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BEFORE THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

IN THE MATTERS OF:

Docket Nos. 15-0062; 15-0071; 15-0075; 15-0078; 15-0079 and 15-084

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

DECLARATION OF JERRY BELUR IN
SUPPORT OF MBA TRUST, BIAW
TRUST, NMTA TRUST, AND CAMBIA'S
OPPOSITION TO OIC STAFF'S MOTION
FOR SUMMARY JUDGMENT

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")

SECOND BELUR DECLARATION - 1

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PHONE 206.462.0000
FAX 206.462.0000

2
3 I, Jerry Belur, declare under penalty of perjury under the laws of the State of
4 Washington that I am over the age of eighteen, I am competent to make this declaration, and
5 make it upon personal knowledge.

6 1. I am Chief Executive Officer of EPK & Associates, Inc. (EPK). I have held
7 this position since 1999. EPK is the third party administrator of the Master Builders
8 Association of King and Snohomish Counties Employee Benefits Group Insurance Trust
9 (MBA Trust), of the Building Industry Association of Washington Health Insurance Trust
10 (BIAW Trust), and of the Northwest Marine Trade Association Health Trust (NMTA Trust),
11 sometimes together called the AHPs.
12

13 2. I have reviewed the May 5, 2015 Declaration of Jim Keogh, Policy and Rules
14 Manager for the Policy Division of the Office of the Insurance Commissioner (OIC), that the
15 OIC submitted in support of its Motion for Summary Judgment ("Keogh Decl."). In that
16 declaration and accompanying charts, Mr. Keogh makes many sweeping statements regarding
17 the rating practices of association health plans that are simply not true regarding MBA Trust,
18 BIAW Trust, and NMTA Trust.
19

20 3. For example, Exhibit A to Mr. Keogh's declaration is a chart, which according
21 to Mr. Keogh, "demonstrates the difference in the premiums between the oldest and youngest
22 enrollees in small group health plans and association health plan." Keogh Decl. ¶ 8. Mr.
23 Keogh broadly states, without reference to any particular association health plan, that "for
24 association health plans, older enrollees were charged as much as 8 times what the youngest
25 enrollees in a plan were charged." *Id.*
26

1 4. The Participating Employers¹ in the MBA Trust and BIAW Trust are uniformly
2 engaged in the building and construction industries. Thus, to the extent that these AHPs enroll
3 more younger males than an association health plan operating in a different industry, or a
4 particular plan offered in the small group market, this reflects the nature of the demographic
5 engaged in the building and construction industries.
6

7 5. Collectively, 35.1% of the Members of MBA Trust, BIAW Trust and NMTA
8 Trust are over 50 years of age. See Exhibit 1. This exceeds the percentage of enrollees over
9 50 in the small group market cited by Mr. Keogh in his declaration (25%) and contradicts his
10 unsupported assertion that “a significant number of employees over 50 are being priced out of
11 the association health plan market.” Keogh Decl., ¶ 10.
12

13 6. Mr. Keogh asserts that “particularly for women in child bearing years,
14 association health plans charge significantly more for women than for men.” Keogh Dec. ¶

15 11. Mr. Keogh makes this statement categorically, without reference to any particular
16 association health plan. The age-banded rates offered to MBA Trust, BIAW Trust and NMTA
17 Trust Participating Employers, however, are not gender based. In fact, gender-based rating
18 factors are not used at all in the AHPs’ rate structures. Thus, there is no difference in the rate
19 paid by a Participating Employer’s female employee of child bearing age and a same-aged
20 male employee. As such, it is simply untrue that a woman of child bearing years would pay a
21 higher premium than a same-aged man under the rating methodologies used by MBA Trust,
22 BIAW Trust and NMTA Trust.
23

24 _____
25 ¹ Capitalized terms not defined in this declaration have the meaning given to them in
26 the Motion for Summary Judgment filed by MBA Trust, BIAW Trust, NMTA Trust, and
Cambia.

1 7. Under the Trust Agreements for the AHPs, Participating Employers are
2 required to pay a minimum of 75% of the premium costs for their employees. The vast
3 majority of the Participating Employers choose to pay 100% of their employees' premium
4 costs. Thus, for the vast majority of Members who receive health care coverage through
5 MBA Trust, BIAW Trust and NMTA Trust, any premium cost variance that might exist
6 among the rate categories is borne 100% by the Participating Employers.

7
8 8. The large premium disparity between older and younger employees cited by
9 Mr. Keogh in Chart 1, Exhibit A, to his declaration is simply untrue for MBA Trust, BIAW
10 Trust and NMTA Trust. To the contrary, for a market plan with a \$1,000 annual deductible
11 offered by MBA Trust, BIAW Trust, and NMTA Trust, the premium for a 64-year-old
12 employee is on average just 2.8-2.9 times greater than the premium paid by the youngest
13 employee. See Exhibit 2. This premium differential between the youngest and oldest
14 enrollees is well under the state's small group market limit of 3.7 (which does not apply to
15 association health plans) and well below the "8 times" figure claimed by Mr. Keogh in his
16 declaration. As noted above, the vast majority of the AHPs Participating Employers cover
17 100% of the cost of their employees' premiums, and thus for those employees any premium
18 differential is borne entirely by their employer.

19
20
21 9. Mr. Keogh opines that association health plans' "selection of the best risk, and
22 rejection of the worst risk, likely accounts for the majority of the difference in the premiums
23 between small group health plans, and association health plans." Keogh Decl., ¶ 14. Again, he
24 makes this statement categorically without identification of any specific association health
25 plans. Accusing MBA Trust, BIAW Trust or NMTA Trust of "cherry picking" their enrollees
26

1 would ignore reality. In 2014, 20% of requests for quotes for these AHPs came from
2 companies that have never had group health insurance. As such, no current rate or plan
3 information is available for these companies, nor is any health status information collected
4 from the employees of such companies (or from any other companies participating in the
5 Trust). Without this type of information, there is simply no way for the AHPs to “select the
6 best risk and “reject the worst risk.” To the extent that the OIC objects to the risk
7 stratification that occurs with industry-aligned association health plans, that objection has no
8 legal consequence, as association health plans remain a lawful, legitimate and important
9 vehicle for providing healthcare benefits to Washington citizens unless and until the
10 Washington State Legislature changes the law.

11
12
13 10. Exhibit A-5 to Mr. Keogh’s declaration provides an inapposite comparison of
14 “sample plan rates” among offices of certified public accountants, carpentry contractors, and
15 offices of optometrists. He does not explain how those comparisons (and his assertion that
16 “rates within AHPs can vary by up to 27% depending on the type of business”) might apply to
17 MBA Trust, BIAW Trust, and/or NMTA Trust. These AHPs are each bona fide association
18 health plans and thus none has Participating Members in disparate industries. In any event,
19 for MBA Trust, there is only a 12.4% difference between the highest and lowest rate paid by
20 Participating Employers in a sample set of representative sub-industries (sprinkler, plumbing,
21 painting, mechanical, roofing and concrete companies). See Exhibit 3. For BIAW Trust,
22 there is a 15.5% difference between the highest and lowest rate paid by Participating
23 Employers in a sample set of representative sub-industries (heating and cooling, general
24 contractor, paving, roofing, landscaping companies). See Exhibit 4. For NMTA Trust, there

1 is only a 6.3% difference between the highest and lowest rate paid by Participating Employers
2 in a sample set of representative sub-industries (yacht charter, marina, boat manufacturer,
3 fishing supplies, propeller manufacturer, yacht club). See Exhibit 5. As noted above, the vast
4 majority of these AHPs' Participating Employers pay 100% of their employees' premium
5 costs, and therefore any rate variance among employees in different sub-industries is absorbed
6 by those Participating Employers.
7

8 11. If a Participating Employer is not satisfied with the options and affordability of
9 the health plans available for its employees, it is free to find other sources of health care
10 coverage. MBA Trust's, BIAW Trust's, and NMTA Trust's Participating Employers are
11 incredibly satisfied with their health benefits. MBA Trust, the longest operating of the three
12 AHPs, has an average retention rate for its health benefit plans of between 85 and 90 percent
13 over the past twenty years. Factors that our Participating Employers and Members find
14 valuable and that keep our health plans competitive and affordable include our innovative plan
15 designs, wellness initiatives, free preventive care (offered eight years before passage of the
16 Affordable Care Act), and trust requirements that provide for a more stable pool (such as
17 requiring Participating Employers to pay 75% of employee costs, and that 80% of all eligible
18 employees enroll in the plan).
19
20

21 12. In its summary judgment motion, the OIC contends that "two identically
22 situated plan participants with the same job classification, collective bargaining unit,
23 geographic location, and hours may pay widely divergent rates for the same benefit package."
24 OIC's Motion at 19. This is demonstrably false. A collective bargaining unit is, by necessity,
25 a unit involving employees from a single Participating Employer. Similarly, job
26

1 classifications are employer-specific. Because all employees of a Participating Employer are
2 assigned to the same Risk Category, similarly situated employees in the same collective
3 bargaining unit and same job classifications cannot be charged the “widely divergent rates”
4 that the OIC claims. There is no situation where the above could occur with respect to the
5 Plans offered by the AHPs.
6

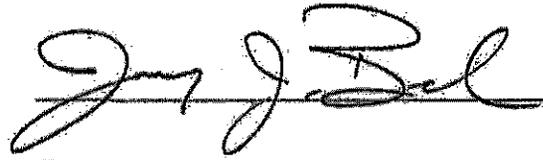
7 13. Contrary to the OIC’s contention, MBA Trust, BIAW Trust, and NMTA Trust
8 are each aggrieved by the OIC’s Disapprovals. If Regence is required to set rates at the
9 association level and thus impose the same rates on all Participating Employers, the rates
10 assigned to many Participating Employers will increase substantially. Those Participating
11 Employers with higher rates are likely to leave the AHPs and obtain health insurance
12 elsewhere. These circumstances and market disruption will in turn impair the AHPs’ ability to
13 effectively compete for healthcare benefit business for employers falling within certain
14 demographics. Instead, its membership will be limited to an aging demographic that will not
15 be sustainable in the long term. In addition, the AHPs’ per-member administrative costs will
16 increase with reduced enrollment.
17

18 14. The OIC’s Disapprovals are not the agency’s first attempt to restrict the rating
19 practices of association health plans. In 2013, the OIC requested comments on its proposed
20 rulemaking (WSR 13-20-141) that would have required issuers to rate large group plans
21 issued through an association based on the overall experience of the entire association, and not
22 use data or information from a specific group purchaser of the association’s health benefit
23 plan to establish rates for that group purchaser. MBA Trust submitted comments and
24 expressed its objections to the proposed rulemaking, noting that the proposed rule conflicted
25
26

1 with the Affordable Care Act as well as Washington law governing association health plans,
2 among other defects. See Exhibit 6 (letter from Patrick Lennon, MBA Trust Board Chair, to
3 OIC dated Nov. 5, 2013). The OIC did not adopt the proposed rules.
4

5 I declare under penalty of perjury under the laws of the State of Washington that the
6 foregoing is true and correct to the best of my knowledge.

7 SIGNED at Bellevue WA this 19th day of May, 2015.
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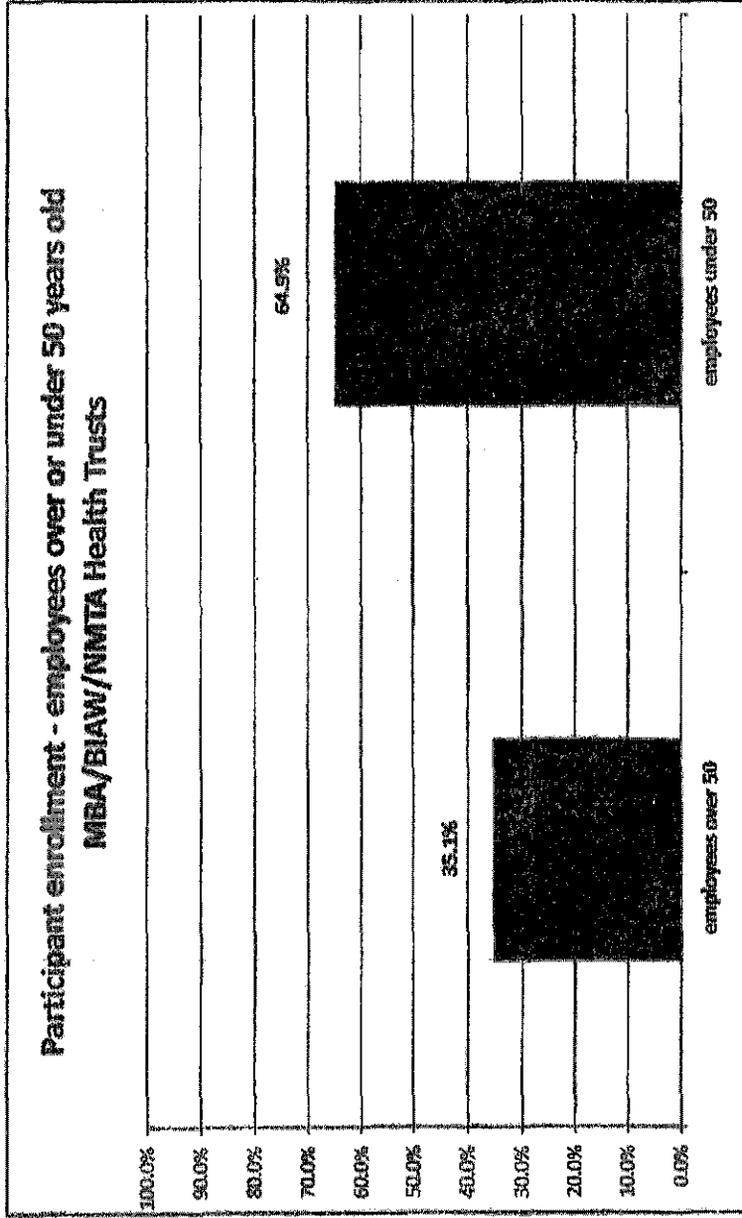
11 Jerry Belur
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27 SECOND BELUR DECLARATION - 8

Beckins Cole LLP
1201 THIRD AVENUE, SUITE 4900
SEATTLE, WA 98101-3099
PHONE: 206.359.8000
FAX: 206.359.2000

EXHIBIT 1

**Participant enrollment - employees over or under 50 years old
MBA/BIAW/NMTA Health Trusts**



Mar-15

MBA Health Trusts			
employees over 50	9,306	34.9%	
employees under 50	17,377	65.1%	
TOTAL	26,683	100%	

NMTA			
employees over 50	3,934	39.4%	
employees under 50	7,328	60.6%	
TOTAL	11,262	100%	

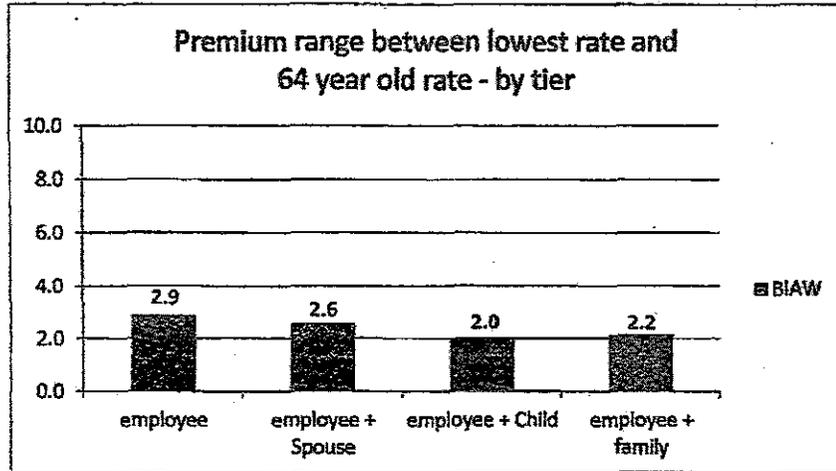
TOTAL			
employees over 50	14,010	35.1%	
employees under 50	25,887	64.9%	
TOTAL	39,897	100%	

EXHIBIT 2

Premium difference - lowest rate and 64 year old rate

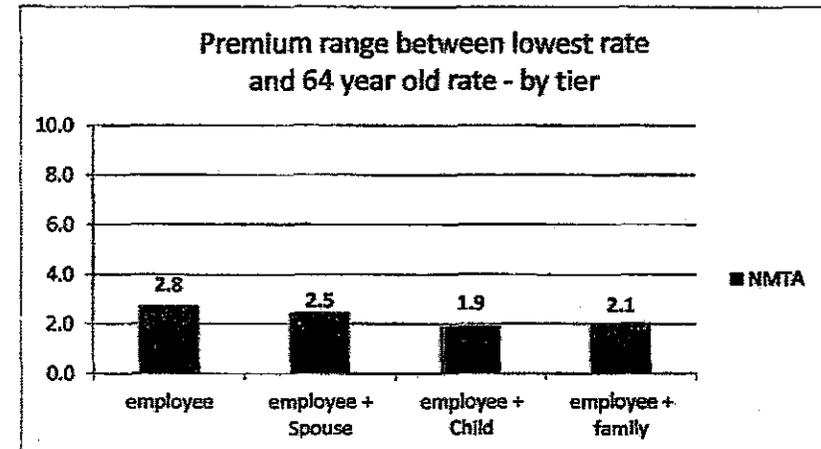
Mar-15

BIAW	employee	employee + Spouse	employee + Child	employee + family
	2.9	2.6	2.0	2.2



Note: \$1,000 deductible - Market plan used for data set among all three association health plans

NMTA	employee	employee + Spouse	employee + Child	employee + family
	2.8	2.5	1.9	2.1



MBA	employee	employee + Spouse	employee + Child	employee + family
	2.8	2.5	1.9	2.1

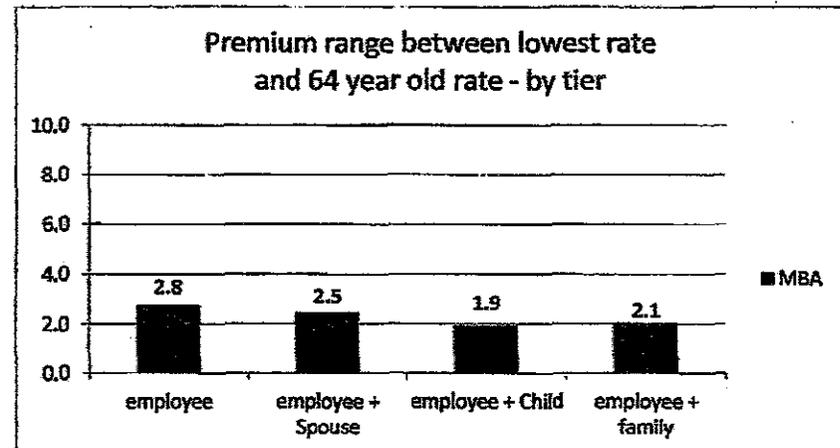
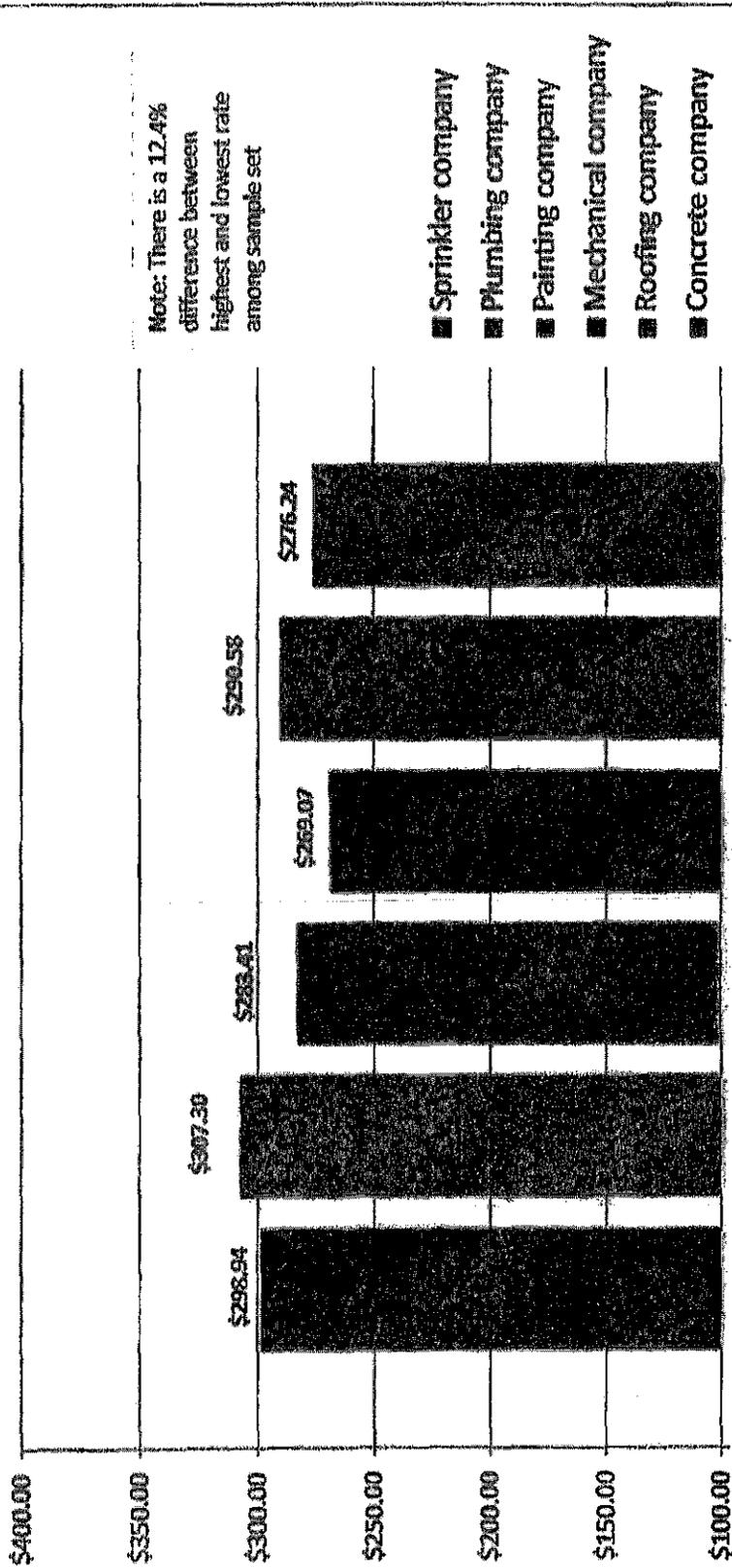


EXHIBIT 3

Rate variation among different business types - MBA Health Trust



Note: There is a 12.4% difference between highest and lowest rate among sample set

Sample plan rates - \$1,000 deductible - under 35 age bracket

EXHIBIT 4

Rate variation among different business types - BIAW Health Trust

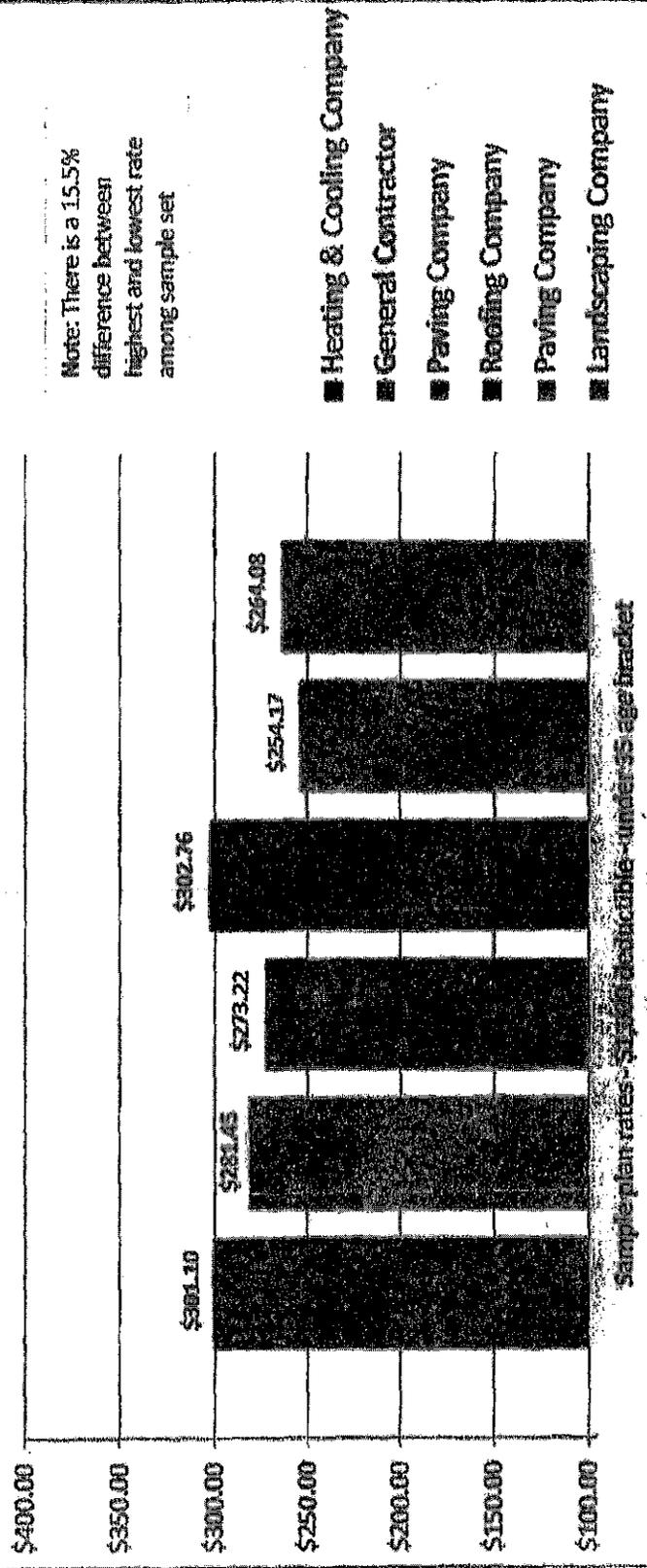
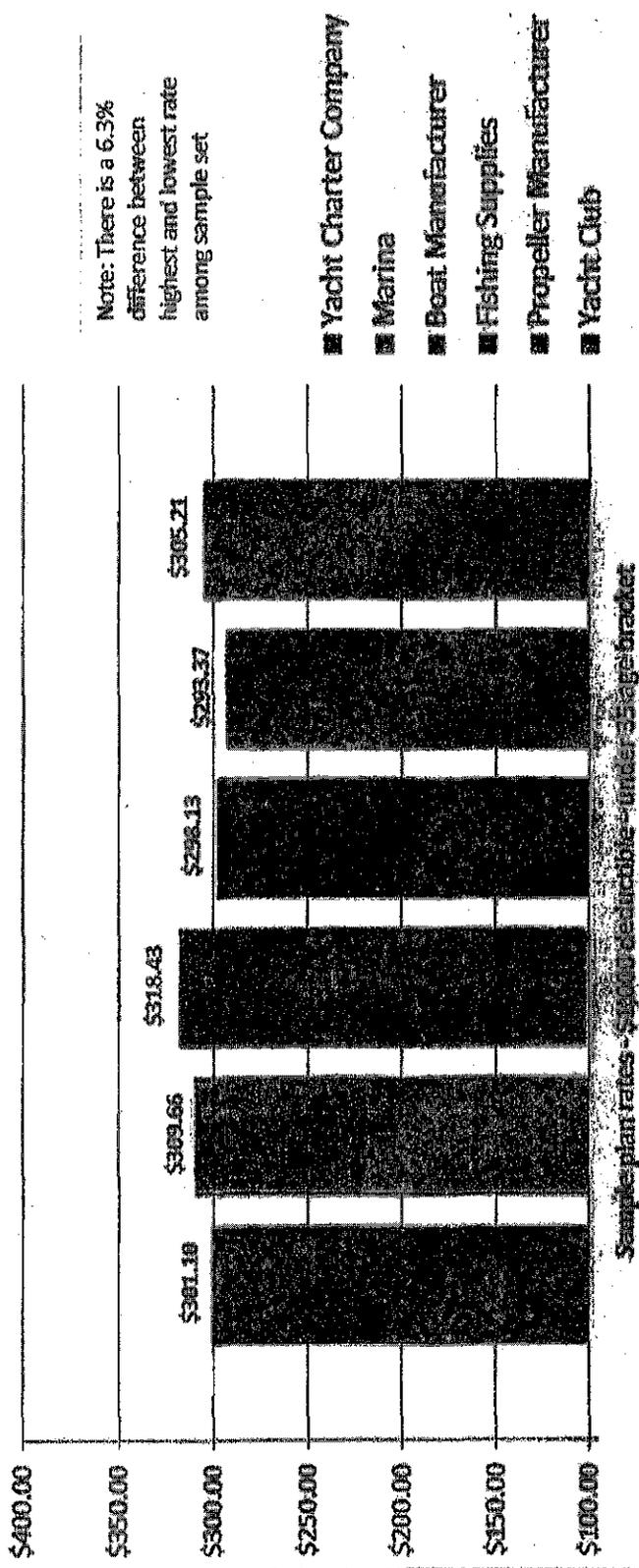


EXHIBIT 5

Rate variation among different business types - NMTA Health Trust



Note: There is a 6.3% difference between highest and lowest rate among sample set

Sample plan rates - \$5000 deductible - under 25 age bracket

EXHIBIT 6



November 5, 2013

**Via Overnight Delivery
and Email (rulescoordinator@oic.wa.gov)**

Office of the Insurance Commissioner
Attn: Meg L. Jones
P.O. Box 40258
Olympia WA 98504

**Re: Response to Request for Comments on Proposed Rule Making WSR 13-20-141
(Oct. 2, 2013)**

Dear Office of the Insurance Commissioner:

The Master Builders Association Health Insurance Trust ("MBA Trust") appreciates the opportunity to comment on the proposed regulation that the Office of the Insurance Commissioner ("OIC") is considering in relation to the market transition of health benefit plans for 2014.

The MBA Trust is the Northwest's largest industry-specific healthcare program, serving over 42,000 enrollees engaged in the building and construction industry. The members of the MBA Trust constitute a bona fide association of employers, and the welfare benefits provided to participating employees through the MBA Trust constitute an "employer" welfare benefit plan under Title I of the Employee Retirement Income Security Act ("ERISA"). For the reasons discussed below, the MBA Trust opposes the adoption of Section 4 of proposed regulation WAC 284-170-958. OIC Proposed Rule Making CR 102 ("Proposed WAC 284-170-958(4)") (Oct. 2, 2013).

Summary

Our comments below address the community rating requirements that the proposed regulation would impose on health plans obtained through bona fide "employer" associations beginning on January 1, 2014. Specifically, our comments address the provisions of the proposed regulation

OFFERED THROUGH THE MBA TRUST

ADMINISTERED BY: EPK & ASSOCIATES, INC. • 15375 SE 30TH PLACE, #380 • BELLEVUE, WA 98007
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requiring that “[a]n issuer . . . rate a large group plan issued through an association that meets the definition of subsection (1)(c) of this section based on the overall experience of the entire association” and that the issuer not “use data or information from a specific group purchaser of the association’s health benefit plan to establish rates for that group purchaser.” See Proposed WAC 284-170-958(4). The following is a summary of our comments, which are described in greater detail in the **Discussion** section that follows.

- I. The Proposed Regulation Conflicts with the Affordable Care Act.
- II. The Proposed Regulation Is Not Required to Implement Any Provision of Federal Law and Is Not Supported by Federal Regulations.
- III. The Proposed Regulation Conflicts with RCW 48.44.024 and RCW 48.44.023(3).
- IV. The OIC Lacks Authority Under Washington Law to Promulgate the Proposed Regulation.
- V. Because the Proposed Regulation Has No Basis in Washington Law It Is Preempted by ERISA.
- VI. Association Health Plans Are Excepted from Community Rating Requirements Under OIC Precedent and Guidance.
- VII. OIC Rule Making Order WSR 13-21-144 (Oct. 23, 2013) Violates the APA and Deprives the MBA Trust of Due Process of Law.

Discussion

I. The Proposed Regulation Conflicts with the Affordable Care Act.

Beginning on January 1, 2014, the federal Patient Protection and Affordable Care Act (“ACA”) will require adjusted community rating in the individual and small group health insurance markets. 42 U.S.C.A. § 300gg. The provision adopting community rating applies solely to “health insurance offered in the individual or small group market.” *Id.* Large, fully insured and self-funded “employers” that meet the requirements of Section 3(5) of ERISA do not fall within this requirement and are, therefore, exempt from community rating. *Id.* The proposed regulation, by requiring that an issuer rate a large group plan issued through an association based on the overall experience of the entire association and by forbidding the issuer from using data or information from a specific group purchaser to establish rates for that group purchaser, fails to recognize this exemption under the ACA for large employer groups.

The ACA's failure to include large group plans in its modified community rating requirements was not unintended. In fact, the same provision of the ACA that imposes these small group rating requirements—42 U.S.C. § 300gg—includes a “special rule” for the large group market, which, notably, does not impose wholesale community rating requirements on these groups, but rather, limits the requirements to issuers who offer coverage through state exchanges. 42 U.S.C. § 300gg(a)(5).

Thus, the framework of the ACA exempts issuers in the large group market from community rating requirements, and, by adopting these requirements through regulation, the OIC would contravene federal law if the proposed regulation were adopted in its current form.

II. The Proposed Regulation Is Not Required to Implement Any Provision of Federal Law and Is Not Supported by Federal Regulations.

The Notice of Rule Making states that the proposed regulation is necessary because of federal regulation at 45 C.F.R. § 150.101(2) and that the proposed regulation is implementing 45 C.F.R. § 147.140. The first regulation listed—45 C.F.R. § 150.101(2)—vests states with primary enforcement authority with respect to the requirements of Title XXVII of the Public Health Services Act (as amended by the ACA). 45 C.F.R. § 150.101(b)(2). Accordingly, the regulation vests states with no greater regulatory power than is mandated by the ACA. *Id.* As discussed above, the proposed regulation acts in derogation of the ACA by erasing the ACA's exemption from community rating requirements for fully insured and self-funded “employers” that meet the requirements of Section 3(5) of ERISA. Therefore, because the proposed regulation has no basis in the ACA, it cannot be necessary due to 45 C.F.R. § 150.101(b)(2), as the Notice indicates.

The second cited regulation—45 C.F.R. § 147.140—also cannot serve as an implementing authority for Section 4 of the proposed regulation. That regulation deals with grandfathered health plan coverage in the ACA, addressing, for example, (a) the definition of grandfathered health plan coverage, (b) general grandfathering provisions, and (c) the applicability of the ACA to grandfathered plans. *See* 45 C.F.R. § 147.140. None of these provisions require, or even allow for, the imposition of community rating requirements on large group plans. In fact, 45 C.F.R. § 147.140 is entirely silent about rate setting and is focused instead on the transition of grandfathered health plans under the ACA, which, as noted, does not impose community rating on large group association health plans (“AHPs”).

In the Notice's discussion of the purpose of the proposed regulation, the Notice correctly states that “[b]eginning January 1, 2014, newly applicable federal health plan form and rating requirements for individual and small group plans require discontinuation and replacement of nongrandfathered health plans.” Proposed WAC 284-170-948(4). However, the clause stating that “the requirements affect not just the commercial individual and small group market, but also

coverage issued through associations or member governed groups to individual and small group purchasers” has no basis in the ACA. *Id.* No other supporting authority is listed.

Because the proposed regulation is not supported by the ACA or 45 C.F.R. § 150.101(2), proposed WAC 284-170-958(4) should be stricken from the rule.

III. The Proposed Regulation Conflicts with RCW 48.44.024 and RCW 48.44.023(3).

Washington law requires that a health care services contractor offering health benefit plans to a small employer develop its rates based on an adjusted community rate. *See* RCW 48.44.023(3). The community rating requirement imposed by the statute is limited, however, by RCW 48.44.024, which explicitly and unambiguously exempts employers purchasing health plans through associations from community rating. *See* RCW 48.44.024 (“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) [community rating]”). Although the proposed regulation tracks the language of RCW 48.44.023(3), it neglects to address the statutory exemption for AHPs included in RCW 48.44.024, and therefore it is inconsistent with existing state law.

In strikingly similar circumstances, a Washington court in 2007 held that requiring exempt entities to use community rating violates these statutes. In *Associated Industries of Inland Northwest v. Washington OIC*, No. 2007-02-00592-1 (Wash. Super. Ct. 2007), the court addressed the legality of the OIC’s Technical Assistance Advisory (TAA) T06-07 (2006). The TAA at issue was, in effect, identical to the proposed regulation here, as the TAA adopted the position that “[r]ates must be based on the health of the *entire association group*.” *Id.* at 3. The plaintiff (an AHP) contended that TAA 06-07 eviscerated the AHP exception for community rating requirements carved out by RCW 48.44.024 and therefore violated the separation of powers doctrine because the OIC, as an executive agency, did not have the power to enact—or overturn—legislation. *Id.* at 4. The court agreed, finding that legislative intent and the statutory language in RCW 48.44.023(3) established that AHPs were exempt from community rating requirements. *Id.* at 4-5. In reaching its holding, the court reasoned that:

The plaintiffs have been operating under [the understanding that AHPs are exempt] for over 12 years and have “experience rated” employer members. The OIC did not officially disagree with plaintiff’s interpretation until the promulgation of TA 06-07 in December 2006.

This court’s view is that the plaintiffs had a right to proceed on the statutory exemption. Their interpretation of that exemption remained unchallenged for over a decade. . . . TA 06-07 amounts to a major policy shift from the plaintiff’s perspective. Policy is made by the legislature. The legislature should make the

decision. More than a decade has past [sic] since the legislation was enacted, if the legislature believes it is time for a change they will act.

Id. at 4-5. The same reasoning is equally compelling for evaluating proposed WAC 284-170-958(4)—the OIC cannot by regulation overturn existing state law, and therefore its proposed rule is invalid.

IV. The OIC Lacks Authority Under Washington Law to Promulgate the Proposed Regulation.

The Notice of Rule Making cites RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050 and 48.46.200 as statutory authority for adopting the rule. None of these provisions, however, vests the OIC with authority to implement a regulation that contravenes the Washington Insurance Code.

RCW 48.02.060 permits the OIC to “make reasonable rules for effectuating any provision of [the Insurance Code].” RCW 48.02.060(3)(a). However, there is no provision of the Washington Insurance Code that the proposed regulation will effectuate. Rather, as discussed above, WAC 284-170-958(4) directly conflicts with the Insurance Code. RCW 48.43.700 is not relevant to the proposed regulation as it instead addresses health plans offered through state exchanges. RCW 48.43.715 is also not relevant because it is limited to individual and small group markets and essential health benefits requirements. It therefore cannot serve as the authority for the community rating requirements that would apply to large group AHPs included in the proposed regulation.

The fourth and fifth statutes cited in the Notice are general enabling provisions.¹ These provisions cannot serve as authority for the proposed regulation because the relevant laws in Chapter 48 of the Washington Insurance Code explicitly *exempt* AHPs from community rating requirements. Therefore, the proposed regulation is not a “reasonable regulation” that is “necessary or proper” to effectuate the Code; rather, it directly contravenes it.

Because none of the provisions above support proposed WAC 284-170-958(4), the rule lacks a necessary foundation in Washington law.

V. Because the Proposed Regulation Has No Basis in Washington Law It Is Preempted by ERISA.

¹ RCW 48.44.050 states that “[t]he insurance commissioner shall make reasonable regulations in aid of the administration of [Chapter 48 of the Insurance Code],” while RCW 48.46.200 states that “[t]he commissioner may, in accordance with the provisions of the administrative procedure act, chapter 34.05, promulgate rules and regulations as necessary or proper to carry out the provisions of this chapter.”

Section 514 of ERISA makes void all state laws to the extent that they “relate to” employer-sponsored health plans. 29 U.S.C.A. § 1144(a) (“the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”). The Supreme Court interprets this clause expansively. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983) (“Congress used the words ‘relate to’ in § 514(a) in their broad sense”); *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129 (1992) (“a law ‘relate[s] to’ a covered employee benefit plan for purposes of § 514(a) if it has a connection with or reference to such a plan”) (internal quotation marks and citations omitted). However, ERISA’s “savings clause,” Section 514(b)(2)(A), provides that a state law that “relates to” an employee benefit plan will not be preempted if it is a law that regulates insurance. 29 U.S.C. § 1144(b)(2)(A).

As discussed above, the association community rating provision of the proposed regulation has no basis in Washington law and directly conflicts with RCW 48.44.023(3) and 48.44.024. There is, therefore, no state statute regulating insurance that the proposed regulation would implement. As such, the regulation if adopted cannot fall within the scope of ERISA’s “savings clause.” Because the regulation would not fall within the “savings clause” and would directly “relate[] to” employer-sponsored health plans, it is preempted by Section 514 of ERISA.

VI. Association Health Plans Are Excepted from Community Rating Requirements Under OIC Precedent and Guidance.

For decades, the OIC’s sub-regulatory guidance has recognized that, under both state and federal law, AHPs are exempt from community rating requirements. For instance, in a letter dated September 25, 2012 from the Insurance Commissioner to the Master Builders Association of King County, the Commissioner stated that “under the federal Affordable Care Act, small group employers’ health plans for their employees obtained through associations will be community rated beginning in 2014, *unless the association constitutes an “employer” under ERISA Sec. 3(5).*” Letter from Mike Kreidler, Wash. Ins. Comm’r, to Sam Anderson, Exec. Officer, Master Builders Ass’n of King & Snohomish Cntys. (Sept. 25, 2012). (emphasis added). In this letter, the Commissioner confirmed that the participating employers in the MBA Trust are entitled to act as an “employer” under ERISA and therefore, by implication, are exempt from community rating requirements. Likewise, in its June 6, 2013 presentation to carriers “to provide clear direction. . . regarding upcoming changes for 2014,” the OIC reiterated that “associations which qualify as True Employer Health and Welfare Benefit Plans under ERISA will continue to be treated as large group . . . by both state and federal regulators . . . [and] rates will be established by pooling the experience of the large group.”

The OIC’s historical recognition of AHP exemption from community rating requirements is further evidenced by the fact that the OIC made no attempt to alter this regime when it issued emergency Rule Making Order CR-103E on June 28, 2013. Specifically, the emergency rule,

WAC 284-170-958 (which closely tracks the current proposed WAC 284-170-958(4)), does not address community rating within qualifying “employer” associations. The language from Section 4 of the proposed regulation was apparently added only after the promulgation of the June 28 emergency rule and represents a radical departure from any prior guidance issued by the OIC. As a result, the emergency regulation’s goal of effectuating “an orderly market transition from noncompliant plans that must be discontinued” is frustrated.² OIC Rule Making Order CR-103E, at 1 (June 28, 2013).

Assuming that the proposed regulation does, in fact, take effect on November 8, 2013, AHPs will have only weeks to restructure their rating practices. Given the OIC’s consistent recognition of the exemption from community rating under federal law for AHPs, this restructuring will come with little notice and high cost. In addition, OIC’s plan to adopt the proposed regulation only two days after the public hearing and comment submission deadline, will likely violate multiple provisions of the Washington Administrative Procedure Act (“APA”). For example, the APA requires that, prior to adopting a final rule, the agency must summarize and respond to “all comments received regarding the proposed regulation, and to the comments by category or subject matter, indicating how the final rule reflects agency consideration of the comments, or why it fails to do so.” RCW 34.05.325(6)(a)(iii). It is highly unlikely that a court would find that the OIC could fulfill this requirement in a two-day window.

VII. Rule Making Order WSR 13-21-144 (Oct. 23, 2013) Violates the APA and Deprives the MBA Trust of Due Process of Law.

On October 23, 2013, the OIC filed Rule Making Order WSR 13-21-144 with an effective date of only three days later, on October 26, 2013. This emergency rule constitutes both a violation of the APA and the Fourteenth Amendment to the United States Constitution.

Here, the OIC claims that the APA permits it to adopt an emergency rule because it is necessary for the preservation of the public health, safety or general welfare and taking the time to observe the notice and comment requirements of permanent rule making would be contrary to the public interest. RCW 34.05.350. In order to adopt an emergency rule under this statute, however, the rule making order must make an *express* finding of the emergency on which the agency is relying. *Mauzy v. Gibbs*, 44 Wn. App. 625, 630-32 (1986). Specifically:

When an agency must announce its reasons for declaring an emergency that requires protection of the public health or welfare, and attempts to justify dispensing with public notice and comment, the reasons should be truly emergent and persuasive to the reviewing court. . . . Therefore, the finding of facts that

² The emergency rule just filed on October 23 replacing the June 28 emergency rule contains the offending provision at WAC 284-170-958(4).

constitute an “emergency” must be more than mere statements of the motivation for the enactment and must provide an adequate basis for judicial review.

Id. In WSR 13-21-144, the OIC identifies no emergency to justify the near-immediate imposition of community rating requirements on large group AHPs. Instead, the OIC states that the emergency rule was designed to effectuate an “orderly market transition from noncompliant plans that must be discontinued, to replacement plans that must be in place by the next renewal date,” noting in addition that “of particular concern is that health plan issuers will adjust renewal dates to lengthen the period of time enrollees remain on noncompliant plans after January 1, 2014.” OIC, Emergency Rules, WSR 13-21-144 (Oct. 23, 2013). The OIC’s basis for the rule constitutes nothing more than “mere statements of the motivation for [its] enactment,” as opposed to express findings of an actual emergency that justifies its imposition. *Mauzy*, 44 Wn. App. at 631. In addition, the OIC identified no findings of fact constituting truly emergent and persuasive circumstances justifying the order.

The lack of an actual emergency here is evidenced by the fact that the emergency order and the proposed regulation include identical rules and are intended to effectuate the same goal (orderly transition of noncompliant plans). As a practical matter, however, that goal is not more likely to be achieved by an emergency rule that goes into effect on October 26 (with no notice and comment) than by a proposed rule that would become permanent thirteen days later on November 8, assuming the proposed regulation is adopted. In the absence of findings supporting such, the OIC’s emergency rulemaking order, WSR 13-21-144, is invalid and should be immediately withdrawn, at least with respect to Section 4 of WAC 284-170-958, which was advanced for the first time in OIC’s October 2013 proposed rule and was not even part of the agency’s June 2103 emergency rulemaking that was replaced by the October 26 emergency rule.

If WSR 13-21-144 is not immediately withdrawn, its adoption will deprive MBA Trust of its procedural due process rights. Before an entity is deprived of a protected property interest, it must be afforded an opportunity for some kind of a hearing, “except for extraordinary situations where some valid governmental interest is at stake that justifies postponing the hearing until after the event.” *Boddie v. Connecticut*, 401 U.S. 371, 379 (1971). It is fundamental “that except in emergency situations . . . due process requires . . . notice and opportunity for hearing appropriate to the nature of the case.” *Bell v. Burson*, 402 U.S. 535, 542 (1971). Courts have recognized that, by enacting emergency regulations, agencies may run afoul of these requirements. *See, e.g., Pac. Nw. Venison Producers v. Smitch*, No. C92-1076WD, 1992 WL 613294 (W.D. Wash. Sept. 2, 1992), *aff’d in part*, 20 F.3d 1008 (9th Cir. 1994) (applying a procedural due process claim to Washington State Wildlife Commission emergency regulations). Here, the MBA Trust has a protected property interest in its ability to remain competitive in the health benefit market by applying rating factors to individual purchasers consistent with existing state and federal law. In addition, there are procedures in place—namely notice and comment procedures with respect to

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the proposed WAC 284-170-958(4)—that are designed to protect this interest. By foregoing notice and comment, OIC deprives MBA Trust of due process of law.

If the OIC declines to withdraw WSR 13-21-144, the MBA Trust will be left with no other option than to consider seeking immediate judicial review of all OIC actions involving both the emergency rules and the proposed regulation.

Conclusion

For the above reasons, the MBA Trust respectfully submits that WSR 13-21-144 be immediately withdrawn and that WAC 284-170-958(4) be stricken from the final rule and Rule Making Order.

Respectfully submitted,


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MBA Trust Board Chair

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