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BEFORE THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of

Business Health Trust,

Petitioner.

Docket No. 14-0246

COMMISSIONER'S REPLY IN
SUPPORT OF A DETERMINATION
OF NO THREATENED AGENCY
ACTION

I. REPLY

Statutes cannot be interpreted in a way that leads to absurd results. BHT's attempt to first delay the issuance of the Commissioner's decision concerning the Premera Blue Cross (Premera) large group health plan filings, then assert that delay as grounds for stripping the Commissioner of any authority to complete his review, is precisely the absurd result that RCW 48.04.010 cannot be meant to allow. Moreover, the misstatements of the facts involved in the Commissioner review of Premera's health plan filings, the evolving basis for the requested hearing, and amorphous claims of what the Commissioner will actually decide, all demonstrate precisely why the phrase "threatened act" must be interpreted more narrowly than Petitioner Business Health Trust (BHT) asserts.

Because the hearing statutes cannot reasonably be read to excuse or strip the Commissioner of his legislatively delegated responsibility, the Commissioner's confirmation that he will fulfill his statutory obligation to complete his review of a health plan filing is insufficient to be a "threatened act". This tribunal, as the Commissioner's delegate, cannot interpret these statutes in the manner asserted by BHT, an entity that wholly lacks standing to bring any claim against the Commissioner, where the result would be contrary to the Legislature's intent that the Commissioner have the authority to ensure the efficient and effective regulation of the insurance industry. Therefore, the Commissioner requests a determination that no "threatened act" has been asserted by BHT, and therefore no automatic

1 stay is in effect. Moreover, because the issue has been raised by BHT, the Commissioner
2 requests that this tribunal find that BHT lacks standing to challenge the Commissioner's
3 review of Premera's large group health plan filings.

4 **A. Factual Clarifications**

5 Although the Commissioner has not requested that this tribunal make any factual
6 determinations, there are several allegations in BHT's Opposition to Commissioner's Request
7 for a Determination of No Threatened Agency Action (Opposition) that the Commissioner
8 disputes. Primarily, the Commissioner disputes the history of the interactions between himself,
9 the Seattle Chamber of Commerce (Chamber) (the parent association of 13 of the associations
10 Premera has sold policies to), BHT (the third party administrator and broker created by the
11 Chamber to administer and market the Chamber's associations health plans), the 13
12 associations created by BHT and the Chamber, the nature of his statements outside of the
13 SERFF filing system, and BHT's description of his authority.

14 **1. Commissioner's Communications with the Seattle Chamber of Commerce**

15 First, the Commissioner disputes that he ever "approved" the approach the Chamber
16 took in allowing BHT to create the 13 associations and the 13 trusts that Premera's plans have
17 been sold to. Although the Declaration of Maud Daudon alleges that in March 2013, the
18 Commissioner indicated acceptance of the Chamber's approach to creating multiple
19 associations, in actuality, since July 31, 2012, the Commissioner has been informing the
20 Chamber that their approach was unlikely to satisfy the definition of employer for the 13
21 associations the Chamber created effective January 1, 2014. Declaration of Richard J.
22 Birmingham in Support of Aggrieved Party's Opposition To Commissioner's Request for A
23 Determination of No Threatened Agency Action (Birmingham Decl.), Exhibit F. Further,
24 when two of the 13 Chamber associations submitted their trust documents and industry codes
25 to the Commissioner's staff for review in 2013, the individuals submitting those records made
26 no indication that the associations were part of the Chamber, or BHT. See Exhibit E. It was

1 not until Premera filed its health plans in January of 2014, that the Commissioner understood
2 that those associations were part of the Chamber.

3 Moreover, the plain language of the letters issued by both Carol Sureau and Charles
4 Brown, indicates that review of both the employer status, and the plans themselves was not
5 concluded. Ms. Sureau's letter indicates two areas were addressed in her review: the trust
6 agreement demonstrated employer member control of the association, and the agreed upon
7 occupational categories constitute a single industry. Birmingham Decl., Exhibit D. Mr.
8 Brown's letter indicates that his review was similarly limited to the trust document and the
9 industry codes, and only notes that he is informing rates and forms staff that the association
10 "may" be an employer, for the purposes of the Commissioner's review of any health plan
11 filings. Birmingham Decl., Exhibit E. These are not broad statements that these associations
12 are in fact employers under WAC 284-170-958, or that the Commissioner approved of the
13 Chamber's structure.

14 Additionally, BHT's characterization of the Commissioner's October 28, 2014, letter as
15 a "threat" to disapprove the association status of the Chamber's 13 new associations,
16 independent of Premera's rate plan filing, is not supported by the contents of the letter. In that
17 letter, the Commissioner did indicate doubt about the associations' status as employers, due to
18 discussions with the United States Department of Labor specifically concerning multiple trust
19 arrangements like the one created by the Chamber. Birmingham Decl., Exhibit F. However,
20 the Commissioner made it clear that his staff was reviewing documentation, and would
21 communicate a decision about the health plan filings submitted by Premera in the coming
22 weeks. *Id.* There is no basis in the letter, or elsewhere, that the Commissioner has ever
23 indicated he will determine employer status, except as necessary in the context of a health plan
24 filing.

1 **2. The Health Plan Filing Review Process**

2 As part of the health plan filing review process, the Commissioner's staff engage in a
3 collaborative, self-contained, multi-disciplinary review of the rates, the insurance contracts,
4 and the proposed network. All health insurance carriers, or issuers, must submit all health
5 plans for review in System for Electronic Rate and Form Filing (SERFF). Birmingham Decl.,
6 Exhibit A (Nollette Decl. ¶9. Prior to disapproval, carriers receive objections detailing
7 shortcoming in the filing, and are given an opportunity to provide additional information and
8 correct deficiencies. All questions and concerns concerning the rate and form filing submitted
9 by an issuer are communicated to the issuers as "objections" in SERFF. Nollette Decl. ¶9. All
10 responses to those objections must be made through the SERFF System. Nollette Decl. ¶9.
11 The SERFF review process includes threshold questions, such as the appropriate market for the
12 health plan that has been submitted, a compliance review of the forms that have been filed, and
13 a technical actuarial review of the rating methodology submitted by the issuer. Nollette
14 Decl. ¶10.

15 The process concludes when the Commissioner issues either an approval, or a
16 disapproval of the health plan filing. If the Commissioner determines that a health plan filing
17 cannot be approved because it does not comply with the law, the Commissioner will
18 disapprove the plan, and provide the issuer with the basis for his decision. In addition, the
19 record of the Commissioner's review, his objections, carrier's responses, and supporting
20 documentation exchanged between the Commissioner and the carrier, are all contained in the
21 SERFF filing. While third parties may have an interest in discussing the filing as it is being
22 reviewed, the only discussions relevant to the filing are contained in SERFF, and only the
23 Commissioner and the carrier have access to that system. The basis for approval or
24 disapproval of the filing, are contained in SERFF. By having this robust and collaborative
25 process, carriers are able to fix errors, provide additional detail to support their filings, and
26 better understand the Commissioner's rationale for his decisions. For each of the 13 plans at
issue here, there are 150-200 pages of correspondence and discussion between the

1 Commissioner's staff and Premera. As a result of this robust review, carriers are generally
2 able to assert the filed rate doctrine in defense to certain types of claims. *See McCarthy Fin.,*
3 *Inc.*, 182 Wn. App. at 11.

4 **3. The Commissioner's Duty To Review Large Group Health Plan Filings**

5 Finally, it is plain that BHT does not fully comprehend the Commissioner's authority
6 concerning the review of health plans. Under State law, the Commissioner has the broad
7 authority and responsibility to review rate and form filings submitted by health plan issuers,
8 such as Premera. RCW 48.44.020; WAC 284-43-920; Informal Schmick Opinion at 2. All
9 issuers who wish to sell plans in Washington are required to submit those plans to the
10 Commissioner for review. WAC 284-43-920. For large group health plans, issuers can submit
11 plans to the Commissioner for review, up to 30 days after the plan has been sold. WAC 284-
12 43-920(2). However, the Commissioner retains the authority and obligation to review large
13 group health plan filings, and to disapprove them if they do not comply with the requirements
14 of the Insurance Code (RCW Title 48), or applicable federal laws, such as the Patient
15 Protection and Affordable Care Act (Affordable Care Act). RCW 48.44.020(2)-(3); WAC
16 284-43-125. Because the Commissioner's review of large group health plans always involves
17 plans that have and are already being sold on the market, approval or disapproval of the plan
18 always occurs after the plan has been sold to consumers. While the Commissioner may
19 institute enforcement action against a carrier from the first date the plan was sold, his approval
20 is not "retroactive" in the sense that consumers are stripped of their coverage back to the date
21 the plan was sold. Rather, when transition to a compliant plan is required, the carrier remains
22 fully liable for both the contract terms of the plan, and any state law requirements that should
23 have been included in the plan from the first date of sale. *See* RCW 48.18.510.

24 The Insurance Code does give the Commissioner discretion in reviewing large group
25 health plans. BHT mistakenly presumes that this means the Commissioner has no duty to
26 review large group health plans. But the Commissioner must conduct this review to maintain

1 the State's authority to review large group health plans under federal law. The Affordable
2 Care Act reserved to state insurance regulators their already existing authority to review
3 health plan rate and form filings. The Affordable Care Act also vested state insurance
4 regulators with the responsibility of ensuring that health plans satisfy the requirements of the
5 act. 42 U.S.C.A. § 300gg-22 ("each State may require that health insurance issuers that issue,
6 sell, renew, or offer health insurance coverage in the State in the individual or group market
7 meet the requirements of this part with respect to such issuers."); 45 C.F.R. § 150.201
8 ("Except as provided in subpart C of this part, each State enforces PHS Act requirements with
9 respect to health insurance issuers that issue, sell, renew, or offer health insurance coverage in
10 the State."). While this grant of authority is phrased as permissive, the Affordable Care Act
11 also provides that in the event a state regulator fails to effectively ensure compliance with the
12 requirements of the act, the federal government will take over review of plan filings, and can
13 subject issuers (such as Premera) to substantial fines of up to \$100 per day in the event the
14 plans they file are not compliant. 42 U.S.C.A. § 300gg-22(a)(2)-(b). Therefore the
15 Commissioner is obligated to exercise this discretion, in order to retain the State's authority to
16 review large group health plans.

17 In addition, one key component of the Commissioner's health plan filing review
18 authority that has already been clarified. The Attorney General's Office has already provided,
19 in an informal opinion, that the Commissioner in fact has the authority, as part of his health
20 plan filing review authority in RCW 48.44.020¹, to review the employer status of a large group
21 employer that will be sold a large group health plan. Letter from Deputy Solicitor General Jay
22 Geck, State of Washington, to Joe Schmick, State Representative, State of Washington
23

24
25 ¹ RCW 48.44.020 is specific to health care service contractors. Other sections of the Washington State
26 Insurance Code vest the Commissioner with the same authority to review health plans filings submitted by other
types of authorized health plan issuers. However, because Premera is registered as a health care service
contractor, this brief will primarily cite only to the provisions applicable to Premera.

1 (February 4, 2013) (Schmick Informal Opinion), at 1. The Attorney General's Office
2 determined that:

3 The Insurance Commissioner's responsibility to review health carrier rate and
4 form filings requires the Commissioner to evaluate whether a plan offered by a
5 health carrier uses a lawful rating method.

6 Schmick Informal Opinion at 1. Further, "The Commissioner has authority to
7 determine if an association falls within the definition of "employer"...because such
8 determinations are needed to implement state law." *Id.* at 4. No federal court or
9 federal agency has issued any conflicting guidance, or taken exception to the
10 Commissioner's evaluation of the employer status of associations in the context of a
11 health plan filing. *See* Appendix A.

12 **B. The Commissioner's Hearing Statutes Cannot Be Given An Absurd Interpretation
13 That Strips The Commissioner Of His Legislatively Delegated Authority**

14 The narrow issue presented by the Commissioner is whether confirmation that he will
15 fulfill his statutory duty to review large group health plan rates, and issue a decision based on
16 his review, can constitute a "threatened act," under RCW 48.04.010. Because the term
17 "threatened act" is not defined in statute, and is susceptible to more than one meaning, it is
18 necessary to interpret this statute. The Courts have found, that "to ensure proper construction,
19 we should consider and harmonize the statutory provisions in relation to each other. *King*
20 *County v. Cent. Puget Sound Growth Mgmt. Hearings Bd.*, 142 Wn.2d 543, 560, 14 P.3d 133
21 (2000). We will "avoid readings of statutes that result in unlikely, absurd, or strained
22 consequences." *Glaubach*, 149 Wash.2d at 833, 74 P.3d 115." *Blueshield v. State Office of*
23 *Ins. Com'r*, 131 Wn. App. 639, 648, 128 P.3d 640, 645 (2006). Therefore, when reviewing the
24 hearing and automatic stay provisions of chapter 48.04 RCW, the Commissioner must consider
25 the Insurance Code (Title 48 RCW), and his legislative mandate to carry out the duties he has
26 been delegated under the Insurance Code, as well.

 Unlike the Administrative Procedure Act (APA), RCW 48.04.010 provides some relief
not only for those who claim to have already been injured by an agency, but also for persons

1 who can demonstrate they are "aggrieved" by a "threatened act" of the Commissioner. The
2 Commissioner has interpreted this "threatened act" to require threatened enforcement action².
3 BHT has provided no precedent mandating a different result. Instead, BHT asks this tribunal
4 to inject into the Insurance Code a definition from the Washington State Administrative
5 Procedure Act (APA), RCW 34.05, that BHT has taken wholly out of context. To be useful,
6 the definition of "agency action" found in RCW 34.05.010(3) must be considered in the
7 context in which it is used in the APA. The APA uses the term "agency action" primarily in
8 the context of seeking judicial review of a completed or final agency decision, generally after a
9 hearing has already been held. *See* RCW 34.05.510, .530, .534, .546, .570.

10 Applying the same definition used for "actions" being appealed to Superior Court after
11 an evidentiary hearing and final adjudicative decision, to regulatory reviews that have not yet
12 even been completed, let alone adjudicated, is a questionable proposition. This is called
13 further into question by the history of these different statutes. [The APA provides significant
14 clarity for the types of procedures that agencies may use]. The language found in
15 RCW 48.04.010, was adopted in 1967, and predates the current APA. Even though
16 RCW 48.04.010 has been revised since the current APA was adopted in 1988, the definition of
17 who is entitled to a hearing before the Commissioner found in RCW 48.04.010, has not been
18 modified.

19 Moreover, imposing the APA definition of "agency action" on the term "threatened
20 act" would lead to the exact absurd results that are currently being advocated by BHT. Under
21 BHT's interpretation of the term "threatened act," every review, every decision, every
22 statement by the Commissioner can be interrupted at any time by virtually any third party
23 claiming disagreement³. Neither of the administrative decisions cited by BHT support this
24

25 ² Confusingly, BHT claims the Commissioner has not provided evidence of this statutory interpretation.
26 Opposition at 11. This is a question of law and statutory interpretation, therefore the "evidence" is the legal
argument presented.

³ RCW 48.04.010 does require that a person be "aggrieved," but in BHT's case, what they have alleged is
speculative financial harm. BHT's lack of standing is addressed below.

1 interpretation. In both the *Cabin* and the *Seattle Children's* matters, the Commissioner's
2 decision had been made and provided to the regulated entity.

3 Specific to the rates and forms review process, if BHT's interpretation is adopted, any
4 health carrier can sell any type of large group plan, even knowing it violates the law, and file it
5 with the Commissioner. Anyone with even an attenuated financial interest in marketing the
6 plan could demand a hearing, and assert an automatic stay of the Commissioner's review.
7 Even if the Commissioner found a plan to be blatantly illegal, he would be barred from issuing
8 any decision on that plan, and from taking any enforcement action concerning those violations
9 until a hearing is completed. As we are already seeing in this case, that hearing will likely be
10 based on the petitioner's shifting and expanding assumptions about what the Commissioner
11 will say, rather than the Commissioner's actual and final determination. *See* Opposition at 10,
12 14. In order to be able to defend against a specious hearing demand involving clearly improper
13 insurance products, the Commissioner may well be forced to give priority to the review of a
14 particular filing, to the detriment of other health plan filings that face tight time constraints,
15 such as individual and small group health plans that must be reviewed in time for the Health
16 Benefit Exchange to enter those plans into their system for the beginning of open enrollment.
17 The Commissioner will likely be unable to grant the generous extensions that were granted to
18 Premera in the review of its 2014 health plan filings, due to the need to provide accurate
19 information to the hearing tribunal, or to mitigate the risk of potential litigation posed by third
20 parties.

21 Further, by interpreting the automatic stay provisions to apply to the Commissioner's
22 regulatory functions, a third party could force a delay of the Commissioner's review, and then
23 claim the Commissioner no longer has authority to review a plan because the Commissioner
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1 “failed” to timely review the product⁴. This is precisely what BHT has done. Opposition at 8-
2 9.

3 Another absurd result from allowing third parties to interrupt, delay, and frustrate the
4 Commissioner’s health plan filing review duties will be to bar carriers from asserting the filed
5 rate doctrine with respect to their large group health insurance rates. *See McCarthy Fin., Inc.*
6 *v. Premera*, 182 Wn. App. 1 (2014) *review granted*, 337 P.3d 325 (Wash. 2014) (approving the
7 filed rate doctrine that advances policies of “(1) reinforcing the agency’s authority to determine
8 the reasonableness of rates, (2) deferring to the agency’s expertise in a particular industry, (3)
9 recognizing and preserving the legislature’s determinations as to the regulatory scheme by
10 allowing for enforcement by statutorily designated state officers, and (4) preventing lawsuits
11 from disrupting the statutory and regulatory scheme for uniformity of rates.”) *Premera* itself is
12 currently before the Washington State Supreme court urging the Court to affirm that the filed
13 rate doctrine can and does apply to all health plans, including large group health plans, because
14 of the Commissioner’s robust review of health plan filings. The Court of Appeals has
15 approved of the application of the filed rate doctrine for all types of health plans because,
16 “Health insurance is more comprehensively regulated than title insurance. Given the extensive
17 legislative and regulatory framework applicable to health insurance rates, the filed rate doctrine
18 applies to health insurance.” *McCarthy*, 182 Wn. App. at 13. If BHT and others are allowed
19 to interrupt the rate review process, and then prevent that process from ever being completed,
20 *Premera* itself may lose the ability to assert the filed rate doctrine for health plans filed with the
21 Commissioner.

22 These absurd results are inconsistent with the Legislature’s clear intent that all health
23 plans receive a complete review by the Commissioner. RCW 48.44.020. By simply limiting
24 threatened act to threatened enforcement actions, and protecting the Commissioner’s and
25

26 ⁴ BHT misunderstands the Commissioner’s authority concerning the review of health plan filings. At any
time, the Commissioner has authority to review a health plan filing, even if previously deemed approved. The
time limits in RCW 48.44.020 do not limit the Commissioner’s ability to review a health plan filing.

1 carrier's rights to a robust, collaborative, and complete filing review process, these absurd
2 results are eliminated, and aggrieved parties are still able to request a hearing, and a stay, under
3 RCW 48.04.010, and 48.04.020(2), after the Commissioner's review is complete, and before
4 any enforcement action is initiated.

5 **C. A Third Party Administrator Lacks Standing To Challenge Any Decision By The**
6 **Insurance Commissioner**

7 Although not originally raised by the Commissioner, the Commissioner disputes BHT's
8 claim that it has standing. See Opposition at 15. First, BHT is not alleging any harm of its
9 own. Instead, it is alleging harm to the 13 associations that were created by the Chamber.
10 BHT has filed this hearing demand, and alleges standing as a fiduciary of the 13 trusts created
11 by the Chamber's 13 associations. Other than the Employment Retirement Income Security
12 Act (ERISA), BHT has not pointed to any statute that gives BHT standing to bring claims on
13 behalf of third parties. However, ERISA only gives limited authority to fiduciaries to bring
14 claims in Federal Court⁵. 29 U.S.C. § 1132 (a)(1)(b)(3), and (e)(1). Therefore BHT as a
15 fiduciary cannot assert standing to bring a claim in an administrative action under ERISA.

16 Second, BHT's tangential financial interest in the Commissioner's decision concerning
17 the employer status of non-parties is not sufficient to create standing for BHT under *To-Ro*
18 *Trade Shows*. To establish standing to challenge a decision by an agency, petitioners must
19 generally establish that they are "aggrieved" by demonstrating three conditions:

- 20 (1) The agency action has prejudiced or is likely to prejudice that person;
21 (2) That person's asserted interests are among those that the agency was required to
22 consider when it engaged in the agency action challenged; and
23 (3) A judgment in favor of that person would substantially eliminate or redress the
24 prejudice to that person caused or likely to be caused by the agency action.

25 ⁵ The OIC disputes that the claims BHT, the Associations, and the Trusts allege in federal court are
26 properly brought under ERISA, and disputes that the question of employer status is a question properly brought
under 29 U.S.C. § 1132(a)(b)(3). However, BHT has cited no other basis for its claim that it is "aggrieved" by the
Commissioner's pending decision, except its status as an ERISA fiduciary.

1 RCW 34.05.530. The Washington State Supreme Court has explained that this requires
2 “injury-in-fact”. *Allan v. Univ. of Wash.*, 140 Wn.2d 323, 327, 997 P.2d 360 (2000). To
3 satisfy the prejudice requirement:

4 “a person must allege facts demonstrating that he or she is ‘specifically and
5 perceptibly harmed’ by the agency decision. *Trepanier v. City of Everett*, 64
6 Wash.App. 380, 382–83, 824 P.2d 524 (1992) (quoting *Save a Valuable Env’t v.*
7 *City of Bothell*, 89 Wash.2d 862, 866, 576 P.2d 401 (1978)). When a person
8 alleges a threatened injury, as opposed to an existing injury, the person must
9 demonstrate an “immediate, concrete, and specific injury to him or herself.”
10 *Trepanier*, 64 Wash.App. at 383, 824 P.2d 524 (citing *Roshan v. Smith*, 615
11 F.Supp. 901, 905 (D.D.C.1985)). “If the injury is merely conjectural or
12 hypothetical, there can be no standing.” *Trepanier*, 64 Wash.App. at 383, 824
13 P.2d 524 (citing *United States v. Students Challenging Regulatory Agency*
14 *Procedures*, 412 U.S. 669, 688–89, 93 S.Ct. 2405, 37 L.Ed.2d 254 (1973)).

15 *Patterson v. Segale*, 171 Wn. App. 251, 259, 289 P.3d 657, 660-61 (2012). The person
16 challenging an administrative decision bears the burden of establishing his or her standing to
17 contest the decision. *Id.*

18 Establishing standing for judicial review, is similar to those requirements for
19 establishing a justiciable controversy in the context of a request for a declaratory order⁶. In the
20 context of issuing declaratory judgments, the courts have:

21 steadfastly adhered to the virtually universal rule that, before the jurisdiction of
22 a court may be invoked under the act, there must be a justiciable controversy.”
23 We defined a justiciable controversy as “(1) ... an actual, present and existing
24 dispute, or the mature seeds of one, as distinguished from a possible, dormant,
25 hypothetical, speculative, or moot disagreement, (2) between parties having
26 genuine and opposing interests, (3) which involves interests that must be direct
and substantial, rather than potential, theoretical, abstract or academic, and (4) a
judicial determination of which will be final and conclusive.” *Diversified
Indus. Dev. Corp.*, 82 Wash.2d at 815, 514 P.2d 137; *see also Wash. Beauty
Coll., Inc. v. Huse*, 195 Wash. 160, 164-65, 80 P.2d 403 (1938). Inherent in
these four requirements are the traditional limiting doctrines of standing,
mootness, and ripeness, as well as the federal case-or-controversy requirement.

To-Ro Trade Shows v. Collins, 144 Wn.2d 403, 411, 27 P.3d 1149, 1153 (2001)

⁶ Assuming this matter were to go to hearing, that is essentially what BHT is asking for: a decision from this tribunal, prior to the Commissioner’s final determination, that the Chamber’s 13 associations are employers.

1 In *To-Ro*, To-Ro Trade Shows was the producer of a recreational vehicle (RV)
2 consumer trade show. In order to fill empty exhibitor space at a Spokane show, To-Ro invited
3 a dealer from Idaho to participate. To-Ro knew that the Idaho dealer was not licensed to
4 conduct business in Washington. *To-Ro* at 407. At the show, a Department of Licensing
5 (DOL) investigator cited the Idaho dealer and forbade the dealer from participating further in
6 the show. *Id* at 408. To-Ro later brought suit against the State, alleging that the failure of the
7 Idaho dealership to participate caused To-Ro significant financial losses. To-Ro sought a
8 declaratory judgment challenging the statute. *Id* at 407.

9 The Supreme Court affirmed that To-Ro had not met the third justiciability factor,
10 which is that there be sufficient factual injury, and the interests sought to be protected are
11 substantial, not theoretical. *Id* at 415. The Court held: "To-Ro is not a vehicle dealer...The
12 interest To-Ro is seeking to protect is its own theoretical interest in increasing the number of
13 exhibitors. To-Ro's potential financial interest as a show promoter clearly does not coincide
14 with the statute's aim." *Id.* (Emphasis Supplied).

15 The Supreme Court's reasoning in *To-Ro* holds true in the present case. BHT cannot,
16 itself, allege any actual injury with sufficient specificity to make a justiciable case. BHT
17 claims that it will suffer financial harm if the Commissioner issues a decision about Premera's
18 filings. But BHT is not an insurer, who is governed by the decision the Commissioner will
19 make. BHT is not even an employer who purchased coverage through the 2014 plans the
20 Commissioner is reviewing, or will purchase coverage through the 2015 plans the
21 Commissioner will review. BHT is also not the associations, who have the master contract
22 with Premera to sell coverage to association member. Instead, BHT is a third party
23 administrator, hoping to continue to profit from the fees it will receive from the Associations
24 and member employers if Premera or other carriers are permitted to keep selling large group
25 health plans to the Chamber Associations. While there is certainly nothing improper in
26 wanting to continue to maximize a profitable business, as in *To-Ro*, this financial interest in the

1 Commissioner's interpretations of insurance requirements is insufficient to meet the third
2 requirement of justiciability and standing.

3 Moreover, BHT's claims of harm are not just hypothetical, but disproven. Despite the
4 alleged "threat" from the Commissioner, now apparently as far back as October 2014, not only
5 did Premera itself continue to sell plans to the Chamber Associations, but Premera agreed to
6 enter into contracts for 2015 with the same associations. If the regulated carrier has not
7 perceived a threat sufficient to stop its sales, the purchaser of those plans cannot credibly claim
8 a sufficient factual injury.

9
10 **D. The Plain Language Of The Rate And Form Review Statutes Limit Hearings
Challenging Those Decision To After A Decision Has Been Made**

11 RCW 48.44.020(2) recognizes the distinction between the regulatory function of the
12 Commissioner's review process, and the enforcement nature of any subsequent enforcement
13 order. RCW 48.44.020(2) provides that "The commissioner may on examination, subject to
14 the right of the health care service contractor to demand and receive a hearing under
15 RCW 48.04 and 34.05, disapprove any individual or group contract..." For Health Care
16 Service Contractors (HCSCs), the Legislature recognized that first, the Commissioner must
17 review, or examine a health plan filing, and then, issue a decision, which may include a
18 disapproval. After that decision is issued, then parties can assert a challenge to the
19 Commissioner's determination, but not before. This is also the case for entities other than
20 HCSCs. This language has been in place since 1969. Laws of 1969, ch. 115, §1. After the
21 Commissioner's decision has been made concerning the underlying rate filing, an HCSC has
22 the ability to request a hearing concerning that determination. RCW 48.44.020(2). Arguably,
23 anyone else who can demonstrate that they are aggrieved by a decision issued by the
24 Commissioner would also have that ability under RCW 48.04.010(1)(b). But until that
25 decision is made, there is no hearing to be had based solely on the fact that the Commissioner
26 will carry out his statutory duty. BHT has offered no other interpretation of this statute, or

1 any basis for permitting the Commissioner to interpret the hearing statute as abrogating the
2 Commissioner's duty to issue a decision concerning his review.

3 **II. CONCLUSION**

4 BHT's requested interpretation is already having the effect of significantly hampering
5 the Commissioner's ability to fulfill his statutory obligations. If it is adopted by this tribunal,
6 it could lead to continued instances where a noncompliant plan is filed, and the Commissioner
7 has no ability to inform consumers who will purchase that plan for their employees, that the
8 plan fails to comply with the law. It could lead to instances where a carrier is vulnerable to
9 challenges concerning rates, because the OIC's review is incomplete. It could lead to
10 continued instances where third parties with financial interests in circumventing the new
11 requirements imposed by the Affordable Care Act bar the Commissioner from conducting the
12 regulatory review necessary to ensure the law is complied with. It will continue to lead to
13 absurd results. Because the distinction between threatened enforcement action and threatened
14 regulatory action is necessary to prevent these absurd results, the Commissioner asks this
15 tribunal to issue that determination. In addition, because the issue has been raised by BHT,
16 and is necessary to determine the propriety of even granting a hearing, the Commissioner asks
17 this tribunal to find that BHT lacks standing to bring the claims asserted here.

18
19 RESPECTFULLY SUBMITTED this 5th day of February 2015.

20 ROBERT W. FERGUSON
21 Attorney General



22 MARTA U. DELEON, WSBA #35779
23 Assistant Attorney General
24 Attorneys for Insurance Commissioner

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PROOF OF SERVICE

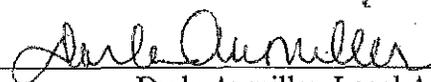
I certify that I served a copy of this document on all parties or their counsel of record on the date below as follows:

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Richard J. Birmingham, Attorney for Plaintiffs
richbirmingham@dwt.com

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 5th day of February, 2015, at Olympia, Washington.



Darla Aumiller, Legal Assistant

APPENDIX A



Bob Ferguson
ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE • PO Box 40100 • Olympia WA 98504-0100

February 4, 2013

The Honorable Joe Schmick
State Representative, District 9
PO Box 40600
Olympia, WA 98504-0600

Dear Representative Schmick:

By letter previously acknowledged, you requested our opinion on the following question, which we paraphrase for clarity:¹

May the Insurance Commissioner independently determine whether a multiple employer health plan arrangement constitutes an “employer” (“association of employers acting for an employer in such capacity”) under ERISA,^[2] 29 U.S.C. § 1002(5) and, acting on his interpretation of federal law, order a health carrier to terminate or amend the employer plan accordingly?

BRIEF ANSWER

Yes. The Insurance Commissioner’s responsibility to review health carrier rate and form filings requires the Commissioner to evaluate whether a plan offered by a health carrier uses a lawful rating method. To make that evaluation, the Commissioner may examine if the health carrier has submitted a rate filing using a rating scheme available only to those who satisfy the definition of “employer” under ERISA. That definition includes a multiple employer health plan arrangement for an “association of employers acting for an employer in such capacity.” When the Commissioner makes such a determination, he may disapprove a plan based on an unlawful rating scheme.

¹ You also asked: “If the Commissioner may make such independent determinations applying federal ERISA law, *what is the ERISA liability of an employer* acting in accordance with the Commissioner’s opinion and the effect of a differing DOL opinion?” (Emphasis added.) This question would require an opinion on the scope of liability imposed by federal law. As a general matter, the Attorney General’s Office does not provide opinions regarding the interpretation of federal law as applied to private entities.

² Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1114.

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ANALYSIS

Your question concerns health plans that are entitled to use an advantageous rating methodology to determine insurance premiums. I will start by providing background regarding the role of the Insurance Commissioner related to health carrier rate and form filings, and the federal and state laws that apply to rating schemes for health insurance. I will then evaluate the state laws that authorize the Commissioner to make and act upon a determination whether a multiple employer health plan arrangement constitutes an "employer" under ERISA.³

A. Background

Before a health carrier⁴ can lawfully sell a health plan in Washington State, the carrier is required to file the contract forms and premium rates applicable to that plan with the Office of Insurance Commissioner. *See* RCW 48.18.100 (commissioner must review insurance policies); WAC 284-43-920(1) ("Carriers must file with the commissioner every contract form *and rate schedule* and modification of a contract form and rate schedule[.]") (Emphasis added.)). The Commissioner reviews the rate and form filings to ensure that the health plan in question complies with applicable state and federal laws. WAC 284-43-920; *see generally* WAC 284-43-901 (filings allow the Commissioner to implement statutes related to "evaluations of premium rates"). Under RCW 48.18.110, the Commissioner is required to disapprove policies that do not comply with RCW Title 48 and the regulations adopted thereunder. Under WAC 284-43-125, "[h]ealth carriers shall comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits."

Over the years, a variety of state and federal laws have addressed the rates that health carriers are permitted to charge. As a general rule in Washington, carriers that offer health plans to individuals and small groups in Washington are required to use "community rating." *See* RCW 48.44.023(3) (describing allowable factors for rating). In general, this community rating scheme requires a carrier to apply the same premium rates to all enrollees in that type of plan, regardless of health status related to individual risks (e.g., current or past illnesses, genetic predispositions to illness). RCW 48.44.023(3). But Washington statutes also provided that health plans offered to associations or member-governed groups formed specifically for the purpose of purchasing health care were exempt from the community rating requirements imposed on the individual and the small group market. RCW 48.44.024(2). Thus, under these state laws, "association health plans" were an exception to community rating requirements applicable to small groups.

³ ERISA, 29 U.S.C. § 1002(5), defines "employer" as an "association of employers acting for an employer in such capacity."

⁴ "Health carrier" means insurance companies, disability insurers, health care service contractors, and health maintenance organizations. RCW 48.43.005(25).

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The federal health care reform law, known as the Patient Protection and Affordable Care Act or ACA, imposes new requirements on the ratings that health carriers may use to set premiums. The federal laws regarding allowable ratings, however, do not mirror the association health plan category under state law. The ACA requires all individual and small group health plans be community rated. *See* Pub. L. No. 111-148, § 1201(4) (Mar. 23, 2010) (enacting amended 42 U.S.C. § 300gg). However, a plan need not comply with the ACA community rating requirements applicable to individual and small group plans under the ACA if the plan is offered to a large group as defined by federal regulations. Pub. L. No. 111-148, § 1201(4) (amending 42 U.S.C. § 300gg-4).

To explain further, federal law provides that any health insurance coverage not offered in connection with a group health plan is "individual market coverage." 45 C.F.R. § 144.103. The term "group market" refers to health insurance coverage offered in connection with a group health plan. *See* 45 C.F.R. § 144.103. The group market is divided into the small group market and the large group market, depending on the number of employees employed by the employer. *See* 42 U.S.C. § 300gg-91(e). Federal law also relies on the definition of "employer" in ERISA, when calculating the number of employees employed by an employer. 42 U.S.C. § 300gg-91(a)(1), (d)(6). ERISA, in turn, defines "employer" to include an individual employer and certain associations of employers acting for an employer. 29 U.S.C. § 1002(5). ERISA also recognizes a "multiple employer welfare arrangement" (MEWA), which is an employee welfare benefit plan established or maintained for the purpose of offering or providing any such benefits to employees of two or more employers. 29 U.S.C. § 1002(40); *see also* 42 U.S.C. § 300gg-91(e)(3) (defining "large group market").

I review this complicated scheme of federal statutes and regulations to establish one point. If an association is a "multiple employer welfare arrangement" for purposes of the definition of employer found in ERISA, then its insurance carrier does not have to pool the members of the arrangement in the community rating pools otherwise required for individual and small group purchasers of health insurance. Instead, all members of the multiple employer welfare arrangement could be pooled and rated together as a large group. Thus, the allowable rating scheme for an insurance plan to be offered to an association of employers in Washington can depend on whether the association is a MEWA as defined by federal law.⁵

⁵ The federal government, through the Department of Labor, provides guidance on how to identify the situations where an ERISA plan exists in the context of an association. *See* Multiple Employer Welfare Arrangement Guide (MEWA Guide), <http://www.dol.gov/ebsa/Publications/mewas.html> (last visited Jan. 30, 2013). For examples of Department of Labor opinions applying the multiple employer welfare association category, *see* Adv. Op. 2008-07A (<http://www.dol.gov/ebsa/regs/aos/ao2008-07a.html>), Adv. Op. 2001-04A (<http://www.dol.gov/ebsa/regs/aos/ao2001-04a.html>), and Adv. Op. 2003-13A (<http://www.dol.gov/ebsa/regs/aos/ao2003-13a.html>).

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B. The Commissioner May Review Ratings Used By Plans

The Commissioner has authority to determine if an association falls within the definition of "employer" (including the "multiple employer welfare arrangement") because such determinations are needed to implement state law.

Under the statutes and regulations cited above, the Commissioner must determine if a carrier is using a lawful basis for rating. Therefore, the Commissioner may need to determine if a plan meets an exception to the community rating requirement, such as the exception for large group multiple employer welfare arrangements. *See generally* RCW 48.18.100, .110; WAC 284-43-920, -901 (the statutes and regulations described above on page 2). If not, the plan is inappropriately avoiding the ACA community rating requirements, and the Commissioner will disapprove the rates that have been filed. *See* WAC 284-43-125.

In addition to the statutes that generally direct the Commissioner to enforce the insurance code, authority to make a determination regarding lawfulness of rating can be found in the statutes authorizing the Commissioner to make investigations and determinations as needed to enforce the code. RCW 48.02.060. In particular, RCW 48.02.060(3)(b) specifically authorizes the Commissioner to "[c]onduct investigations to determine whether any person has violated any provision of [the insurance] code." Subsection (3)(c) authorizes the Commissioner to "[c]onduct . . . investigations . . . in addition to those specifically provided for, useful and proper for the efficient administration of any provision of this code." Finally, RCW 48.02.060(1) states that the Commissioner has "authority expressly conferred upon him or her by or reasonably implied from the provisions of this code."

Therefore, because state law requires the Commissioner to review plans and ratings, the Commissioner is empowered to take reasonable steps to investigate and determine if a plan proposes a lawful rating scheme, including making an independent determination about whether a multiple employer health plan arrangement constitutes an "employer" ("association of employers acting for an employer in such capacity") under ERISA, 29 U.S.C. § 1002(5).

C. The Possibility That State And Federal Agencies May Construe Federal Law Differently Does Not Preclude The Commissioner From Independently Determining That A Multiple Employer Health Plan Arrangement Constitutes An "Employer" Under ERISA

Our opinions do not generally address the question of whether federal law might preempt state law, thereby precluding an action that would take place under state law. This is because our office generally serves the function of defending the validity of state laws. Your question appears to be rooted in the possibility of conflict between the Commissioner's determination and a determination by a federal agency, when those determinations arise from the interpretation of federal law.

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The possibility that state and federal agencies might reach different conclusions regarding the application of federal law does not support a conclusion that the Commissioner cannot review rate filings and, in doing so, examine whether the rate is lawfully available for the plan. In particular, the Commissioner's review of arrangements in the context of reviewing rate filings does not make it impossible to comply with federal law. At most, a conflict might arise from inconsistent determinations about a particular arrangement, but that conflict disappears if the Commissioner yields to a federal determination (which the Commissioner's determination, attached to your inquiry, appears to acknowledge). Additionally, federal law, in the form of the ACA and ERISA provisions reviewed above, recognizes that state Commissioners regulate health insurance and review ratings. Federal law, accordingly, contemplates the Commissioner's enforcement of community rating requirements.

D. The Commissioner Has Statutory Authority To Act On A Determination

Your question also asks if the Commissioner can take actions based on the determination. Under the statutes and regulations reviewed on page 2, the Commissioner may disapprove a filing so that a plan could not be lawfully offered in Washington, under the authorities reviewed above.

I trust that the foregoing will be useful to you.

ROBERT W. FERGUSON

Attorney General



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WROS