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**STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER**

In re

**WASHINGTON COUNTIES
INSURANCE FUND**

Docket No. 15-0034

**OIC STAFF'S RESPONSE TO
MOTION FOR SUMMARY
JUDGMENT AND CROSS
MOTION FOR SUMMARY
JUDGMENT**

NATURE OF CASE

The Washington Counties Insurance Fund ("WCIF") challenges the OIC's disapproval of the rate filings for two 2014 large group plans, one submitted by Group Health Cooperative ("Group Health"), the other submitted by Premera Blue Cross ("Premera"). At the heart of WCIF's hearing demand is its allegation that the "OIC erroneously treats WSAC/WCIF as a single employer, asserting that it must file a single rate at the association level." (Hearing Demand, page 1.) Neither carrier challenges the disapproval of its rate filing, and neither WCIF's hearing demand nor its Motion for Summary Judgment identifies any legal right belonging to WCIF or to any WCIF member to demand that Group Health or Premera sell them large group coverage rated according to WCIF's preferred rating method. WCIF's claim that it must not be treated as a "single employer" at any rate is contrary to the requirements of the Affordable Care Act and to the filings that both carriers submitted identifying the filings as

1 large group filings for WCIF as an association or member-governed true employer group under
2 29 U.S.C. Section 1002(5) of ERISA.

3 The OIC staff believes that WCIF lacks standing. WCIF has not and cannot
4 demonstrate that it suffered any harm or that any purported harm it alleges is anything other
5 than speculative. WCIF cannot force a carrier to offer it coverage rated according to WCIF's
6 preferences and WCIF has no interest that the OIC was required to consider in reviewing the
7 carriers' rating methodology. The OIC staff believes the only entities that would have standing
8 to contest its disapproval of the carriers' rate filings are the carriers that submitted them, and
9 that no meaningful evidentiary review or effective relief is available in their absence.
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11 Even if WCIF had standing to litigate someone else's filing, WCIF's claim that it must
12 not be treated as a "single employer" is contrary to the requirements of the Affordable Care
13 Act and to the filings that both carriers submitted identifying the filings as large group filings
14 for WCIF as an association or member-governed true employer group under 29 U.S.C. Section
15 1002(5) of ERISA. Because the Affordable Care Act permits large group plans to be issued to
16 an association comprised of small common law employers only if the association itself
17 constitutes an ERISA employer, WCIF's claim that it must not be treated as a single employer
18 is simply wrong as a matter of federal law. The second part of WCIF's claim misconstrues the
19 OIC's position and falls with the first. The OIC did not require a single rate for all
20 participating employees. It simply required that the plan be rated as it was filed, at the
21 association level and as a single employer large group plan. The carriers' twenty-one risk tiers
22 are unacceptable, not because of their number, but because they improperly rate at the
23 individual, small employer level and because they improperly discriminate between similarly
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1 situated enrollees based on the claims history or risk characteristics of their particular common
2 law employer rather than any bona fide employment based classification unrelated to health
3 coverage.

4 For these reasons, the OIC staff submits that WCIF's motion should be denied and that
5 summary judgment should be entered dismissing WCIF's hearing demand.

6 **FACTS**

7 The two rate filings at issue were submitted to the OIC through its System for
8 Electronic Rate and Form Filing (SERFF) by Group Health and Premera on February 18 and
9 17, 2014, respectively. Pursuant to WAC 284-43-920(2), rates for large group negotiated plans
10 may be used before they are filed, but must be filed within thirty days after they are used.
11 Under RCW 48.44.020 (HCSCs) and RCW 48.46.060 (HMOs), the Commissioner may
12 disapprove any contract if the benefits provided therein are unreasonable in relation to the
13 amount charged for the contract or if it fails to conform to minimum standards required by rule
14 or statute. As noted, both filings were specifically submitted by the carriers as large group
15 filings predicated upon the Washington Association of Counties' status as an association or
16 member-governed true employer group under ERISA. (Lee Decl., par. 29.)

17 Both carriers filed 21 different rate tiers for active employees for their WCIF large
18 group plans. The rates vary widely between these tiers with tier zero offering the lowest rates
19 and tier twenty the highest. For example, an active employee under the Group Health
20 WCIFHSA plan could be charged a monthly rate for the same benefit package that ranges from
21 \$307.98 to \$696.79 depending on the rate tier to which the employee's common law employer
22 is assigned. Similarly, under the Premera filing, for the same benefit package WCIF 200 Plan,
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1 an employee could be charged a monthly rate ranging from \$548.53 to \$1,241.03 depending
2 upon which rate tier applied. (Lee Decl., par. 31.)

3 In its SERFF correspondence with the carriers, the OIC attempted to elicit from the
4 carriers the basis for these disparities. Although both carriers denied that the health history of
5 individual enrollees was used to assign the risk tiers, the carriers could not identify any
6 employment based criteria that was used. In the non public portion of its filing, Premera
7 eventually acknowledged what WCIF's hearing demand now makes clear, that the tiers are
8 rated and assigned at the small employer level based on the claims experience or risk
9 characteristics of the particular WCIF member employer and the health history of that
10 individual employer's enrolled employees.
11

12 For example, by electronic objection letter dated April 23, 2014, Ms. Lee advised
13 Premera in part as follows:

14 If the association does meet the ACA and ERISA employer test, the association itself is
15 considered one large employer for health plan filing purposes and the HIPAA
16 nondiscrimination provisions are enforced on the association level.

17 ...

18 As a result, under HIPAA an issuer or association must not use health-status related
19 data or information from a specific participant, a subgroup of participants, or a
20 participating purchasing group within the association to establish rates for the
21 participant or the group purchaser.

21 Premera was asked several questions, including the following:

22 In the rate schedule, there are 21 risk tiers for each plan design. For example, for the
23 benefit plan WCIF 200, an employee can be charged a monthly rate ranging from
24 \$548.53 to \$1,241.03. Please respond to the following questions:

- 25 (a) Explain in detail how you define the risk level including the factors used to assign
26 a risk level.

- 1 (b) Provide detailed calculations of the rates for each risk level. Your response must be
detailed enough to allow us to replicate the rate for any new or existing employee.
2 (c) Provide the names of the purchasing groups effective January 1, 2014, and the risk
level for each purchasing group.
3 (d) For each purchasing group, explain in detail how you develop the rate schedule.

4 Premera was also advised that if “carriers fail to comply with state or federal laws or
5 regulations, the OIC has the authority to disapprove rates or forms under RCW 48.18.110,
6 RCW 48.44.020, and RCW 48.46.060. (Lee Decl., par. 33.)

7
8 An almost identical objection letter was sent to Group Health. Neither carrier
9 questioned or challenged the OIC’s authority to disapprove their filings, and neither carrier
10 provided sufficient detail for the OIC to replicate the rate for any new or existing employee.
11 (Lee Decl., paragraphs 32, 34, and 35.)

12 Premera’s response was at least partially revealing however. In its confidential, not-
13 for-public response to the OIC’s objection letter and questions, Premera acknowledged that
14 participating employers “were previously underwritten based upon their specific experience”
15 and advised that “the move to the new business methodology effective 1/1/2014 is producing
16 decreases and increases from current revenue ranging from -40% to 80%.” To avoid this
17 consequence of rating at the true employer association level, Premera appears to have assigned
18 each individual small employer to a risk tier that would produce a percentage premium change
19 for that employer that matched the percentage increase in revenue Premera expected from the
20 association as a whole. (Lee Decl., paragraphs 41 – 43.) Premera then appears to have added
21 “adjustment factors” to each small employer member of WCIF based upon such things as the
22 number of individuals employed by that particular small employer, the age and sex of its
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1 workers, and “persistence,” i.e. how long the particular small employer had offered the
2 Premera WCIF plan to its employees. (Lee Decl., par. 39.)

3 In short, both of the carriers in this case used the past claims history of the individual
4 small employers to initially assign them to rate tiers. Since individual small employers whose
5 employees have generated few health claims in the past received the most favorable rates, it is
6 hardly surprising that they would renew. A persistence bonus for such employers therefore
7 perpetuates the prior rating scheme based on the subgroups’ prior claims history. Similarly, an
8 adjustment factor assigned to a subgroup of employees based on their average age or the
9 percent that are women of child bearing age clearly discriminates on the basis of non
10 employment based factors and is designed to discriminate against those subgroups within the
11 association that are expected to generate the highest claims.
12

13 Because the rating methodology and rates filed for WCIF are inconsistent with the fact
14 the plans were filed for one single large employer group and because the risk tiers are based
15 upon the collective health and claims history of employee subgroups rather than bona fide
16 employment-based classifications, the OIC determined that the rates charged for individual
17 enrollees are discriminatory and unreasonable in relation to the benefits provided. The filings
18 were therefore disapproved January 15, 2015. (Lee Decl., paragraphs 54 – 58.)
19

20 ISSUES

21 1. When a health care service contractor or health maintenance organization files a health
22 plan for review by the Office of the Insurance Commissioner and the plan is disapproved,
23 does an entity that was not a party to the filing have standing to demand a hearing to contest
24 the disapproval?
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1 2. When a carrier files a single large group health plan for issuance to an association that
2 constitutes a single large employer, must the carrier rate the plan at the association level or
3 may it individually rate each individual small employer within the association based on the
4 individual small employer's claims experience?

5 3. Does the Office of the Insurance Commissioner have authority to review large group
6 rate filings?

7 **AUTHORITY AND ARGUMENT**

8 **Summary Judgment**

9
10 In administrative adjudications, summary judgment procedure is governed by rules that
11 mirror CR 56. For example, WAC 10-08-135 provides:

12 A motion for summary judgment may be granted and an order issued if the written
13 record shows that there is no genuine issue as to any material fact and that the moving
14 party is entitled to judgment as a matter of law.

15 In *Island Air, Inc. v. LaBar*, 18 Wn. App. 129, 136, 566 P.2d 972 (1977), the rules
16 governing summary judgment are explained as follows:

17 The purpose of a motion for summary judgment is to examine the sufficiency of the
18 evidence supporting the plaintiff's formal allegations so that unnecessary trials may be
19 avoided where no genuine issue of material fact exists. CR 56; The motion will be
20 granted only if after viewing the pleadings, depositions, admissions and affidavits, and
21 all reasonable inferences that may be drawn therefrom in the light most favorable to the
22 nonmoving party, it can be stated as a matter of law that (1) there is no genuine issue as
23 to any material fact, (2) all reasonable persons could reach only one conclusion, and (3)
24 the moving party is entitled to judgment.

25 **Standing**

26 As a threshold matter, WCIF's hearing demand must be dismissed as a matter of law
because WCIF lacks standing.

1 As noted, these plans were disapproved under RCW 48.44.020 and RCW 48.46.060.

2 Both statutes confine the right to a hearing to contest disapproval of a filing to the carrier that
3 submitted the filing. RCW 48.44.020(2) provides in pertinent part as follows:

4 The commissioner may on examination, subject to the right of the **health care service**
5 **contractor** to demand and receive a hearing under chapters 48.04 and 34.05 RCW,
6 disapprove any individual or group contract form for any of the following grounds:
(Emphasis supplied.)

7 RCW 48.46.060(3) likewise confines the right to a hearing to contest disapproval of an
8 HMO contract to the HMO that submitted the filing:

9 Subject to the right of the **health maintenance organization** to demand and receive a
10 hearing under chapters 48.04 and 34.05 RCW, the commissioner may disapprove an
11 individual or group agreement form for any of the following grounds: (Emphasis
supplied.)

12 These specific provisions limiting the right to a hearing in filing disapproval cases to
13 the HMO or HCSC that made the filing control the more general provision of RCW 48.04.010
14 that "(t)he commissioner shall hold a hearing ... upon written demand for a hearing made by
15 any person aggrieved by any act, threatened act, or failure of the commissioner to act, if such
16 failure is deemed an act under any provision of this code ..." As stated in *State v. Becker*, 39
17 Wn.2d 94, 96, 234 P. 2d 897 (1951):

18 Where general and special laws are concurrent, the special law applies to the subject
19 matter contemplated by it to the exclusion of the general law.

20
21 Even under the more general aggrieved party standard of RCW 48.04.010, WCIF fails
22 to qualify. Neither the WCIF trust nor the Washington Association of Counties that created it
23 claims any direct harm from the OIC's disapprovals, and the association cannot demonstrate
24 any harm either to the individual employers who comprise its membership or to the employees
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1 it is supposed to represent as a true ERISA single employer. The OIC did not disapprove these
2 plans because the rates are too low. It disapproved them because they are experience rated at
3 the wrong level and because they illegally discriminate at the small employer level based on
4 claims experience and health history. WCIF's speculation that correctly rating these plans
5 would increase their cost defies logic unless the intended effect of the rating scheme is to price
6 the small employer WCIF members with the oldest or sickest employees out of the coverage.

7
8 The Insurance Code, Title 48 RCW, does not define "aggrieved." However, the
9 standing test found in the Administrative Procedures Act ("APA"), which uses the same term,
10 is instructive:

11 A person has standing to obtain judicial review of agency action if that person is
12 aggrieved or adversely affected by the agency action. A person is aggrieved or
13 adversely affected within the meaning of this section only when all three of the
following conditions are present:

14 (1) The agency action has prejudiced or is likely to prejudice that person;

15 (2) That person's asserted interests are among those that the agency was
16 required to consider when it engaged in the agency action challenged; and

17 (3) A judgment in favor of that person would substantially eliminate or redress
18 the prejudice to that person caused or likely to be caused by the agency action.

19 "The first and third conditions are often called the 'injury-in-fact requirement and the second
20 condition is known as the 'zone of interest' test." *Wash. Indep. Tel. Ass'n v. WUTC*, 110 Wn.
21 App. 498, 511-12, 41 P.3d 1212 (2002). "[A] person is aggrieved or adversely affected within
22 the meaning of the APA standing test only when the zone of interest *and* injury-in-fact prongs
23 are satisfied." *Allan v. Univ. of Wash.*, 140 Wn.2d 323, 332, 997 P.2d 360 (2000) (emphasis in
24 original, internal citation omitted).
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1 WCIF's hearing demand articulates no claimed harm to itself. Instead WCIF vaguely
2 speculates that "(i)f the OIC's proposed remedy is implemented, Members, consisting
3 primarily of more than 4,000 local government employees and their families, may be forced to
4 move to plans with substantially reduced benefits and/or higher premiums." (Hearing
5 Demand, p. 3.) It is well established that this kind of speculative assertion cannot confer
6 standing. See *Patterson v. Segale*, 171 Wn. App. 251, 254, 289 P.3d 657 (2012), (finding no
7 standing "[W]here a person alleges an injury that is merely conjectural or hypothetical"); *KS*
8 *Tacoma Holdings*, 166 Wn. App. At 129 ("When a person or corporation alleges a threatened
9 injury, as opposed to an existing injury, the person or corporation must show an immediate,
10 concrete, and specific injury to themselves.") *Allan*, 140 Wn.2d at 332 (holding that plaintiff
11 lacked standing where she could not demonstrate a threat "that is 'sufficiently real,' in other
12 words, a threat that is 'neither imaginary nor speculative.'") (quoting *Yesler Terrace Comm.*
13 *Council v. Cisneros*, 37 F.3d 442, 446 (9th Cir. 1994).
14

15 Under the APA the "zone of interest" test requires WCIF to show that its "asserted
16 interests are among those that the agency was required to consider when it engaged in the
17 agency action challenged." RCW 34.05.530(2). "The test focuses on whether the Legislature
18 intended the agency to protect the party's interest when taking the action at issue," and
19 "limit[s] review to those for whom it is most appropriate." *Wash. Indep. Tel. Ass'n*, 110 Wn.
20 App. At 513 (quoting *Seattle Bldg. & Constr. Trades Council v. Apprenticeship & Training*
21 *Council*, 129 Wn.2d 787, 797, 920 P.2d 581 (1996)). None of the statutes bearing on the
22 OIC's disapprovals were intended to benefit third party administrators such as WCIF, and the
23 only interest of WCIF's parent, the Washington Association of Counties, the OIC was required
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1 to consider was whether the association constituted a bona fide true employer eligible for large
2 group coverage. Since this question was resolved in the association's favor and is not at issue
3 here, WCIF and the Washington Association of Counties fail the "zone of interest" test as well.

4 Granting WCIF standing to litigate disapproval of someone else's filings raises serious
5 practical problems as well as legal issues. The factual record made by the carriers was made
6 through the System for Electronic Rate and Form Filing ("SERFF"). Only carriers are allowed
7 to submit filing information through SERFF. That was the record upon which the OIC's
8 decision was based, and key portions of that record consist of information submitted by the
9 carriers on a not-for-public basis. Even if WCIF could establish a right to review the carriers'
10 not-for-public filing information, it should not be allowed to circumvent the OIC's review
11 process by demanding a hearing to offer evidence or arguments that the carriers themselves did
12 not submit through SERFF.
13

14 The law simply does not permit WCIF to step into the shoes of Premera and Group
15 Health and litigate the OIC's disapproval of the carriers' filings. Under RCW 48.44.020(2),
16 RCW 48.46.060(3), they are the only entities that have standing to challenge the disapproval of
17 their plans. Even under the more general hearing statute, RCW 48.04.010, WCIF is not
18 entitled to act as a health carrier's litigation surrogate and is not an aggrieved party. WCIF's
19 hearing demand should therefore be dismissed as a matter of law for lack of standing.
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22 **Rating**

23 Even if WCIF had standing to litigate the OIC's disapproval of these filings, which it
24 does not, WCIF's claim that the OIC erred in treating these filings as single large employer
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1 filings is simply wrong as a matter of law and is subject to dismissal by summary judgment for
2 this reason as well.

3 Prior to the advent of the Patient Protection and Affordable Care Act, Public Law 111-
4 148, March 23, 2010, (“ACA”), Washington law required carriers issuing health coverage to
5 small employers (those with 50 or fewer employees, RCW 48.43.005(33)) to base their rates
6 on an adjusted community rate. RCW §§ 48.44.023, 48.46.066, and 48.21.045. However,
7 employers with 50 or fewer employees purchasing coverage through associations or member
8 governed groups were not deemed small employers under state law. RCW §§ 48.44.024,
9 48.46.068, and 48.21.047 are similarly worded. RCW 48.44.024(2), for example, provides:

11 “Employers purchasing health plans provided through associations or through member-
12 governed groups formed specifically for the purpose of purchasing health care are not
13 small employers and the plans are not subject to RCW 48.44.023(3)”

14 One result of this statutory exemption was that association member employers with
15 fewer than 50 employees were exempt from state community rating requirements.

16 Another result was that, based on the language of the statute that identified the member
17 employer as the “employer purchasing health plans,” the OIC permitted carriers issuing
18 association plans to rate those plans at the purchasing employer level as WCIF wishes the
19 carriers to do here. Carriers could, for example, use the claims history of the purchasing
20 employer as a proper basis for rating.

21 Because of this statutory exemption, the association health plan market for small
22 employers expanded rapidly in Washington. As set forth in the Declaration of Jim Keough, it
23 has since become clear that the practice of rating at the participating employer level permitted
24 carriers and associations to select for lower risk employers, while higher risk employers were
25

1 priced out of the association market and displaced into Washington's small group community-
2 rated market. Over time, this adverse selection has led to relatively high premiums, and
3 comparatively few available plans in that market.

4 Specifically, data collected by the OIC in 2010 revealed that association health plans
5 vary widely in cost to participating employers based on risk factors that lead to higher medical
6 costs. For example, association health plans were charging their oldest enrollees up to 8 times
7 what younger employees were charged. Between the age of 40 and 50, adult 50 year old males
8 were charged 72% more than their 40 year old counter parts. Unsurprisingly, people over 50
9 make up a smaller percentage of association health plan enrollment than in the small group
10 market. In addition, association health plans charged more for women in child bearing years,
11 and for employees of certain industries.

13 This data reveals that the lower premiums claimed as a benefit of association
14 purchasing power are due not to bargaining power, but to the fact of adverse pricing and
15 "cherry-picking" of healthy members. Using claims experience at the participating employer
16 level permits carriers and associations to offer the lowest prices to the healthiest members,
17 making them more likely to continue with the plan. More costly employer members (those
18 with a higher percentage of employees who are older, sicker, or likely to bear children) are
19 quoted a higher price, which is likely to drive them out of association plans, with no alternative
20 but the costlier small group market.

22 The legal landscape that permitted this pricing practice dramatically changed with the
23 enactment of the ACA and the major market reforms instituted by the ACA that became
24 effective for plan years beginning on or after January 1, 2014. For example, 42 U.S.C. §
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1 18032 now requires carriers to community rate all of the plans they offer in the individual and
2 small group markets. 42 U.S.C. § 300gg-6 requires carriers to include all of the essential health
3 benefits in their individual and small group plans. And, relevant to the subject of this suit, new
4 federal language specifically abolished any exemption from federally required community
5 rating or from the other ACA small group market reforms for associations or small employers
6 purchasing through associations. As a result, small business can only avoid the federal
7 essential health benefits and community rating requirements by purchasing through an
8 association that constitutes an “employer” as defined by ERISA.
9

10 Under the ACA, the only group health plans that may be sold by a carrier are those that
11 constitute an “employee welfare benefit plan” as defined in section 3(1) of the Employee
12 Retirement Income Security Act of 1974 (“ERISA”).¹ In order to constitute an employee
13 welfare benefit plan under ERISA, the plan must be “established or maintained by an employer
14 or by an employee organization.” ERISA then defines the term “employer” to mean “any
15 person acting directly as an employer, or indirectly in the interest of an employer, in relation to
16 an employee benefit plan; and includes a group or association of employers acting for an
17 employer in such capacity.” 42 USCS § 1002(5). The large group market is the market under
18 which individuals obtain health insurance coverage through a plan maintained by a large
19 employer. 42 USCS §300gg-91 (e)(2) and (3). The factors used to determine whether an
20 association qualifies as an ERISA “employer” include, among other things, the association
21 members’ history of cooperation on employment-related matters, the similarity of their
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24 ¹42 USCS § 18021 (b)(3) provides that the “term ‘group health plan’ has the meaning given such term by
25 section 2791(a) of the Public Health Service Act (42 USCS § 300gg-91(a).” 42 U.S.C. § 300gg-91(a) in turn
26 provides that the term ‘group health plan’ means an employee welfare benefit plan as defined in section 3(1) of
ERISA.

1 business activities, and a genuine organizational relationship unrelated to the provisions of
2 welfare benefits.²

3 Accordingly, under the ACA, only an association that qualifies as a true employer
4 under the ERISA definition is eligible to purchase a large group health plan for the benefit of
5 the participating employees.

6 Contrary to WCIF's legal theory, the law has indeed changed with the advent of the
7 ACA. Specifically, for association health plans that qualify to sell large group insurance to all
8 its members regardless of size, it has changed which entity is the employer. It is no longer the
9 small member employer within the association - rather, for a bona fide association like WCIF
10 that meets the ERISA "employer" definition, the association itself is now the employer. The
11 health plan a true or bona fide employer association offers to the employees of its purchasing
12 members *exists only at the association level*, not at the association member or small employer
13 level.
14

15 This new legal reality is confirmed by a September 1, 2011 bulletin promulgated by the
16 Centers for Medicare & Medicaid Services, attached hereto as Addendum "A." On page 3 of
17 this bulletin, the federal position on association plans is summarized as follows:
18

19 CMS believes that, in most situations involving employment-based association
20 coverage, the group health plan exists at the individual employer level and not at the
21 association-of-employers level. In these situations the size of each individual employer
22 participating in the association determines whether that employer's coverage is subject
23 to the small group market or the large group market rules.

24 ²*Fossen v. Blue Cross Blue shield of Mont., Inc.*, infra, at 744 F. Supp. 2d 1096, 1102, citing U.S. Dep't
25 of Labor, "Multiple Employer Welfare Arrangements Under ERISA, a Guide to Federal and State Regulation."
26 See also Dep't of Labor Advisory Opinion 2001-04A; and Dep't of Labor Advisory Opinion 2003-13A.

1 In the rare instances where the association of employers is, in fact, sponsoring the
2 group health plan and the association itself is deemed the “employer,” the association
3 coverage is considered a **single group health plan**. In that case, the number of
4 employees employed by all of the employers participating in the association determines
5 whether the coverage is subject to the small group market or the large group market
6 rules. (Emphasis added.)

7
8 WCIF’s 2014 plan is a single plan filing and presents itself as one of those “rare
9 instances” where the “association itself is deemed the ‘employer.’” However, the carriers did
10 not rate WCIF as a single group health plan. Instead, the carriers created 21 separate risk pools
11 based on the past experience of individual employers. Their rating structure effectively creates
12 twenty-one separate plans.

13 The importance of identifying which entity is the employer (also described as
14 determining the level at which the plan exists) is critical for determining whether the plan’s
15 rates discriminate unlawfully, as illustrated by *Fossen v. Blue Cross Blue Shield of Mont., Inc.*,
16 744 F. Supp. 2d 1096 (D. Mont., 2010), affirmed in part, reversed in part, and remanded by
17 *Fossen v. Blue Cross & Blue Shield of Mont., Inc.*, 660 F.3d 1102 (9th Cir. 2011).

18 Fossen was a small employer that purchased employee health coverage from Blue
19 Cross through a multiple employer welfare arrangement comprised of unrelated small
20 employers. At renewal, Blue Cross imposed a 21% premium increase on Fossen, based on the
21 health status of one of Fossen’s employees. Fossen sued, claiming the carrier’s rating method
22 unlawfully discriminated based on individual health history. Blue Cross admitted to using
23 Fossen’s claims experience to achieve the rate increase, but argued that it was lawful to do so,
24 and the court agreed. However, the significance of the case is the rationale applied by the
25 court.
26

1 Applying the HIPPA nondiscrimination provisions set forth in 29 U.S.C. § 1182(b), the
2 court dismissed plaintiff's unlawful rating discrimination claim only because Fossen's
3 association, through which he purchased the plan, did not meet the ERISA definition of
4 "employer." Fossen's association was simply a MEWA, and as a result, the employer for
5 purposes of rating was the individual purchasing employer, Fossen. The *Fossen* court
6 reasoned as follows:

7 The next step in analyzing the motion for summary judgment requires application of 29
8 U.S.C. § 1182(b) to these facts. As this statute makes clear, § 1182(b) applies to
9 prohibit premium disparity based on health status factors at the individual level but not
10 at the employer level. In other words, an individual employee participating in an
11 employer's group health plan cannot be charged more because of his health status. An
12 employer group health plan, however, can be charged a higher premium due to health
13 status factors present among the individual employees—as **long as the increased
premium is borne equally by all participants in that employer's group health plan.**
14 Accordingly, BCBSMT's method of premium calculation for the AMI/MCCT
15 Arrangements, which takes into account health status factors when rating the employer
16 plans separately, is permissible under ERISA's section 1182(b). (Emphasis supplied.)

17 The *Fossen* reasoning is equally applicable here, with one critical difference: WCIF is
18 the association employer for the plan, under the rare exception for that role. As a result, the
19 WCIF plan exists only at the association level, and it must be rated at that level, using only
20 bona fide rating factors that do not discriminate based due to health status factors for any sub-
21 classifications. Rating at the participating employer level violates the HIPAA non-
22 discrimination rules.

23 As noted in *Fossen*, a carrier cannot charge an individual participating in a group health
24 plan more because of his or her health status. A carrier or employer cannot circumvent this
25 requirement through the simple expedient of grouping employees within the same plan into
26 subgroups or rating tiers as Premera and Group Health sought to do here.

1 The HIPAA non-discrimination requirements apply to both discrimination in
2 enrollment eligibility (29 USCS §1182 (a)) and discrimination in rates (29 USCS §1182 (b)).

3 The rate discrimination provisions in 29 USCS §1182 (b) are as follows:
4

5 (b) In premium contributions.

6 (1) In general. A group health plan, and a health insurance issuer offering health
7 insurance coverage in connection with a group health plan, may not require any
8 individual (as a condition of enrollment or continued enrollment under the plan) to pay
9 a premium or contribution which is greater than such premium or contribution for a
10 similarly situated individual enrolled in the plan on the basis of any health status-
11 related factor in relation to the individual or to an individual enrolled under the plan as
12 a dependent of the individual.

13 As noted in the Declaration of Lichiou Lee, some employees in the Premera and Group
14 Health WCIF plan may be charged more than twice as much as others for the same benefits for
15 no discernible reason other than the claims experience of their common law employer. As the
16 carriers admitted in their SERFF filings, the drastic rate disparities between similarly situated
17 employees are not based upon any employment based classification of the employee. The
18 federal regulations implementing and explaining these requirements make clear that carriers
19 and associations may not group employees into rating groups that are not based on bona fide
20 employment-based classifications unrelated to health care. 45 CFR 146.121(d) provides in part
21 as follows:

22 (d) . . . participants may be treated as two or more distinct groups of similarly situated
23 individuals and beneficiaries may be treated as two or more distinct groups of similarly
24 situated individuals in accordance with the rules of this paragraph (d). . . .

25 (1) Participants. Subject to paragraph (d)(3) of this section, a plan or issuer may treat
26 participants as two or more distinct groups of similarly situated individuals if the
distinction between or among the groups of participants is based on a **bona fide
employment-based classification consistent with the employer's usual business
practice**. Whether an employment-based classification is bona fide is determined on
the basis of all the relevant facts and circumstances. Relevant facts and circumstances

1 include whether the employer uses the classification for purposes independent of
2 qualification for health coverage (for example, determining eligibility for other
3 employee benefits or determining other terms of employment). Subject to paragraph
4 (d)(3) of this section, examples of classifications that, based on all the relevant facts
5 and circumstances, may be bona fide include full-time versus part-time status, different
6 geographic location, membership in a collective bargaining unit, date of hire, length of
7 service, current employee versus former employee status, and different occupations.
8 However, a classification based on any health factor is not a bona fide employment-
9 based classification, unless the requirements of paragraph (g) of this section are
10 satisfied (permitting favorable treatment of individuals with adverse health factors).
11 (Emphasis added.)

12 According to WCIF's hearing demand, page 1, the employees of 20 Washington
13 counties and nearly 100 other public employers are covered by the Premera and Group Health
14 plans. WCIF's hearing demand confirms what the filings themselves make clear: the 21 risk
15 tiers are established at the participating employer level and they are not based on any bona fide
16 employment-based classification unrelated to health care. Rather, the small employer
17 members of the association are assigned to the risk tier based primarily on the claims
18 experience of their employees. As WCIF concedes at page 1 of its hearing demand, the 21 risk
19 tiers are "established at the Participating Employer level with potentially different monthly
20 premiums for different Participating Employers." This is further confirmed by the Declaration
21 of Jon Kaino, p. 2, which makes it clear the WCIF 2014 filings were rated "(j)ust as had been
22 the case in past years." As a result, two identically situated plan participants with the same job
23 classification, collective bargaining unit, geographic location, and hours may pay widely
24 divergent rates for the same benefit package.

25 The OIC is not alone in its belief that this rating methodology violates federal law. As
26 stated by Doug Pennington, the Director of the Rate Review Division Oversight Group of the
federal Center for Consumer Information and Insurance Oversight, in his October 16, 2014
email to OIC Deputy Director for Rates and Forms, Molly Nollette:

1 We agree that it would appear to be inappropriate for a bona fide association to
2 differentiate rating or premiums based on the underlying employers, but rather they
3 should/could use general employee classifications to differentiate, which are allowed
4 by an employer group under ERISA. Likewise, it would seem inappropriate to
5 differentiate by member employer length in the association, as again, the association is
6 suppose to be acting as a single employee benefits provider to multiple employers in a
7 bona fide association and not as a sales/marketing channel to disparate employer
8 purchasers and therefore it should act like a bona fide association. (Declaration of
9 Molly Nollette, Exh. "A.")

10 If these rate filings had been submitted for a large employer such as Boeing, there
11 surely would be no debate over their legal shortcomings. A true single employer such as
12 Boeing would not be permitted to group its employees into rating tiers based on their health or
13 claims history, and as a true single employer, it would have no legitimate reason to do so. The
14 OIC staff believes that employer associations such as WCIF must be held to the same standard.
15 They may not evade the ACA's small and large group market reforms by establishing what
16 purports to be a single employer large group employee benefit plan while insisting on
17 individualized rates for each small employer association member.

18 **OIC Authority to Review Rates**

19 At pages 9 – 13 of its Motion for Summary Judgment, WCIF argues the OIC lacked
20 legal authority to review Premera's and Group Health's rates. The OIC is frankly surprised by
21 this argument, since neither carrier ever suggested in their SERFF filings that the OIC lacked
22 authority to review their rates.

23 One of the carriers, Premera, in fact recently invoked and relied upon the OIC's
24 authority to review its large group rates as a defense in a class action lawsuit claiming the rates
25 charged by Premera for plans sold through an association called the Business Health Trust
26

1 (“BHT”) were too high. In *McCarthy Finance, Inc. vs. Premera*, 2015 Wash. LEXIS 351,
2 April 2, 2015, the Washington Supreme Court upheld dismissal of class action claims against
3 Premera and the trust based upon the filed rate doctrine, holding at pages 8-9, as follows:

4 In this case, however, rather than requesting general damages or seeking any damages
5 that do not directly attack agency-approved rates, the Policyholders specifically request
6 (1) a "refund[] of the gross and excessive overcharges in premium payments" and (2) a
7 refund of "the amount of the excess surplus." CP at 28. The Policyholders' requested
8 damages cause their CPA claims to run squarely against the filed rate doctrine. Even
9 assuming that the Policyholders can successfully prove all the elements of their CPA
10 claims, a court's awarding either of the two specific damages requested by the
11 Policyholders would run contrary to the purposes of the filed rate doctrine because the
12 court would need to determine what health insurance premiums would have been
13 reasonable for the Policyholders to pay as a baseline for calculating the amount of
14 damages and the OIC has already determined that the health insurance premiums paid
15 by the Policyholders were reasonable. Accordingly, the Policyholders' claims are
16 barred by the filed rate doctrine because to award either of the specific damages
17 requested by the Policyholders **a court would need to reevaluate rates approved by
18 the OIC and thereby inappropriately usurp the role of the OIC.** (Emphasis added.)

19 Premera's position regarding the OIC's authority and large group rate review process in
20 *McCarthy* is remarkably different from WCIF's position here. As stated by Premera in their
21 Supplemental Brief of Petitioners, dated January 5, 2015, 2015 WA S.C. Briefs LEXIS 10:

22 **Large Group Rates.** Premera negotiates large group rates with each customer because
23 large groups have more bargaining power than individuals and small groups, and there
24 is considerable competition among insurers for their business. CP 345-46 PP 6, 10. As
25 a result, the OIC uses a different, but equally rigorous, procedure to regulate large
26 group rates. The development of large group rates involves a complex process that
requires a team of experienced underwriters, actuaries, brokers and other professionals,
as well as the large groups themselves. CP 345 at P 6. The starting point is the
development and utilization of a Large Group Rating Model, which Premera is required
to file, and does file with the OIC, for review and approval. *Id.*, The OIC then reviews
and either approves Premera's filing or sends Premera "Objections" to the model. *Id.*;
see also, e.g., CP 357-59 (example of the OIC's objection to Premera's large group
filing); CP 537-43 (same),

The model is a highly complex document of approximately 500 pages which weighs
numerous factors, including each large group's prior claims experience, [*13] its

1 demographics, the benefits it wants to include, geographic issues, the provider network
2 to be included, the group's industry, tax issues, and changes in the law such as coverage
mandates, as well as administrative expenses. CP 345-46 at P 8, 9.

3 Under Washington law, the OIC can object to and require modifications to any large
4 group contract, especially those that deviate substantially from the model, and must be
5 supported by a long form filing. CP 347 at P 11. Thus, once a large group's rates are
6 negotiated and agreed to, Premera files every large group contract and rate with the
7 OIC, *Id.* These filings give the OIC the ability to "reverse engineer" any individual
8 large group rate to see any deviations from the previously approved model. *Id.* As part
of this process, the OIC also requires Premera to file large associations' rates. For
9 example, for one year alone, the filing for defendant WAHIT is 5,486 pages long,
10 demonstrating the complexity and comprehensive review that the OIC requires.

11 WCIF's attack on the OIC's rate review authority is not only inconsistent with
12 *McCarthy* and the position of its carrier; it is also inconsistent with logic and the statutes on
13 which WCIF purports to rely.

14 As previously noted RCW 48.44.020 (HCSCs) and RCW 48.46.060 (HMOs) authorize
15 the Commissioner to disapprove any contract if the benefits provided therein are unreasonable
16 in relation to the amount charged for the contract or if it fails to conform to minimum standards
17 required by rule or statute. These two statutes are similarly worded and are consistent with the
18 general rate standard set out in RCW 48.19.020 that "premium rates for insurance shall not be
19 excessive, inadequate, or unfairly discriminatory." RCW 48.44.020 for example provides in
pertinent part as follows:

20 (2) The commissioner may on examination, subject to the right of the health care
21 service contractor to demand and receive a hearing under chapters 48.04 and 34.05 RCW,
22 disapprove any individual or group contract form for any of the following grounds:

23 ...

24 (f) If it fails to conform to minimum provisions or standards required by regulation
25 made by the commissioner pursuant to chapter 34.05 RCW; or
26

1 (3) In addition to the grounds listed in subsection (2) of this section, the commissioner
2 may disapprove any contract if the benefits provided therein are unreasonable in
3 relation to the amount charged for the contract. Rates, or any modification of rates effective on
4 or after July 1, 2008, for individual health benefit plans may not be used until sixty days after
5 they are filed with the commissioner. If the commissioner does not disapprove a rate filing
6 within sixty days after the health care service contractor has filed the documents required in
7 RCW 48.44.017(2) and any rules adopted pursuant thereto, the filing shall be deemed
8 approved.

9
10 WAC 284-43-125 provides:

11 Health carriers shall comply with all Washington state and federal laws relating to the
12 acts and practices of carriers and laws relating to health plan benefits.

13 WCIF's authority argument simply ignores RCW 48.44.020(2)(f) and its HMO
14 counterpart, RCW 48.46.060(e) and the fact that WAC 284-43-125 requires carriers to comply
15 with both state and federal laws relating to their plan benefits.

16 WCIF then tries to separate the plan's forms from its rates as though each should be
17 parsed in a vacuum, arguing that "(i)f the Legislature had intended to refer to 'rates' as a basis
18 for disapproval in RCW 48.46.060(4) and RCW 48.44.020(3), it would have done so." WCIF
19 Motion for Summary Judgment, page 11, lines 14 -15. WCIF's construction of these statutory
20 provisions renders them nullities, since it is impossible to evaluate a plan's benefits in
21 relationship to its rates by considering only one side of the equation and without evaluating
22 both the rates and benefits. As set forth in the Declaration of Lichiou Lee, it is impossible
23 from these filings to replicate or recreate the rate for any specific individual from the
24 information filed by the carriers. If the OIC has no ability to determine whether a carrier is
25 actually following its filed rates and if it has no authority to review large group rates, it is a
26

1 useless act to require carriers to file them. It is axiomatic that statutes should be construed to
2 avoid unlikely, absurd, or strained consequences. *State v. Stannard*, 109 Wn.2d 29, 37 (1987),
3 and if a statute is ambiguous, the interpretation of the agency charged with administration and
4 enforcement of the statute is given great weight. *Puget Soundkeeper Alliance vs. State*, 102
5 Wash. App. 783, 787 (2000).

6 Failing in its statutory argument, at pages 11 and 12 of its motion, WCIF turns to the
7 actuarial standards in WAC 284-43-915(2) for determining when a plan's rates are
8 unreasonable in relation to its benefits, arguing that "these calculations clearly relate to the
9 value of the benefits received for the overall amount charged, not to the purported
10 unreasonableness of individual Members' rates when compared to one another." WCIF of
11 course offers no evidence or actuarial opinion that these plans meet these actuarial standards,
12 even though WCIF bears the summary judgment burden of demonstrating no material issue of
13 fact and even though WCIF would bear the burden of proof at hearing.³

14 WCIF's argument that WAC 284-43-915(2) only applies at the aggregate association
15 level also amounts to bootstrapping. The regulatory assumption behind WAC 284-43-915(2)
16 that carriers will actually rate their plans at the plan level does not save these plans; it
17 underscores their central defect. They are rated at the wrong level. Perhaps WCIF can explain
18 to its enrollees who are charged more than twice as much for the same benefit package as other
19 identically situated employees how their benefits are reasonable in relation to the premium
20
21
22

23
24 ³ See RCW 34.05.570(1)(a), providing for purposes of judicial review that unless that chapter or another
25 statute provides otherwise, "(t)he burden of demonstrating the invalidity of agency action is on the party asserting
26 invalidity." See also *Schaffer v. Weast*, 546 U.S. 49, 57 (2005), applying the default rule in administrative
adjudications "that plaintiffs bear the risk of failing to prove their claims."

1 charged and why their rates are not unfairly discriminatory. The OIC staff certainly has no
2 reasonable explanation to offer.

3 At any rate, RCW 48.44.020(2)(f) and its HMO counterpart, RCW 48.46.060(3)(e),
4 provide express authority to disapprove plans that do not comply with applicable OIC
5 regulations. Whether WAC 284-43-915(2) applies or not, WAC 284-43-125 requires carriers
6 to comply with both state and federal laws relating to their plan benefits. Because these plans
7 admittedly discriminate against enrollees for reasons that are not based on a bona fide
8 employment-based classification consistent with the employer's usual business practice, they
9 violate federal law and were correctly disapproved.
10

11 CONCLUSION

12 WCIF has no standing to litigate the OIC's disapproval of Group Health's and
13 Premera's filings and its purported basis for doing so is without merit as a matter of law.
14 Under the Affordable Care Act, Premera and Group Health were required in 2014 to begin
15 rating these plans as single large group plans issued to a single large employer. Because they
16 failed to do so, their WCIF plans were correctly disapproved. For these reasons, the OIC staff
17 requests entry of an order denying WCIF's Motion for Summary Judgment, granting the OIC
18 staff's Motion for Summary Judgment, and dismissing WCIF's hearing demand.
19

20 Dated at Tumwater, Washington this 29th day of April, 2015.

21 OFFICE OF INSURANCE COMMISSIONER

22 

23 Charles Brown
24 Insurance Enforcement Specialist
25 Office of the Insurance Commissioner
26

CERTIFICATE OF MAILING

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

On the date given below I caused to be served the foregoing OIC STAFF'S RESPONSE TO MOTION FOR SUMMARY JUDGMENT AND CROSS MOTION FOR SUMMARY JUDGMENT; DECLARATION OF MOLLY NOLLETTE; DECLARATION OF JIM C. KEOGH IN OPPOSITION TO WCIF'S MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF OIC STAFF'S CROSS MOTION FOR SUMMARY JUDGMENT; and DECLARATION OF LICHIOU LEE on the following individuals listed below in the manner shown:

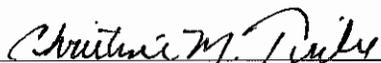
Judge George Finkle (Ret.)
Presiding Officer
Office of the Insurance Commissioner
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via state Consolidated Mail Service with
proper postage affixed to.*

Dated this 29th day of April, 2015, in Tumwater, Washington.


CHRISTINE M. TRIBE
Paralegal
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ADDEMNUM A



Date: September 1, 2011

From: Gary Cohen, Acting Director, Office of Oversight

Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations

Markets: Individual and Group

I. Purpose

This Bulletin affirms the applicability of previous guidance concerning whether health insurance coverage sold to or through associations is individual or group coverage for purposes of the requirements of Title XXVII of the Public Health Service Act ("PHS Act"), in light of the enactment of the Patient Protection and Affordable Care Act, Public Law 111-148, and the Health Care and Education Reconciliation Act, Public Law 111-152 (collectively, the "Affordable Care Act").

II. Background

Since the enactment of the Affordable Care Act in March 2010, the Centers for Medicare & Medicaid Services ("CMS") has received numerous inquiries from State regulators, consumers, issuers, and others on how health insurance coverage sold to or through associations ("association coverage") is treated under the PHS Act with respect to the changes made to the PHS Act by the Affordable Care Act. For purposes of this Bulletin, given that "association coverage" is not defined in the PHS Act, the term means health insurance coverage¹ offered to collections of individuals and/or employers through entities that may be called associations, trusts, multiple employer welfare arrangements ("MEWAs"),² purchasing alliances, or purchasing cooperatives.

¹ CMS's authority under Title XXVII of the PHS Act applies to health insurance coverage and nonfederal governmental plans. CMS does not have authority over self-insured association coverage, although such coverage may be regulated by the States and, if the coverage is employment-based, by the Department of Labor ("DOL").

² The requirements of Title XXVII of the PHS Act apply to individual and group health insurance coverage provided through MEWAs. In addition, private group health plan coverage (whether insured or self-funded) generally is subject to the requirements of Part 7 of the Employee Retirement Income Security Act ("ERISA"), including group health coverage provided through MEWAs. Other ERISA provisions, such as ERISA section 101(g), also impose requirements on MEWAs. The DOL administers ERISA. For further information, please refer to the DOL's MEWA Guide (www.dol.gov/ebsa/Publications/mewas.html).

III. Discussion

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 coverage issued through associations was individual or group health insurance coverage. The analysis set forth in CMS Insurance Standards Bulletin Transmittal No. 02-02 (August 2002), summarized below, remains authoritative for determining when association coverage is considered individual or group coverage under Title XXVII of the PHS Act.³

In short, 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.⁴

A. Individual Market

Under Title XXVII of the PHS Act, “individual market coverage” is any health insurance coverage that is not offered in connection with a group health plan. PHS Act § 2791(e)(1)(A); 45 C.F.R. § 144.103. A group health plan is defined in PHS Act section 2791(a)(1) as an employee welfare benefit plan under ERISA section 3(1). Consequently, coverage issued through an association, but not in connection with a group health plan, is not group health insurance coverage for purposes of the PHS Act. The fact that the same such coverage may be categorized as group market for State law purposes has no bearing on its categorization under the PHS Act. 45 C.F.R. § 144.102(c).⁵

B. Group Market

Conversely, the term “group market” refers to health insurance coverage offered in connection with a group health plan. 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. PHS Act § 2791(e)(2)-(6).

The PHS Act derives its definitions of group health plan and employer from the ERISA definitions of employee welfare benefit plan and employer. PHS Act § 2791(a)(1), (d)(6). Under ERISA

³ This Bulletin is available at: <https://www.cms.gov/HealthInsReformforConsumers/downloads/HIPAA-02-02.pdf>.

⁴ Title XXVII of the PHS Act does recognize coverage offered through “bona fide associations,” but only for purposes of providing limited exceptions from its guaranteed issue and guaranteed renewability requirements. PHS Act §§ 2731(f); 2732(b)(6), (e); 2741(e)(1); 2742(b)(5), (e). The bona fide association concept has no other significance under the PHS Act, and, importantly, does not modify or affect the analysis of whether health insurance coverage belongs to the individual or group market.

A “bona fide association,” within the meaning of Title XXVII of the PHS Act, means an association that: (1) has been actively in existence for five years; (2) has been formed and maintained in good faith for purposes other than obtaining insurance; (3) does not condition membership in the association on health status-related factors; (4) makes coverage available to all members regardless of any health status-related factor; (5) does not make coverage available other than in connection with members; and (6) meets any additional requirements imposed under State law. PHS Act § 2791(d)(3).

⁵ See also the preamble to the interim final regulation on the medical loss ratio (MLR) requirements of the PHS Act, 75 Fed. Reg. 74864, 74871 (Dec. 1, 2010) (explaining that certain group coverage under statutory accounting principles must be classified as individual coverage for MLRs under the PHS Act).

section 3(5), 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.” Thus, reference to ERISA is needed when establishing the existence of a group health plan and determining the identity of the “employer” sponsoring the plan.⁶

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 these situations the size of each individual employer participating in the association determines whether that employer’s coverage is subject to the small group market or the large group market rules.

In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the “employer,” the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules.

C. “Mixed” Associations

A “mixed” association exists where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under the PHS Act, as determined by each member’s circumstances. In this situation, the members of the association cannot be treated as if all of them belonged to same market. For example, it is not permissible under the PHS Act for mixed association coverage to comply only with the large group market rules, even with respect to its individual and small employer members. Accordingly, each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer.

Where to get more information:

If you have any questions regarding this Bulletin, please email phig@cms.hhs.gov or call 877-267-2323, extension 61565.

⁶ For additional information on identifying the situations where an ERISA plan exists at the association level, please refer to the following DOL guidance: (1) MEWA Guide (www.dol.gov/ebsa/Publications/mewas.html); (2) Adv. Op. 2008-07A (www.dol.gov/ebsa/regs/aos/ao2008-07a.html); (3) Adv. Op. 2001-04A (www.dol.gov/ebsa/regs/aos/ao2001-04a.html); and (4) Adv. Op. 2003-13A (www.dol.gov/ebsa/regs/aos/ao2003-13a.html).