that dispensation for the years 2013-2014, but that is no reason for a restitution.

## III. Application of Collateral Estoppel

Finally, Miller asserts that during the administrative appeals process, former counsel for the Plan failed to properly inform him of a pertinent regulation, specifically COMAR 31.17.03.10-1 (A)(2), which states: "The Board may subsidize the premiums . . . of an individual based on the individual's income if the individual [h]as an annual household income that is at or below a percentage of the federal poverty level established by the Board." Miller asserts that he would not have pursued an appeal before the Commissioner if he had known of the regulation. Miller contends that if the Commissioner had been estopped from using the household income regulation in her ruling, the result would have been different.

The doctrine of collateral estoppel is not applicable to this case. "Collateral estoppel means that 'when an issue of ultimate fact has been determined by a valid and final judgment, the issue cannot be litigated between the same parties in any future lawsuit." *State v. Long*, 405 Md. 527, 539 (2008) (quoting *Ashe v. Swenson*, 397 U.S. 436, 443 (1970)). The communication between Miller and the Plan's former counsel were not relied upon by the Commissioner in her conclusion, nor did the communication have any effect on the issues we have addressed above.

Thus, for all of the foregoing reasons, we affirm the circuit court's judgment.

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