IN THE SUPREME COURT OF THE STATE OF HAWAIʻI

---OOO---

STATE OF HAWAIʻI, ex rel. DAVID LOUIE, Attorney General, and DEAN H. SEKI, Comptroller of the State of Hawaiʻi, Petitioners/Plaintiffs-Appellants, Cross-Appellees,

vs.

HAWAII GOVERNMENT EMPLOYEES ASSOCIATION, AFSCME LOCAL NO. 152, AFL-CIO; UNITED PUBLIC WORKERS, AFSCME LOCAL NO. 646, AFL-CIO; ROYAL STATE CORPORATION; ROYAL STATE NATIONAL INSURANCE COMPANY, LIMITED; THE ROYAL INSURANCE AGENCY, INC.; VOLUNTARY EMPLOYEES' BENEFIT ASSOCIATION OF HAWAII; MANAGEMENT APPLIED PROGRAMMING, INC., Respondents/Defendants-Appellees, Cross-Appellants.

SCWC-29352

CERTIORARI TO THE INTERMEDIATE COURT OF APPEALS
(ICA NO. 29352; CIV. NO. 02-1-0685)

FEBRUARY 14, 2014

DISSENTING OPINION BY NAKAYAMA, J.,
IN WHICH POLLACK, J., JOINS

The majority interprets the phrase "the actual monthly cost of the coverage" in a way that sanctions illegally inflated

insurance premiums. Because I believe this interpretation is contrary to fundamental principles of statutory construction, legislative intent, administrative rules that were adopted pursuant to the statute, and the Hawaiʻi Constitution, I dissent.

Although I agree that "the actual monthly cost of the coverage" means the premium charged by and paid to the insurer, I would hold that to the extent those premiums were inflated by fraud, collusion, embezzlement, and other forms of illegality, the premiums paid exceeded the actual cost of the coverage. Here, the State has alleged that illegal transactions constitute a portion of the premiums charged by and paid to the insurer. In my view, these allegations form the basis of an actionable violation of HRS §§ 87-22.3, 87-22.5, and 87-23, and the State should have been granted leave to amend its complaint on that theory.

I. Statutory Interpretation

Our foremost obligation in construing a statute is "to ascertain and give effect to the intention of the legislature, which is to be obtained primarily from the language contained in the statute itself." Hanabusa v. Lingle, 119 Hawaiʻi 341, 349, 198 P.3d 604, 612 (2008) (internal quotations and citations omitted). "[W]here the terms of a statute are plain, unambiguous and explicit, we are not at liberty to look beyond that language

for a different meaning. Instead, our sole duty is to give effect to the statute's plain and obvious meaning." T-Mobile USA, Inc. v. Cnty. of Haw. Planning Comm'n (T-Mobile), 106 Hawaiʻi 343, 352-53, 104 P.3d 930, 939-40 (2005) (internal quotations and citations omitted). "The words of a law are generally to be understood in their most known and usual signification, without attending so much to the literal and strictly grammatical construction of the words as to their general or popular use or meaning." HRS § 1-14 (2009). "[C]ourts are bound to give effect to all parts of a statute, and . . . no clause, sentence, or word shall be construed as superfluous, void, or insignificant[.]" Beneficial Haw., Inc. v. Kida (Beneficial Hawaii), 96 Hawaiʻi 289, 309, 30 P.3d 895, 915 (2001). And, of course, "[e]very construction which leads to an absurdity shall be rejected." HRS § 1-15(3) (2009).

II. The Actual Monthly Cost of the Coverage

What does "the actual monthly cost of the coverage" mean? The majority asserts that it means "the premium charged by and paid to the [insurance] carrier." Majority at 5. But does it mean "the premium charged by and paid to the [insurance] carrier," even if a significant portion of the premium was embezzled through sham transactions that were disguised as administrative expenses? Does it mean "the premium charged by

and paid to the [insurance] carrier," even if a significant portion of the premium was artificially inflated by collusion between interested directors? In short, did the legislature agree to pay "the premium charged by and paid to the [insurance] carrier," no matter what manner or magnitude of corruption permeated that premium? I suggest not.

In my view, the legislature's use of the phrase "actual cost" provides a substantive limitation on the types of health care expenditures that the legislature intended to authorize. Although the phrase "actual cost" is not expressly defined in the statute, the legislature's silence can be construed in either of two ways:

> (1) actual monthly costs are paid regardless of whether the monthly cost was established in bad faith, collusively set, or the result of fraud;
>
> (2) actual monthly cost means the real cost of health insurance coverage, which does not include fraudulent amounts.

The majority opinion's silence on this issue effectively adopts the first interpretation and gives the word "actual" a meaning that would embrace fraudulent expenditures. That reading violates the plain language of the statute, renders the word "actual" superfluous, and tends toward an absurdity that finds no support in the legislative history.

A. The Plain Language of the Statute Controls

The plain language of a statute is the sine qua non of statutory interpretation. See T-Mobile, 106 Hawaiʻi at 352-53, 104 P.3d at 939-40. The plain meaning of "actual cost" is "[t]he actual price paid for goods by a party, in the case of a real bona fide purchase, which may not necessarily be the market value of the goods." Black's Law Dictionary 35 (6th ed. 1991). Bona fide, in turn, means "[m]ade in good faith; without fraud or deceit," and "genuine." Black's Law Dictionary 199 (9th ed. 2009). Based on the plain meaning of the phrase "actual cost," I conclude that the legislature intended to pay the premium charged by and paid to the insurer in the case of a bona fide transaction. But the legislature did not, and could not have, meant for "the actual cost of the monthly coverage" to authorize payments for fraud, embezzlement, collusion, or bad faith.

B. Courts Are Bound to Give Effect to All Parts of a Statute

The majority opinion's statutory interpretation fails because it violates the cardinal rule that "courts are bound to give effect to all parts of a statute." Beneficial Hawaii, 96 Hawaiʻi at 309, 30 P.3d at 915 (internal citations and quotations omitted). "[N]o clause, sentence, or word shall be construed as superfluous, void, or insignificant if a construction can be

legitimately found which will give force to and preserve all words of the statute." Id.

First, the majority opinion renders the word "actual" superfluous because the phrase "the monthly cost of the coverage," with or without the word "actual," still means "the premium charged by and paid to the [insurance] carrier." The majority suggests that the word "actual" is not superfluous because it "indicates that the ported amount constituted the cost that was, in fact, charged and paid for the insurance." Majority at 40 n.24. But the word "cost," as the majority has properly defined it, means "the amount or equivalent paid or charged for something[.]" See Majority at 40 (quoting Merriam-Webster's Collegiate Dictionary 282 (11th ed. 2009)). Thus, the phrase "the monthly cost of the coverage," without the presence of the word "actual," already means the cost in fact. The only non-superfluous reading of the word "actual" is that it substantively limits the health care expenditures authorized by HRS §§ 87-22.3, 87-22.5, and 87-23 to premiums that are bona fide, legitimate, genuine, and legal.

Second, the statutes state that the Health Fund shall pay "the actual monthly cost of the coverage . . . towards the purchase of benefits[.]" HRS § 87-23; see also HRS §§ 87-22.3 and 87-22.5. The majority opinion renders the statutory phrase

"towards the purchase of benefits" superfluous. Here, the legislature specifically chose language that required health care expenditures to go towards the purchase of health benefits. Payments that were illegally diverted through fraud, embezzlement, collusion, and/or bad faith would not have gone towards the purchase of benefits.

C. There Is a Dearth of Legislative History Suggesting That "Actual Cost" Embraces Fraud, Collusion, Embezzlement, or Bad Faith

As stated above, the legislature's silence on the meaning of the words "actual cost" can be construed in either of two ways:

> (1) actual monthly costs are paid regardless of whether the monthly cost was established in bad faith, collusively set, or the result of fraud;
>
> (2) actual monthly cost means the real cost of health insurance coverage, which does not include fraudulent amounts.

Because the first alternative is so startling, one would expect to find some legislative history in support of this interpretation. But there is nothing in the legislative history that indicates that "actual" would have a meaning beyond its plain meaning, or that the legislature intended that "actual" would embrace manifestly illegal charges. And since the second alternative is what could reasonably be expected, legislative

committee reports discussing this intention would not be expected.

Furthermore, the suggestion that the legislature would authorize payments for fraud, collusion, embezzlement, or bad faith tends toward absurdity. See HRS 1-15(3) (Supp. 2009) ("Every construction which leads to an absurdity shall be rejected."). The majority seems to require that the legislature expressly proscribe illegal payments in any statute that authorizes the expenditure of state funds; a fairly extreme proposition. See Majority at 40-43, 56-58. To interpret the statute in that manner would require all analogous statutes to include a provision that the state may not pay fraudulent amounts, which would appear to be self-evident. Cf. CARL Corp. v. State Dep't of Educ., 85 Hawaiʻi 431, 459-61, 946 P.2d 1, 29-31 (1997) (refusing to apply a hyper-literal construction of the procurement code where the legislature did not contemplate a purchasing agency's bad faith in applying the procurement code). The majority cites no other example where the legislature has authorized payment to a private entity that includes fraudulent costs. Moreover, the state has a fiduciary responsibility with respect to health funds. Therefore, it has no need to expressly

specify in the text of a statute that it is not authorizing payment for fraudulently inflated insurance premiums.[1]

In this case, the statutory text reveals a legislative intent to restrain legitimate costs. Specifically, the statutory scheme sets a ceiling on cost by requiring the Health Fund to port the lesser of the actual monthly cost of coverage or an amount determined by the applicable collective bargaining agreement. See HRS §§ 87-22.3, 87-22.5, 87-23. It is difficult to understand why the legislature would intend to pay for fraudulently inflated costs in light of statutory language that reveals its intention to constrain legitimate costs. Nevertheless, the majority construes this statutory ceiling as the only real cost limitation that the legislature intended. But the presence of a statutory ceiling does not compel the conclusion that any payments falling beneath that ceiling, including manifestly illegal payments, are permissible.

D. Administrative Rules Adopted Pursuant to the Statutory Scheme Suggest That "Actual Cost" Is Not Susceptible to a Reading That Would Authorize Illegal Payments

An agency's interpretation of a statute is entitled to deference. See Gillan v. Gov't Emps. Ins. Co., 119 Hawaiʻi 109, 114, 194 P.3d 1071, 1076 (2008). Here, the Department of Budget

[1] "It would be high comedy, were it not for the sometimes sad repercussions, that we solemnly attribute significance to the silence of legislators." Roger J. Traynor, No Magic Words Could Do It Justice, 49 Cal. L. Rev. 620 (1961).

and Finance adopted rules regarding auditing. Hawaiʻi Agency Regulations (HAR) § 6-34-9 (1985) provides:

> To participate in the health fund health benefits plan, each employee organization that has a health benefits plan shall apply for board approval by submitting to the board a copy of its charter and by-laws and a letter in which the employee organization:
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> . . . .
>
> (2) Certifies that its health benefits plan complies with all applicable State laws; and
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> (3) Agrees that its health benefits plan complies and will continue to comply with the following requirements:
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> (A) Maintain reasonable accounting and enrollment records and furnish such records and reports as may be requested by the board, its administrator, or the State comptroller;
>
> (B) Permit representatives of the board and State comptroller to audit and examine its records that pertain to its health benefits plan at reasonable times and places as may be designated by the board or the State comptroller; and
>
> (C) Accept adjustments for error or other reasons as may be required under chapter 87, Hawaii Revised Statutes, and chapters 30 through 36 of title 6, administrative rules.

This regulation imposes several requirements on employee organizations that participate in the state funded health benefits program. First, it requires that participating employee organizations certify that their health benefits plans comply with all applicable state laws. See HAR § 6-34-9(2). State law requires, among other things, that all parties involved in a state contract shall act in good faith. See HRS § 103D-101 (1993). An illegally inflated insurance contract would not

comply with this statute. Second, HAR § 6-34-9(3) mandates that health benefit plans be subject to audits and that the employee organizations "[a]ccept adjustments for error or other reasons as may be required under [HRS] chapter 87[.]" It is illogical to suggest that an auditor would have the power to correct accounting errors but would not have the power to adjust for manifestly illegal charges. Under my interpretation of HRS chapter 87, the auditor would have the authority to adjust insurance premiums that are permeated by illegality.

E. The Hawaiʻi Constitution Compels the Conclusion That "Actual Cost" Is Not Susceptible to a Reading That Would Authorize Illegal Payments

Article VII, section 4 of the Hawaiʻi Constitution provides two relevant limitations on the legislature's spending authority. First, it states: "No . . . appropriation of public money [shall be] made, nor shall the public credit be used . . . except for a public purpose." Second: "No grant of public money or property shall be made except pursuant to standards provided by law."

"Determining what constitutes a public purpose is generally a question for the legislature to decide." State ex rel. Amemiya v. Anderson, 56 Haw. 566, 574, 545 P.2d 1175, 1180-81 (1976) (citation omitted). However, when faced with a constitutional question, "it is the duty of the court to

ascertain and declare the intent of the framers of the Constitution and to reject any legislative act which is in conflict therewith. . . . The presumption, however, is in favor of constitutionality, and all doubts must be resolved in favor of the act." Id. at 574-75, 545 P.2d at 1181. For this reason, where there are two possible interpretations of a statute, one that is constitutional, and another that is unconstitutional, we must adopt the constitutional interpretation.[2]

The majority's interpretation of "actual cost" must be rejected because it is a patently unconstitutional reading of the statute. The majority's interpretation embraces the view that the legislature has authorized payment for fraud, collusion, embezzlement, and bad faith dealings. But any portion of an insurance premium that was embezzled via sham transactions or that was illegally inflated by fraud, collusion, or bad faith, would have unconstitutionally accrued to the sole benefit of private individuals. The fact that illegal sums may have been baked into the monthly cost of an insurance premium does not insulate them from the reach of the public purpose doctrine. See Cnty. of Haw. v. C&J Coupe Family Ltd. P'ship, 119 Hawaiʻi 352,

[2] The majority asserts that "there are no allegations in the instant case that the porting program did not serve a public purpose, or that the legislature's funding of that program did not comply with standards provided by law." Majority at 59. The presence of such allegations is irrelevant. The public purpose doctrine is implicated because it sheds reliable light on the meaning of "actual cost," and compels us to reject an unconstitutional interpretation of that phrase.

385, 198 P.3d 615, 648 (2008) (stating that courts must analyze whether an asserted public purpose merely operates as pretext for an unconstitutional private benefit). And of course, if the legislature had intended to authorize payments for fraud, collusion, embezzlement, or bad faith, that authorization would be unconstitutional because it would not have been made "pursuant to standards provided by law." Haw. Const. art. VII, § 3.

III. Leave to Amend

Dismissing this case at the pleading stage without giving the State leave to amend prevents meaningful judicial review of a matter that is of great public importance. In its proposed amended complaint, the State made several allegations that I think are actionable under HRS §§ 87-22.3, 87-22.5 and 87-23. These include:

> 33. Defendants HGEA, UPW, RSC, TRIA, and VEBAH used, or allowed the use of, ported funds to make payments to themselves or to related parties for Welfare Benefits Plans in amounts that exceeded the actual cost of coverage. . . .
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> 34. Defendants UPW, RSC, TRIA, and VEBAH used, or allowed the use of, ported funds to make improper payments to Gary W. Rodrigues ("Rodrigues"), who was the executive director of UPW, a director of RSC, and a trustee of VEBAH, to Rodrigues' daughter Robin Sabatini, and to corporations owned or controlled by them.
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> 35. Some of said payments were paid through MAP or VEBAH in order to disguise or misrepresent their true nature.
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> 36. Amounts paid as aforesaid between March 28, 1996 and December 19, 2000 totaled $446,278.60. Additional amounts were paid to Rodrigues, Sabatini, and/or corporations owned or controlled by them, at Rodrigues' direction, by insurers that underwrote UPW's medical and dental plans, including Pacific Group Medical Association

> ("PGMA") and Hawaiʻi Dental Service ("HDS"). Those included $146,361.32 paid by PGMA and $231.742.31 paid by HDS.
>
> 37. Amounts paid by or on behalf of UPW as aforesaid exceeded the actual cost of providing insurance coverage to the members of UPW[.] . . .

In addition, the State's expert's report found evidence of suspiciously high administrative expenses that constituted as much as 45% of the monthly premiums. This report also found evidence of suspiciously high profits that averaged as much as 58.7% of the premiums charged over a nine-year period.

In sum, given the seriousness of the State's allegations and the defendants' recalcitrance in submitting to the State's initial audit, dismissing the State's complaint will shield these alleged abuses under a shroud of darkness. In the words of former Justice Louis D. Brandeis: "Sunlight is said to be the best of disinfectants[.]" Louis D. Brandeis, Other People's Money and How Bankers Use It 92 (2d. ed. 1914).

/s/ Paula A. Nakayama

/s/ Richard W. Pollack