

FILED

BEFORE THE STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

2015 JUL -1 P 12: 24

In the Matter of

**WASHINGTON COUNTIES
INSURANCE FUND**

) **Docket No. 15-0034**

) **ORDER ON WASHINGTON
COUNTIES INSURANCE FUND'S
MOTION FOR SUMMARY
JUDGMENT AND OIC STAFF'S
CROSS MOTION FOR SUMMARY
JUDGMENT**

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This case comes before me on the Washington Counties Insurance Fund's ("WCIF's") Motion for Summary Judgment, filed April 1, 2015, and the OIC Staff's Cross Motion for Summary Judgment, filed April 29, 2015.

I have considered the Motions; the OIC Staff's Response to WCIF's Motion, filed on April 29, 2015; and WCIF's Reply and Opposition, filed May 19, 2015; as well as the attachments to such submissions and the oral argument of counsel.

Background.

WCIF submitted a Demand for Hearing (“Demand”), dated and filed February 11, 2015, demanding a hearing to challenge the January 15, 2015, disapprovals by the Office of the Insurance Commissioner (“OIC”) of 2014 rate and form filings by Premera Blue Cross (“Premera”) and Group Health Cooperative (“Group Health”).

The Demand states that WCIF is a multi-employer non-profit trust fund providing fully insured benefit plans through Premera and Group Health to participating county government employees and eligible dependents. In summary, WCIF challenges OIC’s disapprovals on the following grounds: 1) No basis under state law or federal law exists for the OIC’s position that a Bona Fide Association such as WCIF must be treated as a single employer for rating purposes. 2) OIC’s disapprovals will unfairly prejudice WCIF, Participating Employers, and Members – WCIF relied on the OIC’s express representations that it had no issues with prior rates when it quoted 2015 rates. 3) If the OIC’s proposed remedy – that all current enrollees be transitioned to a compliant plan as soon as possible – is implemented, Members may be forced onto plans with reduced benefits and/or higher premiums. 4) The OIC’s proposed remedy does not flow from its disapproval of the filings – disapproval of 2014 Filings cannot logically obligate Premera and Group Health to transfer current enrollees in 2015 plans to new plans. 5) Imposition of the OIC’s proposed remedy would contravene the purpose of the Affordable Care Act – to provide access to affordable health care.

Summary judgment standard.

WAC 10-08-135, which governs motions for summary judgment in administrative proceedings including the present Matter, provides:

ORDER ON CROSS MOTIONS FOR SUMMARY JUDGMENT

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

No genuine issue exists as to any fact that is material to the present Order.

Analysis incorporated by reference.

This Order incorporates by reference my consolidated Order on (1) Motion for Summary Judgment by MBA Trust, BIAW Trust, NMTA Trust and Cambia; (2) OIC Staff's Motion for Summary Judgment, Docket Nos. 15-0062, 15-0071, 15-0075, 15-0078, 15-0079, and 15-0084, filed today, a copy of which is attached hereto. My Order in those Matters appears to dispose of the issues before me in the present Matter.

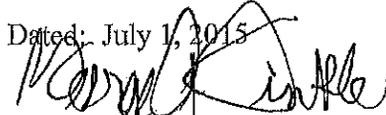
Summary.

WCIF has standing to pursue the present Matter. The OIC had the authority to review the 2014 Filings and to reject them if they failed to comply with specific Washington State or federal laws. No Washington State, or federal, statute or regulation prohibits rating at the Participating Employer level.

Ruling.

The OIC Staff's Cross Motion for Summary Judgment is denied. The Washington Counties Insurance Fund's Motion for Summary Judgment is granted.

Dated: July 1, 2015



JUDGE GEORGE FINKLE (Ret.)
Presiding Officer

Pursuant to RCW 34.05.461(3), the parties are advised that they may seek reconsideration of this order by filing a request for reconsideration under RCW 34.05.470 with the undersigned within 10 days of the date of service (date of mailing) of this order.

Declaration of Mailing

I declare under penalty of perjury under the laws of the State of Washington that on the date listed below, I mailed or caused delivery through normal office mailing custom, a true copy of this document to the following people at their addresses listed above: Maren R. Norton, Mike Kreidler, James T. Odiorne, J.D., CPA, Molly Nollette, Charles Brown and AnnaLisa Gellermann.

DATED this 1st day of July, 2015.


KELLY A. CAIRNS

ATTACHMENT

FILED

BEFORE THE STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

2015 JUL -1 P 12: 24

In the Matters of)

MASTER BUILDERS ASSOCIATION)
OF KING AND SNOHOMISH)
COUNTIES and MASTER BUILDERS)
ASSOCIATION OF KING AND)
SNOHOMISH COUNTIES EMPLOYEE)
BENEFIT GROUP INSURANCE TRUST)
("MBA TRUST"))
No. 15-0062)

CAMBIA HEALTH SOLUTIONS)
(RE MBA TRUST) ("CAMBIA 1"))
No. 15-0071)

BUILDING INDUSTRY ASSOCIATION)
OF WASHINGTON HEALTH)
INSURANCE TRUST ("BIAW TRUST"))
No. 15-0075)

CAMBIA HEALTH SOLUTIONS)
(RE BIAW TRUST) ("CAMBIA 2"))
No. 15-0078)

NORTHWEST MARINE TRADE)
ASSOCIATION and NORTHWEST)
MARINE TRADE ASSOCIATION)
HEALTH TRUST ("NMTA TRUST"))
No. 15-0079)

CAMBIA HEALTH SOLUTIONS)
(RE NMTA TRUST) ("CAMBIA 3"))
No. 15-0084)

Docket Nos. 15-0062; 15-0071; 15-0075
15-0078; 15-0079; and 15-0084

ORDER ON (1) MOTION FOR
SUMMARY JUDGMENT BY MBA
TRUST, BIAW TRUST, NMTA TRUST
AND CAMBIA; (2) OIC STAFF'S
MOTION FOR SUMMARY
JUDGMENT

ORDER ON CROSS MOTIONS
FOR SUMMARY JUDGMENT

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AND TO: Mike Kreidler, Insurance Commissioner
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Molly Nollette, Deputy Commissioner, Rates and Forms Division
AnnaLisa Gellermann, Deputy Commissioner, Legal Affairs Division
Charles Brown, Sr. Insurance Enforcement Specialist, Legal Affairs Division
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This case comes before me on the “Motion for Summary Judgment by MBA Trust, BIAW Trust, NMTA Trust [collectively, the “Association Health Plans” or “AHPs”] and Cambia” and the “OIC Staff’s Motion for Summary Judgment.”

I have considered the Motions, filed May 6, 2015; the AHPs’ and Cambia’s Opposition, filed May 26, 2015; the OIC Staff’s Reply, filed May 26, 2015; the AHPs’ and Cambia’s Reply, filed June 3, 2015; the OIC Staff’s Response, filed June 3, 2015; the declarations and other attachments to such submissions, and the oral argument of counsel.

The parties present three issues: 1) Do the Association Health Plans and Cambia have standing to pursue these Matters? 2) Does the commissioner have the authority to approve or deny the 2014 rate and form filings for the AHPs? 3) May the AHPs’ rating categories be established at the separate Participating Employer level, rather than association-wide?

Background.

Cambia is a non-profit corporation that sells health insurance through subsidiaries, including Regence BlueShield (“Regence”). In early 2014, Regence submitted rate and form filings for health benefit plans for the AHPs (“Plans”) to the OIC (“2014 Filings”).

The 2014 Filings included multiple rating categories at the level of the separate employers in the association (“Participating Employers”), rather than association-wide. The OIC had accepted this rating method in prior years.

In March 2014 and July 2014 the OIC sent Regence substantively identical Objection Letters, citing federal Health Insurance Portability and Accountability Act (“HIPAA”) rules that prohibit discrimination against participants and beneficiaries based on health status-related factors (“non-discrimination rules”) as a basis for its objection to the Plans. Regence responded in April

and August 2014, stating that an individual participant's health status (or medical condition) is not a factor when determining the rating category.

In late October 2014, the OIC sent Regence substantively identical Objection Letters, asking it to identify bona fide employment-based classifications upon which the AHPs' various rating categories were based. Regence responded in November 2014, stating that using different categories when rating subgroups is permissible; its rating categories are consistent with HIPAA non-discrimination rules; each subgroup is an ongoing business and can be treated separately; the rating categories are warranted by differing employment criteria, employment needs, and benefit mix; and no similarly situated individual within a group is discriminated against based on health status.

On January 15, 2015, the OIC disapproved the 2014 Filings "under the authority of RCW 48.44.020(3)," concluding that the "rates, filed for various employers, are unreasonable in relation to the amount charged for the contract for one single employer." The OIC stated that as a result of its disapprovals all current enrollees must "be transitioned to a compliant plan as soon as possible."

The Master Builders Association of King and Snohomish Counties and the Master Builders Association of King and Snohomish Counties Employee Benefit Group Insurance Trust (collectively, "MBA Trust"); the Building Industry Association of Washington Health Insurance Trust ("BIAW Trust"); the Northwest Marine Trade Association and Northwest Marine Trade Association Health Trust (collectively, "NMTA Trust"); and Cambia Health Solutions ("Cambia") submitted Demands for Hearing, challenging the OIC's disapprovals.

The Prehearing Conference Order and Order re Consolidation, filed April 3, 2015, consolidated these Matters, at least for purposes of dispositive motions.

Summary judgment standard.

WAC 10-08-135, which governs motions for summary judgment in administrative proceedings including the present Matters, provides:

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

No genuine issue exists as to any fact that is material to the present Order.

Standing.

The OIC argues that the AHPs and Cambia lack standing to assert Demands for Hearing in these Matters:

RCW 48.04.010(1)(b).

The OIC asserts that the AHPs and Cambia are not “aggrieved” under RCW 48.04.010(1)(b), which provides (with an exception not material to these Matters) that the commissioner shall hold a hearing

upon written demand for a hearing made by *any person aggrieved by any act, threatened act, or failure of the commissioner to act, if such failure is deemed an act under any provision of this code, or by any report, promulgation, or order of the commissioner other than an order on a hearing of which such person was given actual notice or at which such person appeared as a party, or order pursuant to the order on such hearing.*
(Emphasis added.)

RCW 48.04.010(1)(b) does not define “aggrieved.” I therefore assume that the ordinary meaning of that term, which includes injury, damage, and/or adverse effect, accurately expresses the legislative purpose. *See, e.g., Park ‘n Fly, Inc. v. Dollar Park &*

Fly, Inc., 469 U.S. 189, 194 (1985). RCW 48.04.010(1)(b) thus grants expansive standing, to *any* person aggrieved – injured, damaged, and/or adversely affected – by *any* act of the commissioner.

The AHPs assert that they are aggrieved by the OIC’s disapproval of the 2014 Filings in multiple respects: If Regence must set rates at the association level, imposing the same rates on all Participating Employers, many rates will sharply increase; Participating Employers facing higher rates are likely to leave the AHPs; market disruption will impair the AHPs’ ability to effectively compete; membership will be limited to an aging, unsustainable demographic; and per-member administrative costs will rise. May 19, 2015, Declaration of Jerry Belur (CEO of the AHPs’ third-party administrator), Para. 13.

The AHPs further assert that their competitors are now exploiting OIC disapprovals as marketing tools – warning employers that the AHPs may soon impose major rate hikes and that the AHPs may ultimately be forced out of the market. June 2, 2015, Belur Declaration, Para. 3-7.

Although the OIC challenges Mr. Belur’s Declarations as conclusory, his statements are within the scope of his specialized knowledge and experience and are admissible. *See*, ER 702. In any case, strict application of the Rules of Evidence is not required in these Matters, and the Declarations, even if conclusory, have sufficient foundation. *See*, RCW 34.05.452.

A “mini-trial” on the issue of whether the AHPs and Cambia are aggrieved under RCW 48.04.010(1)(b) would cause undue delay and is unnecessary to determine the

threshold question of standing. The AHPs have sufficiently demonstrated that they were “aggrieved” and therefore have standing under RCW 48.04.010(1)(b).

Regence is Cambia’s wholly-owned subsidiary. As the result of the impact on Regence of the OIC’s disapprovals – similar to the impact on the AHPs – Cambia is also “aggrieved.”

RCW 48.44.020(2) and RCW 48.46.060(3).

The OIC asserts that RCW 48.44.020(2) and RCW 48.46.060(3) limit standing to challenge the OIC’s disapprovals to insurance companies/health care service contractors and health maintenance organizations (“HMOs”) – even assuming that standing would otherwise exist under RCW 48.04.010(1)(b).

RCW 48.44.020(2) provides:

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

RCW 48.46.060(3) provides:

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

The OIC did not initially rely on RCW 48.44.020(2) or RCW 48.46.060(3) as a basis for disapproval of the 2014 Filings. But assuming these statutes may now be considered, they grant the right to demand hearings to insurers/health care service contractors and HMOs without expressly or impliedly limiting the standing of any “person aggrieved” to demand hearings under RCW 48.04.010(1)(b).

Administrative Procedure Act, RCW 34.05.530.

The OIC asserts that the AHPs and Cambia lack standing under the Administrative Procedure Act (“APA”), which provides, at RCW 34.05.530:

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

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

By its terms, RCW 34.05.530 applies to judicial review, not to matters before the commissioner or his designee – standing in the present Matters is determined under RCW 48.04.010(1)(b). But even if RCW 34.05.530 were applicable, its standing test would be met, at least as to the AHPs:

(1) The AHPs and Cambia provided evidence that the OIC’s disapprovals have prejudiced them, Participating Employers, and employees in specific respects, an assertion that is sufficiently probative for this threshold standing determination. *See, Belur Declarations; American Legion Post No. 149 v. Wash. Dep’t of Health*, 164 Wn.2d 570, 595 (2008) (organization may have standing in representational capacity).

(2) The AHPs, Participating Employers, and employees are in the “zone of interest” that the OIC was required to consider, and did consider, before issuing its disapprovals.

(3) A decision in favor of the AHPs would redress the prejudice that they allege was caused to them by the OIC disapprovals.

Standing therefore exists under RCW 34.05.530.

RCW 48.04.010(1).

Assuming that the AHPs' and Cambia's standing were not otherwise established, the commissioner has discretion under RCW 48.04.010(1) to hold a hearing for any purpose within the scope of the insurance code as he "may deem necessary." A ruling that the AHPs and Cambia lack standing would unduly delay resolution of important issues affecting health insurance in Washington State. Deciding these Matters on the merits is in the public interest and necessary. Standing therefore exists under RCW 48.04.010(1).

Public importance.

The courts take a more liberal approach to standing where, as in the present Matters, a controversy is of substantial public importance, immediately affects significant segments of the population, and has a direct bearing on commerce, finance, labor, industry, or agriculture. *American Legion Post No. 149*, 164 Wn.2d at 595. The courts' liberal approach to standing is appropriate in the present administrative proceeding, given the importance of the issues to broad segments of the insurance-buying public. Even assuming other bases of standing were marginal, such liberal approach supports the determination that the AHPs and Cambia have standing.

OIC authority to review rate and form filings.

The AHPs and Cambia assert that the OIC lacked the authority to disapprove the 2014 Filings.

RCW 48.44.020(2)(f) authorizes disapproval of group health plans based on failure to conform to the minimum provisions or standards required by regulation made by the commissioner. One such regulation, WAC 284-43-125, provides: "Health 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.” The OIC therefore had the authority and duty to consider whether the 2014 Filings complied with Washington State and federal laws.

Further, RCW 48.02.060(1) broadly vests the commissioner with the authority “reasonably implied” from the provisions of the insurance code, as well as the authority expressly conferred therein. The OIC had the authority to review the 2014 Filings and to reject them if they failed to comply with specific Washington State or federal laws.

OIC disapproval of rate and form filings.

Standard of review.

Under RCW 34.05.570(3), a court will reverse an administrative decision if the decision, among other bases: 1) violates a constitutional provision on its face or as applied; 2) lies outside the agency’s lawful authority or jurisdiction; 3) is a result of an erroneous interpretation or application of the law; 4) is not based on substantial evidence; or 5) is arbitrary or capricious. The court reviews questions of law de novo, but the burden of demonstrating the invalidity of agency action is on the party asserting invalidity, and substantial weight is accorded to the agency’s interpretation of the statutes it administers. *See, Granton v. Washington State Lottery Commission*, 143 Wn. App. 225, 231 (2008).

In considering the present Order, which is an administrative action, I do not act as a reviewing court, but as the commissioner’s designee. I would not be properly discharging my responsibility if I entered an Order that was not well-grounded in law.

The OIC has asserted several bases under Washington State and federal laws for its January 15, 2014, disapproval of the 2014 Filings.

Washington State law.

RCW 48.44.020(3).

The OIC's disapprovals concluded that the AHPs' "rates, filed for various employers, were unreasonable in relation to the amount charged for the contract for one single employer." (Emphasis added.) The OIC disapproved and closed the AHPs' rate and form filings "under the authority of RCW 48.44.020(3)."

RCW 48.44.020(3) provides: "The commissioner may disapprove any agreement if the *benefits* provided therein are unreasonable in relation to the amount charged for the contract." (Emphasis added.)

The legislature is deemed to intend different meanings when it uses different terms. *State v. Roggenkamp*, 153 Wn.2d 614, 625 (2005). Further, in their ordinary meanings "benefits" and "rates" are not synonymous – benefits are advantages derived, and rates are amounts charged.

The OIC itself recognizes the distinction between benefits and rates. WAC 284-43-915 sets out the circumstances under which *benefits* will be found not to be unreasonable, e.g., where there is an actuarially sound estimate of incurred claims associated with the filing for the rate renewal period. None of these circumstances relate to the *rates* charged.

No substantial evidence was offered to support the proposition that the *benefits* – i.e., the advantages derived – under the AHPs are unreasonable in relation to the amount charged.

To the extent that the OIC relied on RCW 48.44.020(3) as the basis of its disapprovals of the AHPs, such reliance was the result of an erroneous interpretation or application of the law.

RCW 48.44.024(2).

RCW 48.44.024(2) provides: "Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.44.023(3)." (RCW 48.44.023(3) requires community rating for small employers.) RCW 48.44.024(2) exempts the AHPs from the small group market community rating requirements that would otherwise apply to small Participating Employers and permits rating at the Participating Employer level.

Federal law.

A "person aggrieved" should be able to rely on the provisions of law cited by the OIC as the basis for disapproval. However, I assume for purposes of this Order, without deciding, that even though the OIC incorrectly relied on RCW 48.44.020(3) for disapproval of the 2014 Filings, it may now rely on any sound basis for disapproval under Washington State or federal law. *See*, RCW 48.44.020(2)(f); WAC 284-43-125, above. This assumption is consistent with the importance of determining – if possible – all legal issues related to the 2014 Filings disapproval before the OIC acts on 2015 and 2016 filings.

RCW 48.44.024(2) clearly permits the AHPs to be rated at the Participating Employer level. Does a sound basis for disapproval nevertheless exist under federal law?

HIPAA non-discrimination provisions.

The OIC cites the Health Insurance Portability and Accountability Act ("HIPAA") "non-discrimination provisions" as a basis for disapproval of rating at the Participating Employer level.

26 C.F.R. Sec. 54.9802-1(c)(1)(i), provides: "A group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium

or contribution that is greater than the premium or contribution for a similarly situated individual ... enrolled in the plan *based on any health factor that relates to the individual or a dependent of the individual.*" (Emphasis added.)

26 C.F.R. Sec. 54.9802-1(d)(1) provides that the requirements of these provisions apply only within a group of individuals who are treated as similarly situated individuals, and a plan may treat 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." However, a classification based on any health factor is not a bona fide employment-based classification.

45 C.F.R. 146.121 generally prohibits discrimination against participants and beneficiaries based on health factors, but 45 C.F.R. 146.121(c)(2)(i) provides: "Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan." Example 1 under this subsection approves a higher per-participant rate based on an employer's higher claims experience, as long as no employee is singled out for higher rates based on *individual* claims experience (and no genetic information is used in computing the group rate).

HIPAA non-discrimination provisions do not apply to the AHPs: 1) The non-discrimination provisions prohibit discrimination at the *individual* level and do not restrict the amount that may be charged at the employer level. 2) A Participating Employer's employees and dependents need not be compared to other Participating Employers' employees and dependents – each Participating Employer's employees and dependents constitute a distinct group of "similarly situated individuals." 3) The express intent of the HIPAA non-discrimination provisions is to prohibit rates based on any "health factor that relates to the *individual* or a dependent of the

individual,” not to prohibit aggregate rating at the employer level. The AHPs do not base any rates on a health factor that relates to any individual employee or dependent.

To the extent that the OIC relied on specified HIPAA provisions as the basis of its disapprovals, such reliance was the result of an erroneous interpretation or application of the law.

Affordable Care Act.

The ACA adopted definitions from prior federal law, including the definition of “employer” in Section 3(5) of the Employee Retirement Income Security Act (“ERISA”): “The term ‘employer’ means 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.” 29 U.S.C. Sec. 1002(5).

A Section 3(5) employer, including a bona fide employer health plan, may group all employers together to determine whether the employer belongs in the small or large group market. *See*, 45 C.F.R. Sec. 144.103; 45 C.F.R. Sec. 146.145. Under the ACA, if an employer has 100 or fewer employees, it generally is subject to “small group market” rules, including community rating. 42 U.S.C. Sec. 300gg(a)(1)(A); 42 U.S.C. Sec. 300gg-91; 45 C.F.R. 144.103. I assume for purposes of this Order that the AHPs, each of which includes far more than 100 employees in total, are industry-specific bona fide Section 3(5) large employers.

The OIC asserts several bases for its view that, in contrast to prior federal law, the ACA requires that where an association qualifies as a Section 3(5) employer, an association health plan be rated at the association level.

The OIC cites a September 1, 2011, bulletin issued by the Centers for Medicare and Medicaid Services (“CMS”). A CMS bulletin is not an authoritative statement of federal law. But

even assuming the bulletin were considered to have evidentiary value, it does not discuss the permissibility of rating at the Participating Employer level, or refer to any statute or regulation that does so. Nor does the bulletin consider when health insurance coverage should be deemed to be in the small group market for community rating or other regulatory purposes.

The OIC cites *Fossen v. Blue Cross Blue Shield of Montana, Inc.*, 744 F. Supp. 2d 1096 (D. Mont. 2010) as supporting its view that federal law requires rating at the association level. *Fossen* was a pre-ACA case brought under a Montana statute prohibiting an insurer from charging an individual a higher premium for group health insurance based on his or her health status. Because the Montana statute was identical to an ERISA provision, 29 U.S.C. Sec. 1182(b), the court held that, since ERISA wholly preempts state law, the case must be analyzed under Sec. 1182(b).

The court noted that it is possible under ERISA for a “multiple employer welfare arrangement” to function as a single employer providing a group health insurance plan, but that the associations to which the individual employer at issue belonged were purchasing consortiums of unrelated employers with no genuine organizational relationship, and the associations therefore were not Section 3(5) employers.

Fossen held that ERISA permits an insurer to charge an employer group health plan a higher premium based on the health status of individual employees, so long as the increased premium is borne equally by all employees. *Fossen* did not hold that any federal law prohibits rate setting at the Participating Employer level where an association is a Section 3(5) employer.

The OIC cites to an October 16, 2014, email from Doug Pennington of the Center for Consumer Information and Insurance Oversight (“CCIIO”), the unit within CMS that helps to

implement ACA reforms and oversees implementation of private health insurance provisions. Mr. Pennington states that “it would appear to be inappropriate for a bona fide association to differentiate rating or premiums based on the underlying employers, but rather they should/could use general employee classifications to differentiate, which are allowed by an employer group under ERISA.”

The CCHIO does not have jurisdiction over the 2014 Filings. Mr. Pennington’s email does not discuss any specific federal statute or regulation, but instead only his opinion of what is “inappropriate.” The email does not provide helpful evidence of federal requirements.

The OIC cites 42 U.S.C. Sec 300gg(a)(1), the community rating provisions of the ACA applicable to plan years commencing on or after January 1, 2014:

- (1) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or *small group market* –
- (A) such rate shall vary with respect to the particular plan or coverage involved only by –
 - (i) whether such plan or coverage covers an individual or family;
 - (ii) rating area, as established in accordance with paragraph (2);
 - (iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c) [42 U.S.C. Sec 300gg-6(c)]); and
 - (iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and
 - (B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).
- (Emphasis added.)

However, this statute restricts rating in the individual and small group markets without addressing the rating of association health plans.

Finally, in its June 3, 2015, Response, the OIC references 45 CFR 154.102, which in its final version (August 16, 2011), provides: “Small group market has the meaning given under the

applicable State's rate filing laws, except that.... (2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage."

76 FR 54969, explains:

... [I]f an association is, in fact, sponsoring a group health plan subject to ERISA, the association coverage should be considered to be one group health plan and the number of employees covered by the association would determine the group size for purposes of determining whether the group health plan is sponsored by a small employer and subject to the rate review process.

In most situations involving association coverage, the group health plan will exist at the individual employer level and not at the association level, in which case the size of the individual employers in the association will determine whether the association coverage is subject to the rate review process. The Department of Labor (DOL) has jurisdiction over ERISA group health plans and, for private sector entities, the determination of whether the group health plan exists at the association level or the employer level is made under ERISA

76 FR 54969 therefore provides that in most situations involving association coverage, a group health plan will exist at the individual employer level and the size of the individual employers in the association will determine whether the association coverage is subject to the federal rate-review process. However, where – as in the present Matters – the association sponsors a group health plan assumed to be subject to ERISA, the association coverage is considered one group health plan and the number of employees determines the group size. The AHPs include far more than 100 employees, and they are not subject to small group market regulation.

Nothing in 45 CFR 154.102 or in the discussion at 76 FR 54969 prohibits rating an AHP at the Participating Employer level if this is permissible under State rate filing laws, as it is under RCW 48.44.024(2). Nor does any other cited federal authority prohibit this practice.

The OIC cites 42 U.S.C. Sec. 300gg-23 for the proposition that that ACA preempts RCW 48.44.024(2). However, this federal statute leaves state law undisturbed, except to the extent it prevents the application of Sec. 300gg et seq.:

- (a) Continued applicability of State law with respect to health insurance issuers.
- (1) In general. Subject to paragraph (2) and except as provided in subsection (b) of this section, this part [42 U.S.C. Sec. 300gg et seq.] and part C of this subchapter [42 U.S.C. Sec. 300gg-91 et seq.] insofar as it relates to this part [42 U.S.C. Sec. 300gg et seq.] *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 issues 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* [42 U.S.C. Sec. 300gg et seq.].
- (Emphasis added.)

As discussed above, RCW 48.44.024(2) does not prevent the application of any requirement of 42 U.S.C. Sec. 300gg et seq. cited by the OIC and is therefore not preempted.

In sum, to the extent that the OIC relied on specified provisions of the ACA as the basis of disapproval, such reliance was the result of an erroneous interpretation or application of the law.

Equitable considerations.

The OIC asserts that the AHPs “cherry-pick” employers with younger, healthier workers, forcing less desirable employers and workers to enter the uncompetitive, high-premium, individual health insurance marketplace. The AHPs assert that if the OIC requires current enrollees to transfer to other plans, they face the risk of higher premiums and reduced benefits.

Whatever the merits of these competing assertions, I base this Order on my understanding of applicable law, not on an attempt to balance the equities.

The Washington State Legislature could address the OIC’s “cherry-picking” and other concerns about association health plan rating practices by repealing or amending RCW

48.44.024(2). Future federal legislation or regulations could preempt that statute. However, as long as RCW 48.44.024(2) exists in its present form and is not preempted, the AHPs may be rated at the Participating Employer level.

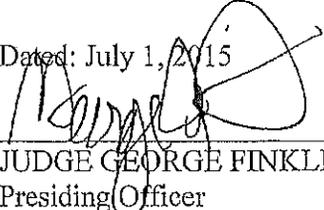
Summary.

The AHPs and Cambia have standing to pursue the present Matters. The OIC had the authority to review the 2014 Filings and to reject them if they failed to comply with specific Washington State or federal laws. No Washington State, or federal, statute or regulation prohibits rating at the Participating Employer level.

Ruling.

The OIC Staff's Motion for Summary Judgment is denied. The Motion for Summary Judgment by MBA Trust, BIAW Trust, NMTA Trust and Cambia is granted.

Dated: July 1, 2015



JUDGE GEORGE FINKLE (Ret.)
Presiding Officer

Pursuant to RCW 34.05.461(3), the parties are advised that they may seek reconsideration of this order by filing a request for reconsideration under RCW 34.05.470 with the undersigned within 10 days of the date of service (date of mailing) of this order.

Declaration of Mailing

I declare under penalty of perjury under the laws of the State of Washington that on the date listed below, I mailed or caused delivery through normal office mailing custom, a true copy of this document to the following people at their addresses listed above: Maren R. Norton, Renee M. Howard, Earle J. Hereford, Mike Kreidler, James T. Odiorne, J.D., CPA, Molly Nollette, Charles Brown and AnnaLisa Gellermann.

DATED this 1st day of July, 2015.



KELLY A. CAIRNS