

2015 MAY 26 A 9 44

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 REPLY TO
MOTION FOR SUMMARY
JUDGMENT BY MBA TRUST,
BIAW TRUST, NMTA TRUST
AND CAMBIA

1 The Motion for Summary Judgment by MBA Trust, BIAW Trust, NMTA Trust, and
2 Cambia (“Appellants”) confuses the OIC’s lack of authority to review loss ratios for HMO and
3 HCSC large group filings with the OIC’s authority to require all health plan issuers to comply
4 with the large group requirements of the Patient Protection and Affordable Care Act (“ACA”) and the
5 nondiscrimination provisions of the Health Insurance Portability and Accountability
6 Act (“HIPAA”). The Motion ignores the fact that federal law now defines which entity is the
7 “employer” for large group association filings, and the Motion conflates the single large
8 “employer” for which the plans were filed with the associations’ small business members. The
9 Motion also confirms that Regence did not file defined rates, but only underwriting criteria that
10 Regence may disregard based on marketing considerations. Finally, the Motion fails to
11 establish any specific injury to any of the entities requesting relief.
12

13 The OIC Staff therefore submits this brief reply.

14 **Commissioner’s Authority**

15 As noted in the OIC Staff’s Motion for Summary Judgment, RCW 48.44.020
16 authorizes the Commissioner to disapprove any HCSC contract if the benefits provided therein
17 are unreasonable in relation to the amount charged for the contract or if it fails to conform to
18 minimum standards required by rule or statute. WAC 284-43-125 requires health carriers to
19 comply with both state and federal laws relating to their plans. Contrary to Appellants’
20 argument, the OIC has not only the authority, but the responsibility, to review the structure of
21 large group rates for compliance with federal law.
22

23 The federalism statement of the United States Department of Labor and Department of
24 Health and Human Services that precedes the HIPAA nondiscrimination rules makes it clear
25 that enforcement of those rules is a state responsibility, stating in part as follows:
26

1 In general, through section 514, ERISA supersedes State laws to the extent that they
2 relate to any covered employee benefit plan, and preserves State laws that regulate
3 insurance, banking, or securities. While ERISA prohibits States from regulating a plan
4 as an insurance or investment company or bank, HIPAA added a new preemption
5 provision to ERISA (as well as to the PHS Act) narrowly preempting State
6 requirements for group health insurance coverage. With respect to the HIPAA
7 nondiscrimination provisions, States may continue to apply State law requirements
8 except to the extent that such requirements prevent the application of the portability,
9 access, and renewability requirements of HIPAA, which include HIPAA's
10 nondiscrimination requirements provisions that are the subject of this rulemaking.

11 In enacting these new preemption provisions, Congress intended to preempt State
12 insurance requirements only to the extent that those requirements prevent the
13 application of the basic protections set forth in HIPAA.¹

14 Immunizing Regence's single employer large group rate filings from state review as
15 Cambia and the associations urge would prevent not only application of the basic protections
16 set forth in HIPAA, but application of the group market reforms of the ACA as well. These
17 associations simply cannot have their cake and eat it too by claiming to be true single ERISA
18 large employers for purposes of avoiding the ACA small group market reforms, while insisting
19 on rates established on the small group level. Implementing the ACA group market reforms
20 for plans commencing in 2014, like HIPAA compliance, is a state responsibility.

21 Underscoring the state's responsibility for ACA compliance and attached hereto as
22 Addendum "A" is a letter dated March 14, 2013, from Teresa Miller, Acting Director,
23 Oversight Division of the federal Centers for Medicare & Medicaid Services, advising
24 Commissioner Kreidler that proposed state legislation to exempt associations from the ACA
25 group market reforms and restrictions on those eligible for large group treatment would be
26 preempted by federal law.

¹ Declaration of Lichiou Lee, Exhibit B, p. 75024.

1 Attached hereto as Addendum "B" is a letter dated February 4, 2013, to State
2 Representative Joe Schmick from the office of the Attorney General of Washington analyzing
3 the OIC's authority after the ACA to review large group association health plan filings in
4 response to the following question: "May the Insurance Commissioner independently
5 determine whether a multiple employer health plan arrangement constitutes an 'employer'
6 ('association of employers acting for an employer in such capacity') under ERISA, 29 U.S.C.
7 §1002(5) and, acting on his interpretation of federal law, order a health carrier to terminate or
8 amend the employer plan accordingly?" The Attorney General's answer to the question is
9 stated on page 1 of the letter as follows:
10

11 **Yes.** The Insurance Commissioner's responsibility to review health carrier rate and
12 form filings requires the Commissioner to evaluate whether a plan offered by a health
13 carrier uses a lawful rating method. To make that evaluation, the Commissioner may
14 examine if the health carrier has submitted a rate filing using a rating scheme available
15 only to those who satisfy the definition of "employer" under ERISA. That definition
16 includes a multiple employer health plan arrangement for an "association of employers
17 acting for an employer in such capacity." When the Commissioner makes such a
18 determination, **he may disapprove a plan based on an unlawful rating scheme.**
19 (Emphasis supplied.)

20 On page 4 of the opinion letter, the AGO's analysis of the Commissioner's
21 authority to review large group rates is explained as follows:
22

23 Under the statutes and regulations cited above, the Commissioner must determine if a
24 carrier is using a lawful basis for rating. Therefore, the Commissioner may need to
25 determine if a plan meets an exception to the community rating requirement, such as
26 the exception for large group multiple employer welfare arrangements. *See*
generally RCW 48.18.100, .110; WAC 284-43-920, -901 (the statutes and regulations
described above on page 2). If not, the plan is inappropriately avoiding the ACA
community rating requirements, and the Commissioner will disapprove the rates that
have been filed. See WAC 284-43-125.

In addition to the statutes that generally direct the Commissioner to enforce the
insurance code, authority to make a determination regarding lawfulness of rating can be
found in the statutes authorizing the Commissioner to make investigations and
determinations as needed to enforce the code. RCW 48.02.060. In particular, RCW

1 48.02.060(3)(b) specifically authorizes the Commissioner to “[c]onduct investigations
2 to determine whether any person has violated any provision of [the insurance] code.”
3 Subsection (3)(c) authorizes the Commissioner to “[c]onduct ... investigations ... in
4 addition to those specifically provided for, useful and proper for the efficient
5 administration of any provision of this code.” Finally, RCW 48.02.060(1) states that
6 the Commissioner has “authority expressly conferred upon him or her by or reasonably
7 implied from the provisions of this code.”

8 Therefore, because state law requires the Commissioner to review plans and ratings, the
9 Commissioner is empowered to take reasonable steps to investigate and determine if a
10 plan proposes a lawful rating scheme, including making an independent determination
11 about whether a multiple employer health plan arrangement constitutes an “employer”
12 (“association of employers acting for an employer in such capacity”) under ERISA, 29
13 U.S.C. § 1002(5).

14 At page 18 of their motion, Appellants cite a 2010 OIC letter to the United States
15 Department of Health and Human Services and a follow up comment in a consultant report for
16 the proposition that the OIC “has admitted that it lacks authority to approve or deny AHP
17 rates.” Appellants take these statements out of context and make no claim that they relied on
18 them in any respect. The OIC’s letter was written prior to the Attorney General’s opinion
19 letter and shortly after the ACA was enacted in connection with proposed federal rule making
20 to limit increases in health care premiums. The sentence in the letter cited by Appellants must
21 be read in this context as addressing the OIC’s pre-ACA authority to apply loss ratio
22 requirements to limit or disapprove large group negotiated rate increases, not the OIC’s
23 authority to enforce the nondiscrimination provisions of HIPAA or the group market reforms
24 of the ACA that had yet to take effect. (Supplemental Declaration of Lichiou Lee, paras. 11-
25 12.) As the letter states on page 8, “[t]he PPACA adds large group and association health plan
26 rate review to the OIC rate review work load.” The Supplemental Declaration of Lichiou Lee
makes clear that the OIC has long reviewed the structure of large group rates to make sure they
match the plans’ forms and comply with applicable laws. Those laws dramatically changed

1 with the enactment of the ACA and group market reforms that took effect in 2014 and the
2 OIC's health plan review responsibilities dramatically changed and increased as well.

3 At any rate, the defect in the rates filed by Regence for these associations is not that an
4 overall increase negotiated by the parties is too high or fails to meet a minimum loss ratio. The
5 defect is structural. The plans are improperly rated at the small group level in violation of the
6 ACA's group market reforms, and they are rated at the subgroup level based on health related
7 factors such as the claims experience, average age, and sex of the individuals in the subgroup
8 in violation of the HIPAA nondiscrimination rules.

9 This structure results in unlawful discrimination between similarly situated individuals.
10 If Regence grouped association members for rating purposes by the percentage of their
11 employees who had a prior cancer diagnosis or were of a certain race, there would surely be no
12 argument about the discriminatory impact of the rate structure. Under Appellants' claim that
13 the OIC lacks any power to review HCSC filings, however, the OIC would be powerless to
14 prevent even these blatant examples of illegal discrimination.
15

16 The OIC is clearly authorized to implement and enforce the ACA group market reforms
17 and the HIPAA nondiscrimination provisions in its rate review process. For these reasons, in
18 addition to those set forth in the OIC Staff's Motion for Summary Judgment, Appellants'
19 attack on the OIC's authority to disapprove these filings is without merit and should be
20 rejected as a matter of law.
21

22 **State Law**

23 At pages 14 through 18 of their Motion, Appellants argue that there is no state statute
24 or regulation that provides the OIC with the authority to reject these filings based on rating
25 methodology. Although this argument has already been addressed in the OIC Staff's Motion
26

1 for Summary Judgment and in the preceding section of this Response, the provision of WAC
2 284-43-125 bears repeating:

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

5 **Federal Law**

6 At pages 18 through 25 of their Motion, Appellants argue that “there is no federal law
7 that prohibits an AHP from utilizing a rating methodology that establishes rates at the
8 Participating Employer level.” Throughout this argument, Appellants engage in semantic
9 sleight of hand, repeatedly conflating the single large “employer” for which a plan was filed
10 with the small business participating “employers” that comprise the association’s membership.
11 The argument ignores the fact that federal law now defines the sole entity that is the
12 “employer” for large group association single employer filings: the association. And it ignores
13 the ACA’s small group community rating requirement, which now prohibits individual rating
14 of small employers. If the Presiding Officer concurs with the AGO’s February 4, 2013,
15 conclusion that the Commissioner may determine “if the health carrier has submitted a rate
16 filing using a rating scheme available only to those who satisfy the definition of ‘employer’
17 under ERISA,” it follows that the rating scheme must match the form filing and fit the ERISA
18 “employer” definition adopted by the ACA. To hold otherwise would allow carriers such as
19 Regence to evade the ACA community rating requirements for small groups by masquerading
20 as true large employers, while in reality pricing their high risk subgroups out of coverage by
21 rating in violation of HIPAA’s nondiscrimination rules.
22
23

24 Appellants’ argument also misconstrues the HIPAA nondiscrimination provisions and
25 the regulations that implement them, again by repeatedly confusing and conflating the entity
26

1 that is the employer under federal law, the association, with the associations' small business
2 members. First, it is important to note that Regence could *not* have filed a separate large group
3 plan for each small business member of these associations, since many of them have fewer
4 than fifty employees and some have as few as two. (Belur Decl. Pars. 2-4.) Employers of this
5 size must purchase a small group plan that is community rated based on the experience of the
6 carrier's entire small group rating pool. 42 U.S.C. § 18032.

7
8 Large group plans, by contrast, are filed on behalf of a single employer (in this case, an
9 association qualified to be a single employer). Contrary to Appellants' argument, the carrier is
10 not free to rate at any level it chooses, or create discriminatory rating subcategories based on
11 health factors. The HIPAA nondiscrimination provisions require that a large group plan be
12 rated as it is filed, at the large group employer level, with any consideration of health status or
13 claims experience applied at that level. As stated in *Fossen v. Blue Cross Blue Shield of Mont.,*
14 *Inc.*, 744 F. Supp. 2d 1096, 1103 (D. Mont., 2010), affirmed in part, reversed in part, and
15 remanded by *Fossen v. Blue Cross & Blue Shield of Mont., Inc.*, 660 F.3d 1102 (9th Cir. 2011),
16 discussed more fully in OIC Staff's Motion for Summary Judgment at page 16:
17

18 An employer group health plan, however, can be charged a higher premium due to
19 health status factors present among the individual employees—as long as the increased
20 premium is borne equally by all participants in that employer's group health plan.

21 On page 5 of their Motion for Summary Judgment, Appellants list factors they claim
22 are used to assign rates to “participating employers.” One factor is the claims experience of
23 the participating employer, which is prohibited. Another factor is “participating employer
24 demographics,” apparently Appellants' euphemism for age and gender. Appellants also list
25
26

1 “competitive consideration,” which is not further defined but appears to permit custom rating
2 in order to make a sale.

3 According to the Declaration of Dale Neer, paragraph 8, Regence also uses the
4 individual claims experience of the member business in setting its rate. As set forth in the
5 Declaration of Lichiou Lee, paragraph 37:

6 Regence stated that each new member group is placed in rating category 0-2. BIAW
7 uses categories 0 & 1 for new member groups that are not currently receiving Regence
8 direct coverage. New member groups placed in category 0 must meet the following
9 criteria: (1) be a part of a stable industry group; (2) currently receive coverage in a
10 group health plan offered by a Regence BlueShield competitor; (3) provide current and
11 renewal rates; (4) maintain at least ten enrolled employees; (5) **maintain an average
12 population age 44 or less; and (6) maintain a male percentage of 79% or greater.**
Other new member groups not currently insured through Regence BlueShield are
placed in category 1 or 2 depending on the competitive position of Regence’s quote.
(Emphasis supplied.)

13 The same “demographics” were used for MBA and NMTA. (Lee Decl., pars. 54 and 71.)

14 As noted in the OIC Staff’s Motion for Summary Judgment, the HIPAA
15 nondiscrimination rules permit a plan or issuer to “treat participants as two or more distinct
16 groups of similarly situated individuals if the distinction between or among the groups of
17 participants is based on a bona fide employment-based classification consistent with the
18 employer’s usual business practice. Whether an employment-based classification is bona fide is
19 determined on the basis of all the relevant facts and circumstances. Relevant facts and
20 circumstances include whether **the employer uses the classification for purposes
21 independent of qualification for health coverage** (for example, determining eligibility for
22 other employee benefits or determining other terms of employment).” 45 CFR 146.121(d)(1),
23 (Emphasis supplied.)
24
25
26

1 Appellants seek to avoid this rule by citing the provision of 26 C.F.R. § 54.9802-1(c)(1)
2 (The Treasury Department’s version of the HIPAA nondiscrimination rules) that “[n]othing in
3 this section restricts the aggregate amount that an employer may be charged for coverage under
4 a group health plan,” arguing at page 21 of their Motion that the “HIPAA non-discrimination
5 provisions explicitly permit aggregate rating at the employer level, even if that rating is based
6 on health factors.” Appellants’ argument again begs the question of which entity is the
7 employer, again conflates the small business members of the association with the single large
8 employer for which the plans were filed, and implicitly and incorrectly assumes that the plan
9 exists at the member level. The CMS statement in its September 1, 2011 bulletin (Addendum
10 “A” to the OIC Staff’s Motion for Summary Judgment) bears repeating:

12 In the rare instances where the association of employers is, in fact, sponsoring the
13 group health plan and the association itself is deemed the “employer,” the association
14 coverage is considered a single group health plan.

15 Read in legal context, the “employer” to which 26 C.F.R. § 54.9802-1(c)(1) refers
16 is clearly the “employer” for which the plan is filed.

17 Appellants, at page 22 of their Motion, also cite a United States Department of Labor
18 Employee Benefits Security Administration answer to a frequently asked question. The
19 question and answer cited by Appellants and the immediately preceding question and answer
20 published on the EBSA website are as follows:

21 **Is it permissible for a health insurance issuer to charge a higher premium to one**
22 **group health plan (or employer) that covers individuals, some of whom have**
23 **adverse health factors, than it charges another group health plan comprised of**
24 **fewer individuals with adverse health factors?**

25 Yes. In fact, HIPAA does not restrict a health insurance issuer from charging a higher
26 rate to one group health plan (or employer) over another. An issuer may take health
factors of individuals into account when establishing blended, aggregate rates for group
health plans (or employers). This may result in one health plan (or employer) being
charged a higher premium than another for the same coverage through the same issuer.

1 **Can a health insurance issuer charge an employer different premiums for each**
2 **individual within a group of similarly situated individuals based on each**
3 **individual's health status?**

4 No. Issuers may not charge or quote an employer or group health plan separate rates
5 that vary for individuals (commonly referred to as "list billing"), based on any of the
6 health factors.

7 This does not prevent issuers from taking the health factors of each individual into
8 account when establishing a blended, aggregate rate for providing coverage to the
9 employment-based group overall. The issuer may then charge the employer (or plan) a
10 higher overall rate, or a higher blended per-participant rate.

11 While HIPAA prohibits list billing based on health factors, it does not restrict
12 communications between issuers and employers (or plans) regarding the factors
13 considered in the rate calculations.

14 Like the provisions of the HIPAA nondiscrimination regulations cited by Appellants,
15 these answers do not support Appellants' position. Read in legal context, the "employment-
16 based group" and the "employer (or plan)" to which these answers refer is the employer or
17 employment-based organization such as a union or Taft Hartley trust to which the plan is
18 issued.

19 The Appellants next attempt to justify their health status based risk categories by
20 analogizing the associations' small business members to unions and arguing that employment
21 by separate participating employers is a bona fide employment-based classification. As Ms.
22 Lee's Declaration makes clear, these risk categories are not based on the identity of the
23 member business. They are created based on the health status and health risk factors of the
24 employees within those businesses. Appellants' analogy is therefore inapt. Labor unions are
25 not created based on the sex, age, or health history of their members as the rate categories here
26 undeniably are. There are hundreds of small business members in these associations, but only
 four rate categories for MBA and NMTA and five for BIAW. Further, these rate category

1 groupings were not created by the member employer, they were created by Regence, and they
2 were created solely for purposes of health coverage, not for “purposes independent of
3 qualification for health coverage” as required by 45 CFR 146.121(d)(1)).

4 The categories therefore clearly violate HIPAA’s nondiscrimination rules.

5 **Equitable Considerations**

6 At pages 26 and 27 of their Motion, Appellants argue that equitable considerations
7 weigh against the OIC’s position. To support this argument, Appellants hypothesize a parade
8 of horrors, ranging from adjusted income tax returns to higher co-payments and co-insurance,
9 that will ostensibly flow from the OIC’s disapproval of these 2014 plans. However, Appellants
10 offer no explanation or factual evidence to support these predictions. They do not even claim
11 that any individuals are still covered by the 2014 plans.
12

13 The OIC is not denying these associations the right to sell large group insurance to their
14 members, so long as it is correctly rated. MBA itself demonstrates the ability to provide lawful
15 member coverage; in 2014, the OIC approved a large group MBA plan offered by Group
16 Health Options. (Lee Decl., pars. 46 and 61.)
17

18 The true equitable considerations in this case are far broader than the interest of these
19 associations in continuing a business model that is now prohibited by the ACA. As set forth in
20 the Declaration of Jim Keogh, the ability of associations to discriminate and differentiate
21 premiums between employer members and enrollees based on demographics and health factors
22 has resulted in pricing small businesses with older or higher risk employees out of the
23 association market. These higher risk enrollees have been displaced into Washington’s small
24 group community-rated market, contributing significantly to that market’s relatively high
25 premiums. The poor risk in that market has also led to comparatively few available plans.
26

1 The ACA group market reforms address this inequity by limiting the large group
2 market to only those entities that constitute bona fide employers and employee organizations.
3 The HIPAA nondiscrimination provisions and regulations also address this inequity by
4 prohibiting the type of discriminatory rate structure that Cambia and these associations seek to
5 perpetuate. There is nothing inequitable about requiring Regence to treat these associations as
6 the single ERISA large employers they hold themselves out to be, and there is nothing
7 inequitable about disapproving Regence's rating categories that violate HIPAA's
8 nondiscrimination requirements.
9

10 **Conclusion**

11 For these reasons in addition to those set forth in OIC Staff's Motion for Summary
12 Judgment, Appellants' Motion for Summary Judgment should be denied and an order should
13 be entered dismissing these hearing demands as a matter of law.
14

15 Dated this 26th day of May, 2015.

16 OFFICE OF INSURANCE COMMISSIONER

17 

18 Charles Brown
19 Insurance Enforcement Specialist
20 Office of the Insurance Commissioner
21
22
23
24
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 RESPONSE TO APPELLANTS' 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

Maren R. Norton, Attorney for Cambia
Robin L. Lamer, Attorney for Cambia
Karin D. Jones, Attorney for Cambia
Stoel Rives, LLP
600 University St., Ste. 3600
Seattle, WA 98101
maren.norton@stoel.com
robin.larmer@stoel.com
karin.jones@stoel.com

Renee M. Howard, Attorney for BIAW and MBA
PerkinsCoie
1201 Third Ave, Suite 4900
Seattle, WA 98101-3099
RHoward@perkinscoie.com

Earl J. Hereford
KHBB Law
705 Second Ave., Hoge Building, Ste. 800
Seattle, WA 98104
jhereford@khbbblaw.com

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

Dated this 26th day of May, 2015, in Tumwater, Washington.



JOSH PACE
Secretary Senior
Legal Affairs Division

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



March 14, 2013

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

Dear Commissioner Kreidler,

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

I. Individual or Group Market

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

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

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

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

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

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

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

II. Small Group or Large Group

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

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

III. Application to House Bill 1700 and Senate Bill 5605

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

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

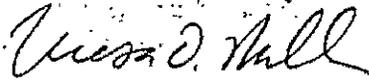
Consequently, House Bill 1700 is inconsistent with the PHS Act and ERISA, to the extent that the legislation (if enacted and implemented by the State as intended) would prevent the application of federal law requirements for coverage offered to small employers through an association.

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

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

Please contact me if you have any questions.

Sincerely,



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



Bob Ferguson
ATTORNEY GENERAL OF WASHINGTON
1125 Washington Street SE • PO Box 40100 • Olympia WA 98504-0100

February 4, 2013

The Honorable Joe Schmick
State Representative, District 9
PO Box 40600
Olympia, WA 98504-0600

Dear Representative Schmick:

By letter previously acknowledged, you requested our opinion on the following question, which we paraphrase for clarity:¹

May the Insurance Commissioner independently determine whether a multiple employer health plan arrangement constitutes an “employer” (“association of employers acting for an employer in such capacity”) under ERISA,^[2] 29 U.S.C. § 1002(5) and, acting on his interpretation of federal law, order a health carrier to terminate or amend the employer plan accordingly?

BRIEF ANSWER

Yes. The Insurance Commissioner’s responsibility to review health carrier rate and form filings requires the Commissioner to evaluate whether a plan offered by a health carrier uses a lawful rating method. To make that evaluation, the Commissioner may examine if the health carrier has submitted a rate filing using a rating scheme available only to those who satisfy the definition of “employer” under ERISA. That definition includes a multiple employer health plan arrangement for an “association of employers acting for an employer in such capacity.” When the Commissioner makes such a determination, he may disapprove a plan based on an unlawful rating scheme.

¹ You also asked: “If the Commissioner may make such independent determinations applying federal ERISA law, *what is the ERISA liability of an employer* acting in accordance with the Commissioner’s opinion and the effect of a differing DOL opinion?” (Emphasis added.) This question would require an opinion on the scope of liability imposed by federal law. As a general matter, the Attorney General’s Office does not provide opinions regarding the interpretation of federal law as applied to private entities.

² Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1114.

ATTORNEY GENERAL OF WASHINGTON

The Honorable Joe Schmick
February 4, 2013
Page 2

ANALYSIS

Your question concerns health plans that are entitled to use an advantageous rating methodology to determine insurance premiums. I will start by providing background regarding the role of the Insurance Commissioner related to health carrier rate and form filings, and the federal and state laws that apply to rating schemes for health insurance. I will then evaluate the state laws that authorize the Commissioner to make and act upon a determination whether a multiple employer health plan arrangement constitutes an "employer" under ERISA.³

A. Background

Before a health carrier⁴ can lawfully sell a health plan in Washington State, the carrier is required to file the contract forms and premium rates applicable to that plan with the Office of Insurance Commissioner. See RCW 48.18.100 (commissioner must review insurance policies); WAC 284-43-920(1) ("Carriers must file with the commissioner every contract form and rate schedule and modification of a contract form and rate schedule[.]") (Emphasis added.). The Commissioner reviews the rate and form filings to ensure that the health plan in question complies with applicable state and federal laws. WAC 284-43-920; see generally WAC 284-43-901 (filings allow the Commissioner to implement statutes related to "evaluations of premium rates"). Under RCW 48.18.110, the Commissioner is required to disapprove policies that do not comply with RCW Title 48 and the regulations adopted thereunder. Under WAC 284-43-125, "[h]ealth carriers shall comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits."

Over the years, a variety of state and federal laws have addressed the rates that health carriers are permitted to charge. As a general rule in Washington, carriers that offer health plans to individuals and small groups in Washington are required to use "community rating." See RCW 48.44.023(3) (describing allowable factors for rating). In general, this community rating scheme requires a carrier to apply the same premium rates to all enrollees in that type of plan, regardless of health status related to individual risks (e.g., current or past illnesses, genetic predispositions to illness). RCW 48.44.023(3). But Washington statutes also provided that health plans offered to associations or member-governed groups formed specifically for the purpose of purchasing health care were exempt from the community rating requirements imposed on the individual and the small group market. RCW 48.44.024(2). Thus, under these state laws, "association health plans" were an exception to community rating requirements applicable to small groups.

³ ERISA, 29 U.S.C. § 1002(5), defines "employer" as an "association of employers acting for an employer in such capacity."

⁴ "Health carrier" means insurance companies, disability insurers, health care service contractors, and health maintenance organizations. RCW 48.43.005(25).

ATTORNEY GENERAL OF WASHINGTON

The Honorable Joe Schmick
February 4, 2013
Page 3

The federal health care reform law, known as the Patient Protection and Affordable Care Act or ACA, imposes new requirements on the ratings that health carriers may use to set premiums. The federal laws regarding allowable ratings, however, do not mirror the association health plan category under state law. The ACA requires all individual and small group health plans be community rated. *See* Pub. L. No. 111-148, § 1201(4) (Mar. 23, 2010) (enacting amended 42 U.S.C. § 300gg). However, a plan need not comply with the ACA community rating requirements applicable to individual and small group plans under the ACA if the plan is offered to a large group as defined by federal regulations. Pub. L. No. 111-148, § 1201(4) (amending 42 U.S.C. § 300gg-4).

To explain further, federal law provides that any health insurance coverage not offered in connection with a group health plan is "individual market coverage." 45 C.F.R. § 144.103. The term "group market" refers to health insurance coverage offered in connection with a group health plan. *See* 45 C.F.R. § 144.103. The group market is divided into the small group market and the large group market, depending on the number of employees employed by the employer. *See* 42 U.S.C. § 300gg-91(e). Federal law also relies on the definition of "employer" in ERISA, when calculating the number of employees employed by an employer. 42 U.S.C. § 300gg-91(a)(1), (d)(6). ERISA, in turn, defines "employer" to include an individual employer and certain associations of employers acting for an employer. 29 U.S.C. § 1002(5). ERISA also recognizes a "multiple employer welfare arrangement" (MEWA), which is an employee welfare benefit plan established or maintained for the purpose of offering or providing any such benefits to employees of two or more employers. 29 U.S.C. § 1002(40); *see also* 42 U.S.C. § 300gg-91(e)(3) (defining "large group market").

I review this complicated scheme of federal statutes and regulations to establish one point. If an association is a "multiple employer welfare arrangement" for purposes of the definition of employer found in ERISA, then its insurance carrier does not have to pool the members of the arrangement in the community rating pools otherwise required for individual and small group purchasers of health insurance. Instead, all members of the multiple employer welfare arrangement could be pooled and rated together as a large group. Thus, the allowable rating scheme for an insurance plan to be offered to an association of employers in Washington can depend on whether the association is a MEWA as defined by federal law.⁵

⁵ The federal government, through the Department of Labor, provides guidance on how to identify the situations where an ERISA plan exists in the context of an association. *See* Multiple Employer Welfare Arrangement Guide (MEWA Guide), <http://www.dol.gov/ebsa/Publications/mewas.html> (last visited Jan. 30, 2013). For examples of Department of Labor opinions applying the multiple employer welfare association category, see Adv. Op. 2008-07A (<http://www.dol.gov/ebsa/regs/aos/ao2008-07a.html>), Adv. Op. 2001-04A (<http://www.dol.gov/ebsa/regs/aos/ao2001-04a.html>), and Adv. Op. 2003-13A (<http://www.dol.gov/ebsa/regs/aos/ao2003-13a.html>).

ATTORNEY GENERAL OF WASHINGTON

The Honorable Joe Schmick
February 4, 2013
Page 4

B. The Commissioner May Review Ratings Used By Plans

The Commissioner has authority to determine if an association falls within the definition of "employer" (including the "multiple employer welfare arrangement") because such determinations are needed to implement state law.

Under the statutes and regulations cited above, the Commissioner must determine if a carrier is using a lawful basis for rating. Therefore, the Commissioner may need to determine if a plan meets an exception to the community rating requirement, such as the exception for large group multiple employer welfare arrangements. *See generally* RCW 48.18.100, .110; WAC 284-43-920, -901 (the statutes and regulations described above on page 2). If not, the plan is inappropriately avoiding the ACA community rating requirements, and the Commissioner will disapprove the rates that have been filed. *See* WAC 284-43-125.

In addition to the statutes that generally direct the Commissioner to enforce the insurance code, authority to make a determination regarding lawfulness of rating can be found in the statutes authorizing the Commissioner to make investigations and determinations as needed to enforce the code. RCW 48.02.060. In particular, RCW 48.02.060(3)(b) specifically authorizes the Commissioner to "[c]onduct investigations to determine whether any person has violated any provision of [the insurance] code." Subsection (3)(c) authorizes the Commissioner to "[c]onduct . . . investigations . . . in addition to those specifically provided for, useful and proper for the efficient administration of any provision of this code." Finally, RCW 48.02.060(1) states that the Commissioner has "authority expressly conferred upon him or her by or reasonably implied from the provisions of this code."

Therefore, because state law requires the Commissioner to review plans and ratings, the Commissioner is empowered to take reasonable steps to investigate and determine if a plan proposes a lawful rating scheme, including making an independent determination about whether a multiple employer health plan arrangement constitutes an "employer" ("association of employers acting for an employer in such capacity") under ERISA, 29 U.S.C. § 1002(5).

C. The Possibility That State And Federal Agencies May Construe Federal Law Differently Does Not Preclude The Commissioner From Independently Determining That A Multiple Employer Health Plan Arrangement Constitutes An "Employer" Under ERISA

Our opinions do not generally address the question of whether federal law might preempt state law, thereby precluding an action that would take place under state law. This is because our office generally serves the function of defending the validity of state laws. Your question appears to be rooted in the possibility of conflict between the Commissioner's determination and a determination by a federal agency, when those determinations arise from the interpretation of federal law.

ATTORNEY GENERAL OF WASHINGTON

The Honorable Joe Schmick
February 4, 2013
Page 5

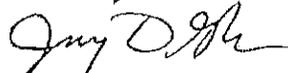
The possibility that state and federal agencies might reach different conclusions regarding the application of federal law does not support a conclusion that the Commissioner cannot review rate filings and, in doing so, examine whether the rate is lawfully available for the plan. In particular, the Commissioner's review of arrangements in the context of reviewing rate filings does not make it impossible to comply with federal law. At most, a conflict might arise from inconsistent determinations about a particular arrangement, but that conflict disappears if the Commissioner yields to a federal determination (which the Commissioner's determination, attached to your inquiry, appears to acknowledge). Additionally, federal law, in the form of the ACA and ERISA provisions reviewed above, recognizes that state Commissioners regulate health insurance and review ratings. Federal law, accordingly, contemplates the Commissioner's enforcement of community rating requirements.

D. The Commissioner Has Statutory Authority To Act On A Determination

Your question also asks if the Commissioner can take actions based on the determination. Under the statutes and regulations reviewed on page 2, the Commissioner may disapprove a filing so that a plan could not be lawfully offered in Washington, under the authorities reviewed above.

I trust that the foregoing will be useful to you.

ROBERT W. FERGUSON
Attorney General


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

WROS

FILED

2015 MAY 26 A 9 44

**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

DECLARATION OF LICHIOU LEE

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

3 2. I am a member of American Academy of Actuaries and meet its general
4 qualification standard, including continuing education requirements. I am also a qualified
5 actuary as defined under Washington Administrative Code (WAC) 284-05-060.
6

7 3. I am employed by the State of Washington Office of the Insurance
8 Commissioner (OIC) as the lead health actuary, a position I have held since 1999. My
9 responsibilities include reviewing health insurance plan rate filings submitted for sale to
10 Washington State consumers. As part of this process, I analyze benefits, reserves, rating data,
11 underwriting procedures, financial data and other facets of health carrier and insurance
12 company operations, and perform actuarial analyses of rate filings and reports applicable to
13 specific regulatory issues.
14

15 4. The OIC's health actuarial staff, including me, are responsible for rate review of
16 large group health plans submitted to the OIC.

17 5. The term "rate review," or "review of rates" encompasses many actuarial tasks
18 that occur during review of a plan.

19 6. Issuers design and sell one of three types of plans to consumers based on the
20 size of the "group" purchasing the plan: large, small, and individual. One task within rate
21 review is examination of the plan's design and rating information, to determine that they meet
22 the requirements of applicable state and federal law. This includes ensuring that plans are not
23 discriminatory, and are designed for the applicable consumers based on the size of the "group"
24 purchasing the plan: large, small, and individual.
25
26

1 7. The OIC is authorized and obligated to review all large group filings to
2 determine whether their plan design and rating information comply with state and federal law.

3 8. Issuers are required to file large group rate filings. There is no specific
4 requirement that issuers rate and file all large groups together. As a result, issuers can choose
5 to file a large group rate filing for each employer or one large group rate filing for multiple
6 employers.
7

8 9. In 2009, the OIC received more than 400 large group rate filings from Regence
9 BlueShield, and we questioned and sent out objections to at least 40 rate filings. The objections
10 in Regence large group rate filings include questions such as the validity of the size of the
11 group (OIC filing SERFF Tracking Number RGWA-126120899), the applicable information
12 not submitted (OIC SERFF Tracking Number B861-126099311), and incomplete rate schedule
13 (OIC SERFF Tracking Number B861-126041928).
14

15 10. Another task within the large group rate review is to evaluate the rate filings to
16 determine that they comply with Washington state requirements, including minimum loss ratio
17 requirements. As part of this review, we evaluate information of rating assumptions issuers
18 used to set the premiums. The rating assumptions include medical trend, administrative
19 expenses and profits.
20

21 11. The loss ratio regulations apply to all (individual, small group, and large group)
22 plans written by disability carriers. [Chapter 284-60 WAC]. They do not apply to plans
23 written by HCSCs (such as Regence BlueShield) and HMOs.

24 12. The Commissioner's May 14, 2010 letter to Ms. Sebelius generally describes
25 the risk of market instability posed by inadequate review of rate filings. In that context, the
26 statement that OIC lacks authority to review large group rates, other than for disability

1 insurers, refers to the OIC's lack of authority to review the large group loss ratio requirements
2 for HCSCs and HMOs.

3
4 SIGNED this 21st day of May, 2015 at Tumwater, Washington.

5 
6 Lichiou Lee

7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26