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2015 MAY 18 A 11:34

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In re

WASHINGTON COUNTIES
INSURANCE FUND,

Docket No. 15-0034

DECLARATION OF CHARLES
BROWN

1. I am over the age of 18, and I make this declaration on the basis of first hand personal knowledge and am competent to testify to the matters set forth herein.

2. I am employed by the state of Washington Office of the Insurance Commissioner ("OIC") as an Insurance Enforcement Specialist.

3. Attached hereto as Exhibit 1 is a true copy of an opinion letter dated February 4, 2013 from the Attorney General of Washington to State Representative, Joe Schmick, analyzing the OIC's authority to review large group rate filings.

4. Attached hereto as Exhibit 2 is a true and correct copy of a letter dated March 14, 2013 to the Washington State Insurance Commissioner from Teresa Miller of the federal Centers for Medicare and Medicaid Services analyzing the Public Health Service Act and its preemption provisions as applied to state laws dealing with association coverage.

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

Signed this 18th day of May, 2015 at Tumwater, Washington.


Charles Brown
Insurance Enforcement Specialist
Legal Affairs

CERTIFICATE OF MAILING

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2 The undersigned certifies under the penalty of perjury under the laws of the state of
3 Washington that I am now and at all times herein mentioned, a citizen of the United States, a
4 resident of the state of Washington, over the age of eighteen years, not a party to or interested
5 in the above-entitled action, and competent to be a witness herein.

6 On the date given below I caused to be served the foregoing DECLARATION OF
7 CHARLES BROWN on the following individuals listed below in the manner shown:

8 Judge George Finkle (Ret.)
9 Presiding Officer
10 Office of the Insurance Commissioner
11 kellyc@oic.wa.gov

12 *Via email and hand delivery*

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*Via email and by depositing in the U.S. mail
via state Consolidated Mail Service with
proper postage affixed to.*

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16
17 Dated this 18th day of May, 2015, in Tumwater, Washington.

18
19 
20 _____
21 JOSH PACE
22 Secretary Senior
23 Legal Affairs Division
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25
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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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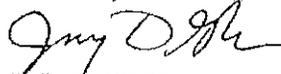
The possibility that state and federal agencies might reach different conclusions regarding the application of federal law does not support a conclusion that the Commissioner cannot review rate filings and, in doing so, examine whether the rate is lawfully available for the plan. In particular, the Commissioner's 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



JAY D. GECK
Deputy Solicitor General
(360) 753-6200

WTOS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850



March 14, 2013

The Honorable Michael B. Kreidler
Washington State Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504-0258

Dear Commissioner Kreidler,

I am writing in reference to House Bill 1700 and Senate Bill 5605, as introduced during the current legislative session. We understand the intent of this proposed legislation to be to deem health plans provided through associations or member-governed groups as large group health benefits plans for all purposes, if certain requirements are met. The bills would amend the Washington Insurance Code as it relates to 1) insurers offering a health benefit plan to a small employer; 2) health care service contractors offering a health benefit plan to a small employer; and 3) health maintenance organizations (HMOs) offering a health benefit plan to a small employer.¹ We understand that the legislation is specifically intended to exempt the association coverage at issue from requirements under Title XXVII of the Public Health Service Act (PHS Act) that apply to small employer group plans. If House Bill 1700 and Senate Bill 5605 were determined to have this effect, they would conflict with the manner in which such coverage is classified under the PHS Act, the Employee Retirement Income Security Act (ERISA), and guidance issued by the Centers for Medicare & Medicaid Services (CMS) addressing association coverage. I write to clarify these provisions, and the effect of enactment and implementation of the proposed legislation.

I. Individual or Group Market

As stated in a CMS Insurance Standards Bulletin published September 1, 2011 (CMS Bulletin):² Although the Affordable Care Act revised and added to Title XXVII of the PHS Act, it did not modify the underlying PHS Act framework for determining whether health insurance issued through associations was individual or group health insurance coverage... the test for determining whether association coverage is individual or group market coverage for purposes of Title XXVII of the PHS Act is the same test as that applied to health insurance offered directly to individuals or employers. Association coverage does not exist as a distinct category of health insurance coverage under Title XXVII of the PHS Act.

¹ The legislation cites: Wash. Rev. Code §§48.21.045(3) (employer-sponsored group health plan), 48.44.023(3) (health care service contractor), and 48.46.066(3) (HMO).

² Available at http://ccio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.pdf

If health insurance coverage offered to an individual through an association is not offered in connection with a group health plan, it is defined in PHS Act section 2791(b)(5) and (e)(1)(A) as individual health insurance coverage being sold in the individual market.

Health insurance coverage offered in connection with a group health plan is generally considered to be offered through the group market (45 C.F.R. §144.103). The PHS Act derives its definition of group health plan from the ERISA definitions of employee welfare benefit plan (*see* PHS Act section 2791(a)(1)).

We note that the Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review final rule (Market Rule final rule) states:

Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage . . . If the coverage is offered to an association member other than in connection with a group health plan, or is offered to an association's employer-member that is maintaining a group health plan that has fewer than two participants who are current employees on the first day of the plan year, the coverage is considered individual health insurance coverage . . . The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under state law. If the health insurance coverage is offered in connection with a group health plan . . . it is considered group health insurance coverage . . .³

II. Small Group or Large Group

Section 2791(d)(6) of the PHS Act, derives its definition of "employer" from ERISA, which states that an employer is "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." Such association plans may be called multiple employer welfare arrangements (MEWAs), trusts, purchasing alliances, or purchasing cooperatives.

Nonetheless, the CMS Bulletin states that "CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level." In such situations, the size of each individual employer determines whether the employer's coverage belongs to the small or large group market. In the rare case in which the group health plan is sponsored by the association of employers, the number of employees employed by all participating employers determines the market in which the association participates.

III. Application to House Bill 1700 and Senate Bill 5605

According to the general preemption standard under § 2724(a)(1) of the PHS Act: "[Title XXVII] shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage *except to the extent that such standard or requirement prevents the application of a requirement of this part*" (emphasis added). Section 731(a)(1) of ERISA has a parallel language.

³ 78 Fed. Reg. 13406 (Feb. 27, 2013) (to be codified at 42 C.F.R. § 144.102(c)).

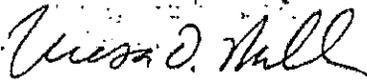
Consequently, House Bill 1700 is inconsistent with the PHS Act and ERISA, to the extent that the legislation (if enacted and implemented by the State as intended) would prevent the application of federal law requirements for coverage offered to small employers through an association.

Similarly, Senate Bill 5605, as amended, does not mitigate the prevention of the application of title XXVII of the PHS Act by authorizing the United States Department of Labor to prohibit the treatment of a health plan issued to an association or member-governed group as a large group plan. Accordingly, Senate Bill 5605, as amended, would be preempted by the PHS Act and ERISA to the extent that it prevents the application of federal law by preventing the application of PHS Act and ERISA requirements in the absence of an affirmative action by the Department of Labor that is not required or contemplated by the PHS Act or ERISA.

In summary, House Bill 1700 and Senate Bill 5605, as amended, would prevent the application of federal law to health insurance coverage provided through an association, and, consequently, would prevent the application of the market reform provisions under the PHS Act to the Washington State market. This legislation, if enacted and implemented as intended, would be preempted by federal law. Should the State either inform us that it would not be enforcing federal law with respect to the coverage at issue, or substantially fail to do so, this could give rise to CMS directly enforcing applicable federal requirements for health insurance coverage offered through an association.

Please contact me if you have any questions.

Sincerely,



Teresa Miller,
Acting Director, Oversight Division
CCRO/CMS/HHS