

Received **FILED**
MAY - 6 2015
2015 MAY - 6 4:44
Insurance Commissioner

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

In the Matter 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 No. 15-0062; 15-0071;
15-0075; 15-0078; 15-0079; and
15-0084

OIC STAFF'S MOTION FOR
SUMMARY JUDGMENT

NATURE OF CASE

1
2 Three associations, Master Builders Association of King and Snohomish Counties
3 (“MBA”), Building Industry Association of Washington (“BIAW”) and Northwest Marine
4 Trade Association (“NMTA”), and an insurance holding company, Cambia Health Solutions
5 (“Cambia”), challenge the OIC’s disapproval of the rate filings for the 2014 large group plans
6 sold by Regence Blue Shield (“Regence”) to the three associations. At the heart of these
7 hearing demands is the allegation that the “OIC erroneously treats (the association) as a single
8 employer, asserting that it must file a single rate at the association level.” (Cambia Hearing
9 Demand, page 1; MBA and BIAW Hearing Demands, page 2; and NMTA Hearing Demand,
10 page 2.) The carrier that actually submitted the filings, Regence, has not challenged the
11 disapproval of its rate filings, and none of the hearing demands identifies any legal right
12 belonging to any of the associations or to any association member to demand that Regence sell
13 them large group coverage rated according to the association’s preferred rating method. The
14 claim that the association must not be treated as a “single employer” at any rate is contrary to
15 the requirements of the Affordable Care Act and to the filings that Regence submitted
16 identifying each filing as a large group filing for the association as an association or member-
17 governed true employer group under 29 U.S.C. Section 1002(5) of ERISA.

20 The OIC staff believes that the associations and Cambia lack standing. The associations
21 have not demonstrated, and cannot demonstrate, that they suffered any harm or that any
22 purported harm they allege is anything other than speculative. An association cannot force a
23 carrier to offer it coverage rated according to the association’s preferences and the associations
24 have no interest that the OIC was required to consider in reviewing the carrier’s rating
25 methodology. Although Cambia may own the stock of Regence, Cambia is likewise a legal
26

1 stranger to these filings. The OIC staff believes the only entity that would have standing to
2 contest its disapproval of the carrier's rate filings is the carrier that submitted them, Regence,
3 and that no meaningful evidentiary review or effective relief is available in Regence's absence.

4 Even if these entities had standing to litigate someone else's filing, their claim that the
5 association must not be treated as a "single employer" is contrary to the requirements of the
6 Affordable Care Act and to the filings that Regence submitted identifying the filings as large
7 group filings for each association as an association or member-governed true employer group
8 under 29 U.S.C. Section 1002(5) of ERISA. Because the Affordable Care Act permits large
9 group plans to be issued to an association comprised of small common law employers only if
10 the association itself constitutes an ERISA employer, the claim of Cambia and each association
11 that the association must not be treated as a single employer is simply wrong as a matter of
12 federal law. The second part of the Appellants' claim misconstrues the OIC's position and falls
13 with the first. The OIC did not require a single rate for all participating employees. It simply
14 required that the plans be rated as they were filed, at the association level and as a single
15 employer large group plan. The carrier's multiple rate tiers are unacceptable, not because of
16 their number, but because they improperly rate at the individual, small employer level and
17 because they improperly discriminate between similarly situated enrollees based on the claims
18 history or risk characteristics of their particular common law employer rather than any bona
19 fide employment-based classification unrelated to health coverage.
20
21

22 For these reasons, the OIC staff submits that summary judgment should be entered
23 dismissing these hearing demands.
24
25
26

FACTS

1
2 The three rate filings at issue were submitted to the OIC through the System for
3 Electronic Rate and Form Filing (SERFF) by Regence on February 12, 2014 (MBA), and
4 February 13, 2014 (NMTA), and April 25, 2014 (BIAW). (Lee Decl., pars. 27, 44 and 62.)
5 Pursuant to WAC 284-43-920(2), rates for large group negotiated plans may be used before
6 they are filed, but must be filed within thirty days after they are used. Under RCW 48.44.020,
7 the Commissioner may disapprove any contract if the benefits provided therein are
8 unreasonable in relation to the amount charged for the contract or if it fails to conform to
9 minimum standards required by rule or statute. As noted, these filings were specifically
10 submitted by the carriers as large group filings predicated upon the particular association's
11 status as an association or member-governed true employer group under ERISA. (Lee Decl.,
12 pars. 30, 47, and 64.)

13
14 For BIAW, Regence filed 5 risk categories and a "custom" rating exception for
15 common law employers with 50 or more enrolled employees who request it. For NMTA,
16 Regence filed 4 risk categories and 7 "Custom Rated Groups," and for MBA, Regence filed 4
17 risk categories and 61 "Custom Rated Groups." (Lee Decl., pars. 41, 49, and 66.) Depending
18 on the risk category to which an enrolled employee's common law employer is assigned, the
19 rates vary widely between these tiers with tier zero offering the lowest rates and tier four or
20 five the highest. For example, an active 30 year old employee under the Regence BIAW
21 benefit plan E30 with no dependents could be charged a monthly rate for the same benefit
22 package that ranges from \$264.36 (Category 0) to \$443.95 (Category 4.) (Lee Decl., par. 32.)

23
24
25 In its SERFF correspondence with Regence, the OIC attempted to elicit the basis for
26 these disparities. Regence could not identify any employment-based criteria that was used.

1 Regence acknowledged what the hearing demands in these cases now make clear, that the tiers
2 are rated and assigned at the small employer level based on the claims experience or risk
3 characteristics of the particular association member's employer and the health history of that
4 individual employer's enrolled employees. Even then, Regence reserves discretion to establish
5 "custom rates" for favored common law employers with more than fifty enrolled employees
6 and discretionary rates for new member groups that depend "on the competitive position of
7 Regence's quote." (See Lee Decl., pars. 37 – 41.) Needless to say, Regence's filing does not
8 permit the OIC to recreate the specific rate for any particular enrollee. (Lee Decl., pars. 33, 50,
9 and 67.)
10

11 In short, Regence's rate filings in this case are really nothing but general methodology
12 descriptions which Regence may disregard if it chooses. The methodology Regence disclosed
13 is based on the past claims history and aggregate risk demographics, such as age and sex, of
14 the individual small employer's employees which Regence uses to assign those small
15 employers to rate categories. Treating a subgroup of employees differently based on their
16 average age or the percent that are women of child bearing age clearly discriminates on the
17 basis of non-employment based factors and is designed to discriminate against those subgroups
18 within the association that are expected to generate the highest claims. Regence treats newly
19 enrolled members of the association differently than previously enrolled members, and it
20 reserves discretion to abandon even this methodology to negotiate rates at the individual, small
21 employer level depending on the competitive position of its quote.
22

23 Because the rating methodology and rates filed for these associations are inconsistent
24 with the fact the plans were filed for one single large employer group and because the risk tiers
25 are based upon the collective health and claims history of employee subgroups rather than bona
26

1 fide employment-based classifications, the OIC determined that the rates charged for
2 individual enrollees are discriminatory and unreasonable in relation to the benefits provided.
3 The filings were therefore disapproved January 15, 2015. (Lee Decl., pars. 84 – 88.)

4 ISSUES

5 1. When a health care service contractor or health maintenance organization files a health
6 plan for review by the Office of the Insurance Commissioner and the plan is disapproved,
7 does an entity that was not a party to the filing have standing to demand a hearing to contest
8 the disapproval?
9

10 2. When a carrier files a single large group health plan for issuance to an association that
11 constitutes a single large employer, must the carrier rate the plan at the association level or
12 may it individually rate each individual small employer within the association based on the
13 individual small employer's claims experience?

14 3. Does the Office of the Insurance Commissioner have authority to review large group
15 rate filings?
16

17 AUTHORITY AND ARGUMENT

18 Summary Judgment

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

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

24 In *Island Air, Inc. v. LaBar*, 18 Wn. App. 129, 136, 566 P.2d 972 (1977), the rules
25 governing summary judgment are explained as follows:
26

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

5 **Standing**

6 As a threshold matter, these hearing demands must be dismissed as a matter of law
7 because Cambia and the associations lack standing.

8 As noted, these plans were disapproved under RCW 48.44.020 which confines the right
9 to a hearing to contest disapproval of a filing to the carrier that submitted the filing. RCW
10 48.44.020(2) provides in pertinent part as follows:

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

15 This specific provision limiting the right to a hearing in filing disapproval cases to the
16 HCSC that made the filing controls the more general provision of RCW 48.04.010 that "(t)he
17 commissioner shall hold a hearing ... upon written demand for a hearing made by any person
18 aggrieved by any act, threatened act, or failure of the commissioner to act, if such failure is
19 deemed an act under any provision of this code . . ." As stated in *State v. Becker*, 39 Wn.2d 94,
20 96, 234 P. 2d 897 (1951):

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

23 Even under the more general aggrieved party standard of RCW 48.04.010, Cambia and
24 the associations fail to qualify. None of the associations claim any direct harm from the OIC's
25 disapprovals, and the associations cannot demonstrate any harm either to the individual
26

1 employers who comprise their membership or to the employees they are supposed to represent
2 as a true ERISA single employer. The OIC did not disapprove these plans because the rates are
3 too low. It disapproved them because they are experience rated at the wrong level and because
4 they illegally discriminate at the small employer level based on claims experience and health
5 history. The speculation that correctly rating these plans would increase their cost defies logic
6 unless the intended effect of the rating scheme is to price the small employer association
7 members with the oldest or sickest employees out of the coverage.
8

9 Under the Administrative Procedures Act (“APA”):

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

25 RCW 48.04.010(2) requires in part that a hearing demand “specify in what respects”
26 the appellant is aggrieved. None of the hearing demands in these cases articulates any claimed

1 harm to the entity demanding a hearing. Cambia's demand is completely silent on the question
2 while the associations vaguely speculate that members may be forced to move to plans with
3 substantially reduced benefits and/or higher premiums. (MBA Hearing Demand, page 3;
4 BIAW Dearing Demand, page 4; MTA Hearing Demand, page 1.) It is well established that
5 this kind of speculative assertion cannot confer standing. See *Patterson v. Segale*, 171 Wn.
6 App. 251, 254, 289 P.3d 657 (2012), (finding no standing "[W]here a person alleges an injury
7 that is merely conjectural or hypothetical"); *KS Tacoma Holdings*, 166 Wn. App. At 129
8 ("When a person or corporation alleges a threatened injury, as opposed to an existing injury,
9 the person or corporation must show an immediate, concrete, and specific injury to
10 themselves.") *Allan*, 140 Wn.2d at 332 (holding that plaintiff lacked standing where she could
11 not demonstrate a threat "that is 'sufficiently real;' in other words, a threat that is 'neither
12 imaginary nor speculative.'") (quoting *Yesler Terrace Comm. Council v. Cisneros*, 37 F.3d
13 442, 446 (9th Cir. 1994).

14
15 The other element of the APA "injury in fact" test, a remedy that would actually redress
16 the alleged injury, is also missing. The APA provides no mechanism for joinder of an
17 involuntary indispensable party and the OIC has no authority to require a carrier to guarantee
18 issuance of a large group health plan. Ninety days has now elapsed since the OIC's January 15,
19 2015 disapprovals. As to Regence, the OIC's decision is now final and non appealable.

20
21 RCW 48.04.010(3) provides:

22
23 Unless a person aggrieved by a written order of the commissioner demands a hearing
24 thereon within ninety days after receiving notice of such order, or in the case of a
25 licensee under Title 48 RCW within ninety days after the commissioner has mailed the
26 order to the licensee at the most recent address shown in the commissioner's licensing
records for the licensee, the right to such hearing shall conclusively be deemed to have
been waived.

1 In short, no remedy is available that would actually redress the injury the associations claim
2 gives them standing.

3 The “zone of interest” test requires the associations and Cambia to show that their
4 “asserted interests are among those that the agency was required to consider when it engaged
5 in the agency action challenged.” RCW 34.05.530(2). “The test focuses on whether the
6 Legislature intended the agency to protect the party’s interest when taking the action at issue,”
7 and “limit[s] review to those for whom it is most appropriate.” *Wash. Indep. Tel. Ass’n*, 110
8 Wn. App. At 513 (quoting *Seattle Bldg. & Constr. Trades Council v. Apprenticeship &*
9 *Training Council*, 129 Wn.2d 787, 797, 920 P.2d 581 (1996)). None of the statutes bearing on
10 the OIC’s disapprovals were intended to benefit third party administrators such as these
11 associations or insurance holding companies such as Cambia. The only association interest the
12 OIC was required to consider was whether the association constituted a bona fide true
13 employer eligible for large group coverage. Since this question was resolved in the
14 associations’ favor and is not at issue here, the associations as well as Cambia fail the “zone of
15 interest” test as well.
16
17

18 Granting entities standing to litigate disapproval of someone else’s filings raises serious
19 practical problems as well as legal issues. The factual record made by the carrier was made
20 through the System for Electronic Rate and Form Filing (“SERFF”). Only carriers are allowed
21 to submit filing information through SERFF. That was the record upon which the OIC’s
22 decision was based, and key portions of that record consist of information submitted by the
23 carrier on a not-for-public basis. Even if the associations could establish a right to review the
24 carrier’s not-for-public filing information, they should not be allowed to circumvent the OIC’s
25
26

1 review process by demanding a hearing to offer evidence or arguments that the carrier itself
2 did not submit through SERFF.

3 The law simply does not permit these associations or Cambia to step into the shoes of
4 Regence and litigate the OIC's disapproval of the carrier's filings. Under RCW 48.44.020(2),
5 Regence is the only entity that had standing to challenge the disapproval of its plans. Even
6 under the more general hearing statute, RCW 48.04.010, associations and holding companies
7 are not entitled to act as a health carrier's litigation surrogate and are not aggrieved parties.
8 Each of these hearing demands should therefore be dismissed as a matter of law for lack of
9 standing.
10

11 **Rating**

12 Even if these parties had standing to litigate the OIC's disapproval of these filings,
13 which they do not, their claim that the OIC erred in treating these filings as single large
14 employer filings is simply wrong as a matter of law and is subject to dismissal by summary
15 judgment for this reason as well.
16

17 Prior to the advent of the Patient Protection and Affordable Care Act, Public Law 111-
18 148, March 23, 2010, ("ACA"), Washington law required carriers issuing health coverage to
19 small employers (those with 50 or fewer employees, RCW 48.43.005(33)) to base their rates
20 on an adjusted community rate. RCW §§ 48.44.023, 48.46.066, and 48.21.045. However,
21 employers with 50 or fewer employees purchasing coverage through associations or member-
22 governed groups were not deemed small employers under state law. RCW §§ 48.44.024,
23 48.46.068, and 48.21.047 are similarly worded. RCW 48.44.024(2), for example, provides:
24
25
26

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

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

6 Another result was that, based on the language of the statute that identified the member
7 employer as the “employer purchasing health plans,” the OIC permitted carriers issuing
8 association plans to rate those plans at the purchasing employer level as BIAW, MBA and
9 NMTA wish Regence to do here. Carriers could, for example, use the claims history of the
10 purchasing employer as a proper basis for rating.

11 Because of this statutory exemption, the association health plan market for small
12 employers expanded rapidly in Washington. As set forth in the Declaration of Jim Keogh, it
13 has since become clear that the practice of rating at the participating employer level permitted
14 carriers and associations to select for lower risk employers, while higher risk employers were
15 priced out of the association market and displaced into Washington’s small group community-
16 rated market. Over time, this adverse selection has led to relatively high premiums, and
17 comparatively few available plans in that market.

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

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

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

25 Under the ACA, the only group health plans that may be sold by a carrier are those that
26 constitute an “employee welfare benefit plan” as defined in section 3(1) of the Employee

1 Retirement Income Security Act of 1974 (“ERISA”).¹ In order to constitute an employee
2 welfare benefit plan under ERISA, the plan must be “established or maintained by an employer
3 or by an employee organization.” ERISA then defines the term “employer” to mean “any
4 person acting directly as an employer, or indirectly in the interest of an employer, in relation to
5 an employee benefit plan; and includes a group or association of employers acting for an
6 employer in such capacity.” 42 USCS § 1002(5). The large group market is the market under
7 which individuals obtain health insurance coverage through a plan maintained by a large
8 employer. 42 USCS § 300gg-91 (e)(2) and (3). The factors used to determine whether an
9 association qualifies as an ERISA “employer” include, among other things, the association
10 members’ history of cooperation on employment-related matters, the similarity of their
11 business activities, and a genuine organizational relationship unrelated to the provisions of
12 welfare benefits.²

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

18 Contrary to Appellants’ legal theory, the law has indeed changed with the advent of the
19 ACA. Specifically, for association health plans that qualify to sell large group insurance to all
20 its members regardless of size, it has changed which entity is the employer. It is no longer the

22 ¹42 USCS § 18021 (b)(3) provides that the “term ‘group health plan’ has the meaning given such term by
23 section 2791(a) of the Public Health Service Act (42 USCS § 300gg-91(a).” 42 U.S.C. § 300gg-91(a) in
24 turn provides that the term ‘group health plan’ means an employee welfare benefit plan as defined in
25 section 3(1) of ERISA.

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

1 small member employer within the association - rather, for bona fide associations like BIAW,
2 MBA, and NMTA that meet the ERISA “employer” definition, the association itself is now the
3 employer. The health plan a true or bona fide employer association offers to the employees of
4 its purchasing members *exists only at the association level*, not at the association member or
5 small employer level.

6 This new legal reality is confirmed by a September 1, 2011 bulletin promulgated by the
7 Centers for Medicare & Medicaid Services, attached hereto as Addendum “A.” On page 3 of
8 this bulletin, the federal position on association plans is summarized as follows:
9

10 CMS believes that, in most situations involving employment-based association
11 coverage, the group health plan exists at the individual employer level and not at the
12 association-of-employers level. In these situations the size of each individual employer
13 participating in the association determines whether that employer’s coverage is subject
14 to the small group market or the large group market rules.

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

21 Each of these 2014 plans is a single plan filing that presents itself as one of those “rare
22 instances” where the “association itself is deemed the ‘employer.’” However, Regence did not
23 rate these plans as single group health plans. Instead, Regence created multiple separate risk
24 pools based on the past experience of individual employers and the risk characteristics of each
25 employer’s workers. Regence’s rating structure effectively creates multiple separate plans
26 within each association.

The importance of identifying which entity is the employer (also described as
determining the level at which the plan exists) is critical for determining whether the plan’s

1 rates discriminate unlawfully, as illustrated by *Fossen v. Blue Cross Blue Shield of Mont., Inc.*,
2 744 F. Supp. 2d 1096 (D. Mont., 2010), affirmed in part, reversed in part, and remanded by
3 *Fossen v. Blue Cross & Blue Shield of Mont., Inc.*, 660 F.3d 1102 (9th Cir. 2011).

4 Fossen was a small employer that purchased employee health coverage from Blue
5 Cross through a multiple employer welfare arrangement comprised of unrelated small
6 employers. At renewal, Blue Cross imposed a 21% premium increase on Fossen, based on the
7 health status of one of Fossen's employees. Fossen sued, claiming the carrier's rating method
8 unlawfully discriminated based on individual health history. Blue Cross admitted to using
9 Fossen's claims experience to achieve the rate increase, but argued that it was lawful to do so,
10 and the court agreed. However, the significance of the case is the rationale applied by the
11 court.
12

13 Applying the HIPPA non-discrimination provisions set forth in 29 U.S.C. § 1182(b),
14 the court dismissed plaintiff's unlawful rating discrimination claim only because Fossen's
15 association, through which he purchased the plan, did not meet the ERISA definition of
16 "employer." Fossen's association was simply a MEWA, and as a result, the employer for
17 purposes of rating was the individual purchasing employer, Fossen. The *Fossen* the court
18 reasoned as follows:
19

20 The next step in analyzing the motion for summary judgment requires application of 29
21 U.S.C. § 1182(b) to these facts. As this statute makes clear, § 1182(b) applies to
22 prohibit premium disparity based on health status factors at the individual level but not
23 at the employer level. In other words, an individual employee participating in an
24 employer's group health plan cannot be charged more because of his health status. An
25 employer group health plan, however, can be charged a higher premium due to health
26 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.
Accordingly, BCBSMT's method of premium calculation for the AMI/MCCT
Arrangements, which takes into account health status factors when rating the employer
plans separately, is permissible under ERISA' s section 1182(b). (Emphasis added.)

1 The *Fossen* reasoning is equally applicable here, with one critical difference: MBA,
2 BIAW, and MTA are the association employer for their respective plans, under the rare
3 exception for that role. As a result, each of these plans exists only at the association level, and
4 each must be rated at that level, using only bona fide rating factors that do not discriminate due
5 to health status factors for any sub-classifications. Rating at the participating employer level
6 violates the HIPAA non-discrimination rules.

7
8 As noted in *Fossen*, a carrier cannot charge an individual participating in a group health
9 plan more because of his or her health status. A carrier or employer cannot circumvent this
10 requirement through the simple expedient of grouping employees within the same plan into
11 subgroups or rating tiers as Regence sought to do here.

12 The HIPAA non-discrimination requirements apply to both discrimination in
13 enrollment eligibility (29 USCS §1182 (a)) and discrimination in rates (29 USCS §1182 (b)).
14 The rate discrimination provisions in 29 USCS §1182 (b) are as follows:

15
16 (b) In premium contributions.

17 (1) In general. A group health plan, and a health insurance issuer offering health
18 insurance coverage in connection with a group health plan, may not require any
19 individual (as a condition of enrollment or continued enrollment under the plan) to pay
20 a premium or contribution which is greater than such premium or contribution for a
21 similarly situated individual enrolled in the plan on the basis of any health status-
22 related factor in relation to the individual or to an individual enrolled under the plan as
23 a dependent of the individual.

24 As noted in the Declaration of Lichiou Lee, some employees in these plans may be
25 charged approximately twice as much as others for the same benefits for no discernible reason
26 other than the claims experience of their common law employer. The drastic rate disparities
between similarly situated employees are not based upon any employment-based classification
of the employee. The federal regulations implementing and explaining these requirements

1 make clear that carriers and associations may not group employees into rating groups that are
2 not based on bona fide employment-based classifications unrelated to health care. 45 CFR

3 146.121(d) provides in part as follows:

4 (d) Similarly situated individuals. The requirements of this section apply only within a
5 group of individuals who are treated as similarly situated individuals. A plan or issuer
6 may treat participants as a group of similarly situated individuals separate from
7 beneficiaries. In addition, participants may be treated as two or more distinct groups of
8 similarly situated individuals and beneficiaries may be treated as two or more distinct
9 groups of similarly situated individuals in accordance with the rules of this paragraph
10 (d). Moreover, if individuals have a choice of two or more benefit packages, individuals
11 choosing one benefit package may be treated as one or more groups of similarly
12 situated individuals distinct from individuals choosing another benefit package.

13 (1) Participants. Subject to paragraph (d)(3) of this section, a plan or issuer may treat
14 participants as two or more distinct groups of similarly situated individuals if the
15 distinction between or among the groups of participants is based on a **bona fide**
16 **employment-based classification consistent with the employer's usual business**
17 **practice**. Whether an employment-based classification is bona fide is determined on
18 the basis of all the relevant facts and circumstances. Relevant facts and circumstances
19 include whether the employer uses the classification for purposes independent of
20 qualification for health coverage (for example, determining eligibility for other
21 employee benefits or determining other terms of employment). Subject to paragraph
22 (d)(3) of this section, examples of classifications that, based on all the relevant facts
23 and circumstances, may be bona fide include full-time versus part-time status, different
24 geographic location, membership in a collective bargaining unit, date of hire, length of
25 service, current employee versus former employee status, and different occupations.
26 However, a classification based on any health factor is not a bona fide employment-
based classification, unless the requirements of paragraph (g) of this section are
satisfied (permitting favorable treatment of individuals with adverse health factors).
(Emphasis added.)

...

(3) Discrimination directed at individuals. Notwithstanding paragraphs (d)(1) and (d)(2)
of this section, if the creation or modification of an employment or coverage
classification is directed at individual participants or beneficiaries based on any health
factor of the participants or beneficiaries, the classification is not permitted under this
paragraph (d), unless it is permitted under paragraph (g) of this section (permitting
favorable treatment of individuals with adverse health factors). Thus, if an employer
modified an employment-based classification to single out, based on a health factor,
individual participants and beneficiaries and deny them health coverage, the new
classification would not be permitted under this section.

The rate categories in these plans are not established at the participant employee level

and they are not based on any bona fide employment-based classification unrelated to health
care. Rather, each small employer member of the association is assigned to the rate category

1 based on the aggregate claims experience and risk characteristics of its employees. As a result,
2 two identically situated plan participants with the same job classification, collective bargaining
3 unit, geographic location, and hours may pay widely divergent rates for the same benefit
4 package.

5 The OIC is not alone in its belief that this rating methodology violates federal law. As
6 stated by Doug Pennington, the Director of the Rate Review Division Oversight Group of the
7 federal Center for Consumer Information and Insurance Oversight, in his October 16, 2014
8 email to OIC Deputy Director for Rates and Forms, Molly Nollette:
9

10 We agree that it would appear to be inappropriate for a bona fide association to
11 differentiate rating or premiums based on the underlying employers, but rather they
12 should/could use general employee classifications to differentiate, which are allowed
13 by an employer group under ERISA. Likewise, it would seem inappropriate to
14 differentiate by member employer length in the association, as again, the association is
15 suppose to be acting as a single employee benefits provider to multiple employers in a
16 bona fide association and not as a sales/marketing channel to disparate employer
17 purchasers and therefore it should act like a bona fide association. (Nollette Decl. , Exh.
18 "A.")

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

1 **OIC Authority to Review Rates**

2 The hearing demands of the three associations argue the OIC lacked legal authority to
3 review Regence's filings for the associations. The OIC is frankly surprised by this argument,
4 since Regence never suggested in its SERFF filings that the OIC lacked authority to review
5 their rates.

6 Another carrier, Premera, in fact recently invoked and relied upon the OIC's authority
7 to review its large group rates as a defense in a class action lawsuit claiming the rates charged
8 by Premera for plans sold through an association called the Business Health Trust were too
9 high. In *McCarthy Finance, Inc. vs. Premera*, 2015 Wash. LEXIS 351, April 2, 2015, the
10 Washington Supreme Court upheld dismissal of class action claims against Premera and the
11 trust based upon the filed rate doctrine, holding at pages 8-9, as follows:
12

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

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

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

13 The model is a highly complex document of approximately 500 pages which weighs
14 numerous factors, including each large group's prior claims experience, [*13] its
15 demographics, the benefits it wants to include, geographic issues, the provider network
16 to be included, the group's industry, tax issues, and changes in the law such as coverage
17 mandates, as well as administrative expenses. CP 345-46 at P 8, 9.

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

The associations' attack on the OIC's rate review authority is not only inconsistent with
McCarthy; it is also inconsistent with logic and the statutes on which the associations purport
to rely.

As previously noted RCW 48.44.020 authorizes the Commissioner to disapprove any
HCSC contract if the benefits provided therein are unreasonable in relation to the amount
charged for the contract or if it fails to conform to minimum standards required by rule or
statute. This is consistent with the general rate standard set out in RCW 48.19.020 that

1 “premium rates for insurance shall not be excessive, inadequate, or unfairly discriminatory.”

2 RCW 48.44.020 for example provides in pertinent part as follows:

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

6 ...

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

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

17 WAC 284-43-125 provides:

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

20 The association’s authority argument simply ignores RCW 48.44.020(2)(f) and the fact
21 that WAC 284-43-125 requires carries to comply with both state and federal laws relating to
22 their plan benefits.

23 It ignores as well the provision of RCW 48.02.060(1) vesting the commissioner with
24 the authority “reasonably implied” from the provisions of the insurance code as well as that
25 expressly conferred.

26 The associations’ construction of the commissioner’s authority to review large group
rates renders RCW 48.44.020(3) a nullity, since it is impossible to evaluate a plan’s benefits in

1 relationship to its rates by considering only one side of the equation and without evaluating
2 both the rates and benefits. As set forth in the Declaration of Lichiou Lee, it is impossible from
3 these filings to replicate or recreate the rate for any specific individual from the information
4 filed by the carriers. If the OIC has no ability to determine whether a carrier is actually
5 following its filed rates and if it has no authority to review large group rates, it is a useless act
6 to require carriers to file them. It is axiomatic that statutes should be construed to avoid
7 unlikely, absurd, or strained consequences. *State v. Stannard*, 109 Wn.2d 29, 37 (1987), and if
8 a statute is ambiguous, the interpretation of the agency charged with administration and
9 enforcement of the statute is given great weight. *Puget Soundkeeper Alliance vs. State*, 102
10 Wash. App. 783, 787 (2000).

11
12 The associations also refer in their hearing demands to the actuarial standards in WAC
13 284-43-915(2), arguing that “by OIC’s own regulations, RCW 48.44.020(3) provides no
14 authority for OIC’s disapproval of the Filings.” (See BIAW Hearing Demand, page 2.) In its
15 SERFF filings, Regence of course offered no evidence or actuarial opinion that these plans
16 meet these actuarial soundness standards, and the Declaration of Lichiou Lee, paragraphs 77
17 and 78, indicates that the rate filings are not actuarially sound.

18
19 The regulatory assumption behind WAC 284-43-915(2) at any rate is that carriers will
20 actually rate their plans at the plan level and that their rates can be verified and duplicated
21 using objective criteria so that the actuarial soundness of the rates can be evaluated. The fact
22 these plans are rated at the wrong level, and that even these rates may be varied based upon
23 Regence’s subjective marketing judgments only underscores the defects of these filings.
24 Perhaps these associations can explain to their enrollees who are charged twice as much for the
25 same benefit package as other identically situated employees how their benefits are reasonable
26

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

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

10 CONCLUSION

11 These associations and Cambia have no standing to litigate the OIC's disapproval of
12 Regence's filings and their purported grounds for doing so are without merit as a matter of law.
13 Under the Affordable Care Act, Regence was required in 2014 to begin rating these plans as
14 single large group plans issued to a single large employer. Because Regence failed to do so, its
15 plans for these associations were correctly disapproved. For these reasons, the OIC staff
16 requests entry of an order granting the OIC staff's Motion for Summary Judgment, and
17 dismissing these hearing demands.
18

19 Dated this 6th day of May, 2015.

20 OFFICE OF INSURANCE COMMISSIONER

21 

22 Charles Brown
23 Insurance Enforcement Specialist
24 Office of the Insurance Commissioner
25
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 MOTION FOR SUMMARY JUDGMENT on the following individuals listed below in the manner shown:

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

Via email and hand delivery

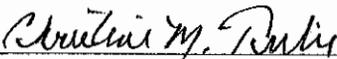
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Via email and by depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to.

Dated this 6th day of May, 2015, in Tumwater, Washington.


CHRISTINE M. TRIBE
Paralegal
Legal Affairs Division

ADDENDUM 1



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(I). 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/HealthInsReformforConsume/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).