FILED

2015 MAY -6 P 5:04

BEFORE THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

IN THE MATTERS OF:

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

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

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

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

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

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

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

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

I. INTRODUCTION

Master Builders Association of King and Snohomish Counties and Master Builders Association of King and Snohomish Counties Employee Benefit Group Insurance Trust

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

(collectively "MBA Trust"), Building Industry Association of Washington Health Insurance Trust ("BIAW Trust"), and Northwest Marine Trade Association and Northwest Marine Trade Association Health Trust (collectively, "NMTA Trust") are industry-specific association health plans (collectively referred to herein as the "AHPs") that facilitate the purchase of healthcare benefits for over 2,000 member employers. The fully-insured plans ("the Plans") offered by these AHPs through its issuer, Regence BlueShield ("Regence") (a subsidiary of Cambia Health Solutions ("Cambia")), provide health care coverage to approximately 57,500 employees and eligible dependents, all of whom are negatively affected by the Office of Insurance Commissioner's ("OIC") disapproval of the 2014 rate forms and filings for these AHPs ("the Filings").[1]

For more than a decade, the OIC has approved plans submitted by Regence that utilized the same rating method as the 2014 Filings. The OIC has now abruptly changed its policy, despite the fact there has been no change in the law or other supportable reason for the OIC's inexplicable about-face. Indeed, the OIC cannot explain its current posture; its arguments have continuously shifted, highlighting its futile search for a legal basis for its position. The OIC first focused on the Health Insurance Portability and Accountability Act ("HIPAA") in its Objection Letters to Regence, then shifted its focus to rely exclusively on an inapplicable state law in its Rejections. What is more, the OIC previously admitted that it lacks the authority to approve or deny AHP rates at all.

The OIC's disapprovals are without basis in federal or state law, and they have the inequitable effect of prejudicing tens of thousands of Washington citizens in direct contravention of the central purpose of the Affordable Care Act ("ACA"): to provide

[1] Only the rating methodology and rates are at issue.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

individuals with access to affordable health care. MBA Trust, BIAW Trust, NMTA Trust, and Cambia therefore move for judgment as a matter of law, pursuant to WAC 10-08-135.

II. BACKGROUND

A. MBA Trust

MBA Trust facilitates the purchase of health benefits for over 1,300 companies in the building and construction industry. It is the Northwest's largest industry-specific healthcare program, serving over 40,000 enrollees. Declaration of Jerry Belur in Support of MBA Trust, BIAW Trust, and NMTA Trust's Motion for Summary Judgment ("Belur Decl."), ¶ 2. In 2014, MBA Trust provided fully-insured benefit plans through Regence ("the MBA Plans") to over 1,300 companies in the building and construction industry located in King and Snohomish Counties ("MBA Participating Employers"), ranging in size from two to over 800 employees. The MBA Participating Employers, in turn, offered the MBA Plans to their employees and eligible dependents ("MBA Members"). *Id.* Approximately 40,000 MBA Members were enrolled in the Plans in 2014. *Id.*

B. BIAW Trust

Modeled after MBA Trust, BIAW Trust provides companies in the building and construction industry located outside King and Snohomish Counties with health insurance for their employees. *Id.* at ¶ 3. In 2014, BIAW provided fully-insured benefit plans through Regence ("BIAW Plans") to 600 employer members ("BIAW Participating Employers"), ranging in size from two to approximately 600 employees. BIAW's Participating Employers offered the BIAW Plans to approximately 15,000 employees and eligible dependents ("BIAW Members") in 2014. *Id.*

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

C. NMTA Trust

NMTA Trust offers healthcare benefit plans to companies in the recreational boating and marine industries. *Id.* at ¶ 4. In 2014, NMTA Trust provided fully-insured health benefit plans (through Regence) ("NMTA Plans") for over 114 companies ("NMTA Participating Employers"). *Id.* NMTA Trust's Participating Employers offered the NMTA Plans to approximately 2,500 employees and eligible dependents ("NMTA Members"). *Id.* Recently created, NMTA Trust first began serving NMTA Members in 2014. *Id.*

D. Regence's 2014 Filings

Cambia is a non-profit corporation that sells health insurance through several subsidiaries, including Regence, a Washington healthcare services contractor. Declaration of Dale Neer in Support of Motion for Summary Judgment by MBA Trust, BIAW Trust, NMTA Trust, and Cambia ("Neer Decl."), ¶¶ 2-3. In mid-February 2014, Regence submitted the 2014 rate and form filings associated with the Plans for the NMTA Trust and MBA Trust to the OIC, via the System for Electronic Rate and Form Filing ("SERFF"). *Id.* at ¶ 5. Regence similarly filed the rate and form filings for the BIAW Trust on April 25, 2014. *Id.* Although the Filings were submitted by Regence, they were the result of a collaborative process that included the three AHPs. *Id.* at ¶ 6.

Just as had been the case in past years for the MBA Plans and the BIAW Plans, and as previously approved by the OIC, the 2014 Filings included multiple rate categories and custom rates that applied to the Plans, with different monthly rates associated with each category or custom rate.[2] *Id.* at ¶ 8. The rating categories are established at the Participating

[2] 2014 was the first year in which Regence filed rate and form filings for NMTA Trust. However, Regence has filed rate and form filings for MBA Trust and BIAW Trust since such

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

Employer[3] level, rather than across the entire association. *Id.* Each Participating Employer is assigned to one of several rate categories or a custom rate was developed and filed specific to a Participating Employer. *Id.* MBA Trust and NMTA Trust utilize three rate categories for new Participating Employers, and four rate categories for Participating Employers that renew with each Trust. New Participating Employers are generally placed in either rate category 0, 1, or 2. *Id.* at ¶ 9. MBA Trust and NMTA Trust use rate categories 0, 1, and 2 for new Participating Employers that are not currently receiving Regence Direct Coverage. *Id.* New Participating Employers moving from Regence direct coverage to the MBA Trust or NMTA Trust usually receive category 2 rates or custom rates. *Id.* Participating Employers renewing coverage with MBA Trust or NMTA Trust are either left in their current rate categories or moved to new rate categories based on the following factors: (1) Participating Employer demographics and enrollment changes; (2) geographical location of Members; (3) Participating Employer contribution; (4) current benefit selection; (5) participation in wellness and prevention programs; (6) length of participation in the Trust; (7) the overall claims experience of the Trust and Participating Employer;[4] and (8) competitive consideration. *Id.* BIAW Trust utilizes a very similar rating methodology to MBA Trust and NMTA Trust, with

---

filings were first required by law. Regence has maintained electronic records for BIAW dating back to 2001 and for MBA dating back to 2002. Neer Decl., ¶ 7.

[3] Employers participating in the MBA Trust, BIAW Trust or NMTA Trust are collectively referred to as "Participating Employers."

[4] Regence reviews claims experience and large claims data for Participating Employers and has historically used this information to assign Participating Employers to rate categories or in the development of custom rates, as is customary with industry-standard underwriting practices. Neer Decl., ¶ 8.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

the exception that it utilizes five rate categories for Participating Employers that renew with the Trust. *Id.* at ¶10.

This approach is illustrated in the following hypothetical:

- Participating Employer A is assigned to rate category 3, based on factors such as Participating Employer A's demographics, geographical location, contribution, benefit selection, participation in wellness and prevention programs, and length of participation in the Trust. All Members employed by Participating Employer A pay the rates associated with rate category 3, regardless of their health status.

- Participating Employer B is assigned to rate category 4, based on factors such as Participating Employer B's demographics, geographical location, contribution, benefit selection, participation in wellness and prevention programs, and length of participation in the Trust. All Members employed by Participating Employer B pay the rates associated with rate category 4, regardless of their health status.

- The Members who are employees of Participating Employer A and the Members who are employees of Participating Employer B pay different monthly rates, because the Participating Employers are assigned to different rate categories. Thus, a 30-year-old employee of Participating Employer A pays the rates associated with rate category 3, while a 30-year-old employee of Participating Employer B pays the different rates associated with rate category 4.

This method of rating—establishing multiple rate categories at the Participating Employer level—is not new to Regence's 2014 Filings for these AHPs. The OIC accepted this method of rating and approved Regence's rate and form filings associated with the MBA Trust and BIAW Trust Plans for more than a decade.[5] *Id.* at ¶¶ 8, 11.

[5] 2014 was the first year in which Regence filed rate and form filings for NMTA Trust. Neer Decl. at ¶ 7.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

C. The OIC's Initial Objection Letters

In March 2014, the OIC sent Regence substantially identical Objection Letters related to the MBA and NMTA Plans through SERFF. *Id.* at ¶¶ 12-13 & Exs. 1, 3. On July 3, 2014, the OIC sent a nearly identical Objection Letter to Regence regarding the BIAW Plans. *Id.* at ¶ 14 & Ex. 5. The Objection Letters read, in relevant part:

> For all large groups, including associations who qualify under the ERISA 3(5) definition of an employer, the federal Health Insurance Portability and Accountability Act (HIPAA) prohibits discrimination against participants and beneficiaries based on a [sic] health status-related factors. Specifically, a group health plan, and health insurance issuer offering group health coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual related to the health-related factors. Federal law prohibits use of the following factors: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. 29 CFR Chapter XXV, Section 2590.702.
>
> As a result, under HIPAA an issuer or association must not use health-status related data or information from a specific participant, a subgroup of participants, or a participating purchasing group within the association to establish rates for the participant or the group purchaser. This includes specific health status, claims experience, participating requirements, etc. As an example, for any two similarly situated individuals (the same age group and gender) within the association employer, the association health plan as the group health plan or the carrier as the issuer cannot charge higher rates for one individual simply because the one individual has more medical claim history or existing medical conditions than the other individual.
>
> Issuers are permitted to use non-health status-related rating factors permitted by federal or state law for a particular large group health plan. Permitted factors include demographics, age, area, and gender.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

Id. at Exs. 1, 3, 5 (emphases added). The Objection Letters noted that Regence's rate schedules identified different rate categories and asked Regence to "[e]xplain in detail how you define a rate category including factors used to assign a rate category." *Id.*

Regence responded to the OIC's Objection Letters regarding the MBA and NMTA Plans in April 2014 and to the OIC's Objection Letter regarding the BIAW Plans on August 1, 2014, clarifying that Regence did not utilize individual health-related factors in setting rates. *Id.* at ¶¶ 12-14 & Exs. 2, 4, 6. For example, in its Response Letter regarding the BIAW Plans,[6] Regence clarified:

> The [AHP] utilizes three rating categories for new member groups, and five rating categories for member groups that renew with the trust. Each new member group is placed in rating category 0-2. [AHP] uses categories 0 & 1 for new member groups that are not currently receiving Regence direct coverage. New member groups placed in category 0 must meet the following criteria: (1) be a part of a stable industry group; (2) currently receive coverage in a group health plan offered by a Regence BlueShield competitor; (3) provide current and renewal rates; (4) maintain at least ten enrolled employees; (5) maintain an average 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 our quote. All new member groups moving from merit sized Regence direct to the [AHP] receive category 2 rates. An individual participant's health status (or medical condition) is not a factor when determining the rating category. Renewal groups are either left in their current category or moved to a new category at renewal with the goal of balancing the overall needed premium increase for the association's renewal. Member groups may be moved from their current categories based on the following factors: (1) member group demographics and enrollment changes; (2) geographical location of employees; (3) member group contribution; (4) current benefit

[6] Regence's Response Letters regarding the MBA and NMTA Plans were substantively similar. *See* Neer Decl., Exs. 2, 4.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

selection; (5) participation in wellness and prevention programs; (6) length of participation in the trust; and (7) the overall claims experience of the [AHP]. An individual participant's health status (or medical condition) is not a factor when determining the new rate category. For new member groups, the general agent for the Association assigns the new business rate categories, which are reviewed & approved by Regence upon enrollment. For renewal rate categories, the general agent moves member groups into the appropriate renewal category. Regence reviews and approves the overall premium increase for the Association as a whole.

(a) If requested, a group with 50 or more enrolled employees may be offered a custom rate. Regence recognizes that for larger groups, administering an age banded rate structure can be administratively cumbersome. In an effort to partner with our groups, Regence will calculate custom rates when applicable. In order to be eligible to receive custom rates, the group must have at least 50 employees or be individually approved as an exception. The exception process is largely a creature of historical significance. The exception would occur where the coverage is moving from one Regence BlueShield association to another. This is incredibly rare, because Regence BlueShield associations are bona fide.

(b) New member groups of 125+ employees that have claims data available are experience rated. Member groups with less than 125 employees receive a blended rate that is revenue neutral to categories 0-2. The only exception to a revenue neutral rate is where the rate is lowered based on competitive information. Regence BlueShield creates the blended rate by taking the current census and calculating the total premium for a specific age banded category and then setting 4 tier rates that result in the same premium as the age banded quote. There are rare instances where knowledge of competitive pricing may be used to adjust the rates. At the Association renewal, each custom rated group is assigned a unique rate increase that is added to their current rates. The general agent assigns the group specific rate increase with the intent to balance the overall needed premium increase for the association renewal. An individual participants health status (or medical condition) is not a factor when determining the rate category.[7] Regence reviews and

[7] Regence's responses to the April Objection Letters further clarified that Regence does not require any new or existing members of the AHPs to provide any information regarding their health or claims history. *Id.*

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

> approves the overall premium increase for the Association as a whole.

Id. at Ex. 6 (emphasis added); *see also id.* at Exs. 2, 4.

D. The OIC's October Objection Letters

Several months later, on October 24, 2014, the OIC sent Regence nearly identical Objection Letters through SERFF on October 28, 2014 as to all three AHPs' Plans. *Id.* at ¶ 15 & Exs. 7-9. Notably, the OIC's October Objection Letters focused on a different issue than the initial Objection Letters. In the Objection Letters, the OIC asked Regence, "[p]ursuant to 26 CFR § 54.98021(d)," to "identify the bona fide employment-based classification upon which the [AHP's various] rate categories are based." *Id.* at Exs. 7-9. Regence responded to the October Objection Letters on November 12, 2014, clarifying that (i) it was permitted to use different rating categories when rating subgroups; (ii) the use of the rate categories was consistent with the HIPAA non-discrimination rules cited by OIC in its objection letters; (iii) each subgroup may be treated separately because each subgroup is an independent ongoing business and is managed separately from other subgroups; (iv) the various rate categories are warranted given that employment criteria, employment needs, and benefit mix may be unique to each subgroup, (v) none of the rating criteria are based on the purchase of health insurance; and (vi) none of the similarly situated persons in each group are discriminated against based on health status. *Id.* at ¶ 15 & Exs. 10-12; *see also* Belur Decl., ¶ 8.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

F. The OIC's Rejections of the Filings

On January 15, 2015, the OIC issued its disapprovals of the AHPs' Filings. *Id.* at ¶ 16 & Exs. 13-15. The disapprovals were substantively similar. Once again, the OIC shifted its position and focused on an issue that differed from the prior Objection Letters. *See id.* at Exs. 13-15. Implicitly recognizing the inapplicability of the HIPAA non-discrimination provisions to the Filings and its lack of authority to reject the Filings on that basis, the OIC instead exclusively relied on RCW 48.44.020(3), a statute that is equally inapplicable.

The MBA Trust disapproval provided as follows:

> Your rate and form filings for Master Builders Association of King and Snohomish Counties are disapproved and closed under the authority of RCW 48.46.060(4).
>
> The rating methodology and rates filed on behalf of the Master Builders Association of King and Snohomish Counties and the Master Builders Association of King and Snohomish Counties Employee Benefit Group Insurance Trust are inconsistent with the fact that you filed one single large employer group.
>
> In the rate schedule, there are 4 Rate Categories for each plan design. For example, for the Enhances E10 Plan, an employee age between 35 and 49 can be charges a monthly rate ranging from $498.42 to $688.50. In our rate objections, we asked you to explain in detail how you define a Rate Category and the factors used to assign an employee to a Rate Category. We also asked you to provide detailed calculations of the rates assigned to each Rate Category. Your response to the first objection letter indicated that you have separately rated various "member groups" within the Master Builders Association of King and Snohomish Counties. You also stated that the Association renewal, each "custom rated group" is assigned a unique rate that is added to their current rates. This means that your rates filed are for various "employers" -- contrary to your form filing for one employer only.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

> We also asked you to identify the bona fide employment-based classifications upon which the 4 Rate categories are based (per 26 CFR § 54.9802-1(d).) (Examples for bona fide employment-based classifications include current versus former employees, and employees located in different geographic areas.) You stated that "each subgroup" may be treated separately as each subgroup is an independent ongoing business. You further stated that each subgroup is managed separately from other subgroups and "employment" criteria, "employment" needs, benefit mix, may be unique to each subgroup. Your response reiterates that you have separate rates various 'member groups.' Your response failed to identify how each Risk Level is related to bona fide employment-based classifications.
>
> This tells us that your rates, filed for various employers, are unreasonable in relation to the amount charged for the contract for one single employer, Master Builders Association of King and Snohomish Counties. Therefore, your rate and form filings are disapproved and closed under the authority of RCW 48.44.020(3).
>
> As a result of this disapproval, it is necessary for all current enrollees to be transitioned to a compliant plan as soon as possible. Please contact the Deputy Insurance Commissioner for Rates and Forms to discuss your plan to transition current enrollees to a compliant plan, including the proposed notice and replacement rate schedule.

Id. at Ex. 13; *see also id.* at Exs. 14-15.

The three AHPs and Cambia each timely filed a demand for hearing challenging the OIC's disapprovals pursuant to RCW 48.04.010 *et seq.* *See* Demands for Hearing filed by MBA Trust, BIAW Trust, NMTA Trust, and Cambia 1-3.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

III. STANDARD OF DECISION

Summary judgment in an administrative proceeding is appropriate "if the written record shows that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." WAC 10-08-135; *see also Stewart v. Dep't of Soc. & Health Servs.*, 162 Wn. App. 266, 270, 252 P.3d 920 (2011). All facts are viewed "in the light most favorable to the nonmoving party." *Granton v. Wash. State Lottery Comm'n*, 143 Wn. App. 225, 230, 177 P.3d 745 (2008).

Here, the parties agree that this matter presents legal issues that would be decided most efficiently via dispositive motions. *See* Prehearing Conference Order and Order of Consolidation at 3.

IV. ARGUMENT

The OIC lacks any foundation in state or federal law to disapprove the Filings at issue. These baseless disapprovals undermine the AHP's entire business structure and rating model and thus stand to deprive tens of thousands of Washington citizens and their dependents of affordable health care options. Specifically, the OIC's denial hinges on the fact that the AHPs utilize multiple rating categories applied at the Participating Employer level, rather than to the association as a whole. *See* Neer Decl., Exs. 13-15. But absolutely nothing in state or federal law prohibits such an approach or authorizes the OIC to disapprove the Filings on that basis.

When the courts examine administrative decisions upon judicial review, they:

> will reverse an administrative decision that (1) violates a constitutional provision on its face or as applied, (2) lies outside the agency's lawful authority or jurisdiction, (3) is a result of an erroneous interpretation or application of the law, (4) is not based on substantial evidence, or (5) is arbitrary or capricious.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

Granton, 143 Wn. App. at 231; RCW 34.05.570(3). The OIC's disapprovals fall into several categories that would justify reversal if the OIC's decisions were appealed to a superior court. The disapprovals "lie[] outside the agency's lawful authority or jurisdiction," as there is no legal basis for the OIC's disapproval of the Filings. *Granton*, 143 Wn. App. at 231. The Rejections are also "a result of [the OIC's] erroneous interpretation or application of the law," and their lack of any legal support renders them "arbitrary." *Id.*

A. The OIC's Position Is Not Supported by State Law

1. RCW 48.44.020(3) Does Not Support the OIC's Position

The OIC's disapprovals cite RCW 48.44.020(3) as the exclusive basis for the decisions, stating:

> [Y]our rates, filed for various employers, are unreasonable in relation to the amount charged for the contract for one single employer, Master Builders Association of King and Snohomish Counties. Therefore, your rate and form filings are disapproved and closed under the authority of RCW 48.44.020(3).

Neer Decl., Ex. 13. *See also id.* at Exs. 14-15.

RCW 48.44.020(3) does not provide any "authority" or basis for disapproving the Filings. It provides only a limited basis on which to disapprove a health care benefits contract, which does not apply to the facts here: "[T]he commissioner may disapprove any agreement if the benefits provided therein are unreasonable in relation to the amount charged for the agreement." RCW 48.44.020(3) (emphasis added). The OIC has made no assertion whatsoever that the benefits provided under the Plans are somehow "unreasonable in relation to the amount charged for the agreements." The provision is simply inapplicable here.

The OIC appears to have implicitly recognized the inapplicability of this provision, as it added non-existent language to the statute in its disapprovals. Rather than disapproving the

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

Filings because "the benefits provided therein are unreasonable in relation to the amount charged for the agreement,"[8] as the statute provides, the OIC disapproved the Filings because the "rates, filed for various employers, are unreasonable in relation to the amount charged for the contract for one single employer." Neer Decl., Exs. 13-15 (emphasis added). That is not what the statute provides.

RCW 48.44.020(3) does not provide the OIC with the authority to reject Filings based solely on the rates charged to Members. The term "benefits" is not synonymous with the term "rates."[9] "[T]he legislature is deemed to intend a different meaning when it uses different terms." *State v. Roggenkamp*, 153 Wn.2d 614, 625, 106 P.3d 196 (2005). Significantly, the same statute mentions "rates"[10]—but does not authorize the Commissioner to reject filings on the grounds that differing Member rates are purportedly "unreasonable." Instead, the sole statutory basis to disapprove a filing under RCW 48.44.020(3) must be based on a comparison of the healthcare benefits offered by the contract with "the amount charged for the agreement." The Legislature clearly intended "benefits" and "rates" to mean two different things; they are not interchangeable. *See Roggenkamp*, 153 Wn.2d at 625; *In re Forfeiture of One 1970 Chevrolet Chevelle*, 166 Wn.2d 834, 838-39, 215 P.3d 166 (2009) (holding that "the ordinary meaning of words . . . and the statutory context" factor into a determination of legislative intent).

Nor does RCW 48.44.020(3) impose special restrictions on filings related to associations. The statute means exactly what it says and no more: that "the commissioner may

---

[8] RCW 48.44.020(3) (emphasis added).

[9] "Benefits" are the advantages to which the Member is entitled under the terms of the Plan, while "rates" are the sums paid in exchange for those benefits.

[10] *See* RCW 48.44.020(3) ("Rates, or any modification of rates effective on or after July 1, 2008, for individual health benefit plans may not be used until sixty days after they are filed with the commissioner.").

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

disapprove any agreement if the benefits provided therein are unreasonable in relation to the amount charged for the agreement." RCW 48.44.020(3). "When a statute is plain on its face, we give effect to that plain meaning as an expression of legislative intent." *In re Forfeiture of One 1970 Chevrolet Chevelle*, 166 Wn.2d at 838. A "court will not read into [a] statute the language that it believes was omitted." *State v. Moses*, 145 Wn.2d 370, 374, 37 P.3d 1216 (2002). If the Legislature had intended to refer to "rates" as a basis for disapproval in RCW 48.44.020(3), it would have done so.

The inapplicability of RCW 48.44.020(3) is further emphasized by the OIC's own rules implementing that provision. In WAC 284-43-915, entitled "Demonstration that benefits provided are not reasonable in relation to the amount charged for a contract per RCW 48.44.020 and 48.46.060," the OIC outlines the circumstances under which "[b]enefits will be found not to be unreasonable:"

> if the projected earned premium for the rate renewal period is equal to the following:
>
> (a) An actuarially sound estimate of incurred claims associated with the filing for the rate renewal period, where the actuarial estimate of claims recognizes, as applicable, the savings and costs associated with managed care provisions of the plans included in the filing; plus
>
> (b) An actuarially sound estimate of prudently incurred expenses associated with the plans included in the filing for the rate renewal period, where the estimate is based on an equitable and consistent expense allocation or assignment methodology; plus
>
> (c) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges, where the justification recognizes the carrier's investment earnings on assets other than those related to claim reserves or other similar liabilities; minus

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

> (d) An actuarially sound estimate of the forecasted investment earnings on assets related to claim reserves or other similar liabilities for the plans included in the filing for the rate renewal period.

WAC 284-43-915(2) (emphasis added). These calculations clearly relate to the value of the benefits received for the overall amount charged, not to the purported unreasonableness of individual Members' rates when compared to one another.

In sum, the sole statutory basis OIC cites for its disapprovals does not address the OIC's articulated reason for the disapprovals: the fact that the Plans involve multiple rate categories established at the Participating Employer level.

2. No Other State Law Supports the OIC's Position

Neither is there any other basis in state law for the OIC's Rejections. There is no state statute or regulation that provides the OIC with the authority to reject the Filings based on rating methodology. And there is no state statute or regulation that prohibits an AHP from utilizing a rating methodology that establishes rates at the Participating Employer level. In fact, there is no state statute or regulation that limited the rating methodology used by large group association health plans at all. To the contrary, state law expressly exempts AHPs from community rating requirements otherwise applicable to the small group market. *See* RCW 48.44.024(2) ("Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to RCW 48.44.023(3) [community rating].").

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

The OIC has admitted that it lacks authority to approve or deny AHP rates. In a 2010 letter to the Secretary of the United States Department of Health and Human Services ("DHHS"), Commissioner Mike Kreidler stated:

> We [the OIC] do not have authority to review large group rates, other than for disability insurers. We interpret our statutory requirements as treating association health plans as large groups. . . . While the [Patient Protection and Affordable Care Act] requires the Secretary's and/or the relevant state's review of 'unreasonable' rates, the law gives neither the Secretary nor the states specific authority to approve or deny rate requests.[11]

The agency's lack of authority to deny rates was further confirmed in a 2011 report on AHPs commissioned by the OIC, which noted: "For AHPs, the OIC can require prior approval of both rates and forms only for disability carriers. For all other carriers that write AHP business, the OIC has authority to require filing of rates and forms, but can review only forms, and cannot disapprove either rates or forms."[12]

By the plain language of the statute it cites and by its own admission, the OIC had no authority, in RCW 48.44.020(3) or otherwise, to base its disapprovals of the Filings on Regence's rating methodology.

B. The OIC's Position Is Not Supported by Federal Law

The OIC did not identify any basis in federal law for its disapprovals of the Filings, nor is there any applicable basis for doing so. Simply put, there is no federal law that prohibits an AHP from utilizing a rating methodology that establishes rates at the Participating Employer level. The OIC may attempt to say otherwise, pointing to its prior Objection

---

[11] *See* Letter from Mike Kreidler to the Hon. Kathleen Sebelius, Secretary, DHHS (May 14, 2010), at 7-8 (emphasis added) (attached as **Exhibit 1**).

[12] *See* Mathematica Policy Research, Association Health Plans and Community-Rated Small Group Health Insurance in Washington State, Final Report (Sept. 30, 2011) at Appx. A, available on OIC's website at: http://www.insurance.wa.gov/about-oic/commissioner-reports/documents/association-health-plans.pdf (emphasis added) (attached as **Exhibit 2**).

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

Letters. That argument fails on its face because the disapprovals were not issued on the basis of federal law. Even if that were not the case, any attempt to now point to federal law to support the disapprovals would also fail for the reasons set forth below.

1. The HIPAA Non-Discrimination Provisions Do Not Support the OIC's Position

The OIC's Objection Letters cited to the Health Insurance Portability and Accountability Act ("HIPAA") so-called "non-discrimination" provisions.[13] *See* Neer Decl., Exs. 1, 3, 5, 7-9.

The HIPAA non-discrimination provisions provide, in relevant part:

> A group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.

26 C.F.R. § 54.9802-1(c)(1)[14] (emphases added). The provisions further provide:

> ***Group rating based on health factors not restricted under this section.*** Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

---

[13] The HIPAA non-discrimination provisions are found in the Tri-Department Rule adopted by DHHS (codified at 45 C.F.R. § 146.121), the Department of Labor, Employee Benefits Security Administration ("EBSA") (codified at 29 C.F.R. § 2590.702), and the Department of the Treasury (codified at 26 C.F.R. § 54.9802-1). The identical language found in all three code sections is referred to, collectively, as the "HIPAA non-discrimination provisions."

[14] For purposes of brevity, only the Treasury Department's version of the HIPAA non-discrimination provisions will be cited. The other two Departments' versions are identical. *See* n.13, *supra*.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

26 C.F.R. § 54.9802-1(c)(2)(i) (some emphasis added).

"The requirements of [the provisions] apply only within a group of individuals who are treated as similarly situated individuals." 26 C.F.R. § 54.9802-1(d).

> [A] plan may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. . . . [E]xamples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification . . . .

26 C.F.R. § 54.9802-1(d)(1) (emphasis added).

Notably, the OIC's initial Objection Letters cited different purported concerns under the HIPAA non-discrimination provisions than did the October Objection Letters. Neer Decl., Exs. 1, 3, 5, 7-9. And the OIC's disapprovals did not cite to the HIPAA non-discrimination provisions at all. *Id.* at Exs. 13-15.

In its initial Objection Letters, the OIC noted:

> [U]nder HIPAA an issuer or association must not use health-status related data or information from a specific participant, a subgroup of participants, or a participating purchasing group within the association to establish rates for the participant or the group purchaser. This includes specific health status, claims experience, participating requirements, etc. . . .
>
> [HIPAA] prohibits discrimination against participants and beneficiaries based on a [sic] health status-related factors. Specifically, a group health plan, and health insurance issuer

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

> offering group health coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual related to the health-related factors.

Neer Decl., Exs. 1, 3, 5. The OIC required Regence to "[e]xplain in detail how you define the risk level including the factors used to assign a rate category," suggesting concern that the rating methodology involved health status-related factors. *Id.*

In its October Objection Letters, the OIC shifted its focus, demanding that Regence "identify the bona fide employment-based classification upon which the [various] rate categories are based," "[p]ursuant to 26 CFR § 54.98021(d)." *Id.* at Exs. 7-9. Thus, the OIC's new concern appeared to be whether Members employed by different Participating Employers constituted "distinct groups of similarly situated individuals." *See* 26 C.F.R. § 54.9802-1(d)(1).

None of the concerns implied in the initial or October Objection Letters were justified by the HIPAA non-discrimination provisions. To the extent the OIC's disapprovals are purportedly based upon those provisions, that reliance is misplaced. As with the state statute to which the OIC cited, the HIPAA non-discrimination provisions are completely inapplicable to the Filings for three primary reasons: (1) the provisions address the issue of discriminatory premiums at the individual level; (2) Members employed by Participating Employers and their dependents are distinct groups of similarly situated individuals, and Participating Employers' Members need not be compared to one another for purposes of the non-discrimination provisions; and (3) the non-discrimination provisions prohibit only rates based on individual health-related factors.

The HIPAA non-discrimination provisions explicitly permit aggregate rating at the employer level, even if that rating is based on health factors. *Id.* The provisions do not carve

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

out any exception to that general rule for AHPs. *Id.* Indeed, the provisions only address rating methodology at the individual level, prohibiting discriminatory rating based on health factors associated with individuals. 26 C.F.R. § 54.9802-1(c)(1). Use of differing aggregate rates at the employer level, even when those rates take into account aggregate health status data (for example, the overall claims experience of the Trust and/or Participating Employer), is expressly permitted. 26 C.F.R. § 54.9802-1(c)(2)(i).

The fact that rating at the Participating Employer level is not prohibited by the HIPAA non-discrimination provisions was further confirmed by the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in the Frequently Asked Questions it published in connection with the provisions, which included the following exchange:

> **Q:** Can a health insurance issuer charge an employer different premiums for each individual within a group of similarly situated individuals based on each individual's health status?
>
> **A:** No. Issuers may not charge or quote an employer or group health plan separate rates that vary for individuals (commonly referred to as "list billing"), based on any of the health factors.
>
> This does not prevent issuers from taking the health factors of each individual into account when establishing a blended, aggregate rate for providing coverage to the employment-based group overall. The issuer may then charge the employer (or plan) a higher overall rate, or a higher blended per-participant rate.[15]

Here, the differing rates are applied at the Participating Employer level—which is expressly permitted by the provisions— not at the individual Member level. No individual is

---

[15] http://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html (DOL website, with EBSA FAQ) (last visited May 5, 2015) (emphasis added).

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

charged a higher premium "based on any health factor that relates to the individual or a dependent of the individual." 26 C.F.R. § 54.9802-1(c)(1) (emphasis added). Instead, an employee of Participating Employer A may pay a higher rate than an employee of Participating Employer B because of aggregate (rather than individual) factors affecting the rate category assigned to each Participating Employer.

The OIC appears to be asserting that MBA Trust, BIAW Trust and NMTA Trust must each be treated as a single employer for purposes of rate filing, and utilize a single employer rate at the association level, simply because a bona fide association of employers is deemed to be an "employer" under the Employee Retirement Income Security Act ("ERISA") § 3(5). Yet the concepts are not analogous; an association's status as an employer for purposes of ERISA has no bearing on its ability to rate at the Participating Employer level. There is simply no basis for treating each of these AHPs as a single "employer" for filing purposes, turning a blind eye to the reality that an association is comprised of multiple, separate Participating Employers.

Even if the OIC were correct—and it is not—in deeming each AHP the overarching "employer," "[t]he requirements of [the non-discrimination provisions] apply only within a group of individuals who are treated as similarly situated individuals." 26 C.F.R. § 54.9802-1(d).

> [A] plan may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. . . . [E]xamples of classifications that,

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

> based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification . . . .

26 C.F.R. § 54.9802-1(d)(1) (emphasis added). If factors such as "different geographic location" and "membership in a collective bargaining unit" constitute bona fide employment-based classifications, then surely employment by separate Participating Employers is unquestionably a bona fide employment-based classification, warranting different rates for these "distinct groups of similarly situated individuals." *Id.* Such distinctions have long been consistent with the business practices of MBA Trust and BIAW Trust, and the OIC has never previously objected to their rating approach. Neer Decl., ¶ 11. Thus, a comparison of an employee of Participating Employer A with an employee of Participating Employer B is not appropriate under the provisions.

Even if the HIPAA non-discrimination provisions did limit rating at the Participating Employer level, as the OIC incorrectly asserted in the Objection Letters, and even if the Participating Employers were not permissible "distinct groups of similarly situated individuals," the HIPAA non-discrimination provisions are still inapplicable. That is because the rating is not based on individual health status-related factors. Neer Decl., ¶¶ 9-10. The HIPAA non-discrimination provisions only prohibit charging an individual a higher premium "based on any health factor that relates to the individual or a dependent of the individual." 26 C.F.R. § 54.9802-1(c)(1) (emphasis added). The OIC itself has acknowledged:

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

> Issuers are permitted to use non-health status-related rating factors permitted by federal or state law for a particular large group health plan. Permitted factors include demographics, age, area, and gender.

Neer Decl., Exs. 1, 3, 5 (emphasis added). Regardless of whether rating is established at the individual or Participating Employer level, differences in rates are completely irrelevant where, as here, they are not based on individual health status-related factors. *Id.* at ¶¶ 9-10; 26 C.F.R. § 54.9802-1(c)(1).[16]

2. No Other Federal Law Supports the OIC's Position

The HIPAA nondiscrimination provisions are the only federal provisions cited by the OIC in connection with the Filings—and even then only in the Objection Letters and not in the ultimate disapprovals. As discussed above, those provisions do not apply to the Filings. And there is no other basis in federal law for the OIC's disapprovals. To the extent the OIC relies loosely on "the Affordable Care Act" for its decisions, it has failed to cite to any provision of the ACA. Nor could it do so, as no language in the ACA supports the OIC's position.

C. The OIC Lacks the Authority to Impose its Proposed Remedy

The OIC, in its disapprovals, mandates a remedy that does not flow from its decisions. The disapprovals state:

> As a result of this disapproval, it is necessary for all current enrollees to be transitioned to a compliant plan as soon as possible. Please contact the Deputy Insurance Commissioner for Rates and Forms to discuss your plan to transition current enrollees to a compliant plan, including the proposed notice and replacement rate schedule.

---

[16] The Filings each contained a "Certification of Compliance" with the HIPAA non-discrimination provisions, signed by a representative of each AHP. The OIC has not maintained that these certifications are false or inaccurate. *See* Neer Decl., ¶ 5.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

Neer Decl., Exs. 13-15 (emphasis added).

The OIC has rejected Regence's 2014 Filings. *Id.* As of the date of this Motion, MBA Trust, BIAW Trust and NMTA Trust have not received any indication that the OIC has approved Regence's 2015 Filings for these AHPs, involving the Plans in which their Members are currently enrolled. Neer Decl., ¶ 17. Because the OIC has made no decision regarding the currently-applicable plans, it cannot mandate that current enrollees transfer to different plans.

D. Equitable Considerations Further Weigh Against the OIC's Position

The OIC's disapprovals lack any basis whatsoever under state or federal law. The agency's arbitrary and baseless disapprovals of the Filings will negatively affect tens of thousands of Washington employees (and their dependents) if the OIC's proposed remedy is imposed. Members will be obligated to transfer to other benefit plans that may have substantially higher premiums. Belur Decl., ¶ 13; Neer Decl., ¶ 18. Additional harm to several thousand Members of the AHPs will be incurred in the form of potentially reduced benefits and adjusted income tax filings for both the employer groups and their employees. *Id.* Should previously paid benefits require adjustment due to the OIC's dilatory disapprovals, Members will also have larger co-payments, co-insurance, and other out of pocket expenses. *Id.* This result is directly contrary to the underlying purpose of the ACA: to provide citizens with affordable health care.

This result is particularly egregious given the OIC's long history of approving identical rating methodologies of MBA Trust and BIAW Trust and its substantial delay in issuing its disapprovals (nearly one year after the Filings occurred). For more than a decade, the OIC has approved Regence's MBA Trust and BIAW Trust rate filings that involved the very same type

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

of rate categories utilized in the 2014 Filings.[17] Neer Decl., ¶¶ 8, 11. There has been no change in the law since then that would justify a different result, including the ACA. Indeed, the interim final rule containing the HIPAA non-discrimination provisions cited in the Objection Letters was promulgated by DHHS over fourteen years ago, in 2001.[18]

The OIC's long delay in disapproving the Filings has prejudiced the AHPs and Regence. Although Regence submitted the 2014 Filings in February and April 2014, the OIC did not issue its disapprovals for nearly a year—until January 15, 2015. Neer Decl., ¶¶ 5, 16. and Exs. 13-15. The OIC did not issue its initial Objection Letters until several months after Regence submitted the Filings, and then another several months passed before the OIC issued its follow-up Objection Letters. *Id.* at Exs. 1, 3, 5, 7-9. Despite Regence's prompt responses, the OIC still did not issue its disapprovals for two more months. *Id.* at Exs. 10-15. The OIC's delay has placed the three AHPs, Regence, the Participating Employers, and their Members in the inequitable position of facing a significant, negative, and abrupt change to their benefit plans in the middle of a plan year.

V. CONCLUSION

For the reasons set forth above, MBA Trust, BIAW Trust, NMTA Trust and Cambia respectfully request that the OIC's disapprovals be overturned and that the 2014 rate and form Filings be approved by the OIC.

---

[17] As noted above, the 2014 plan year was the first filing Regence made with the OIC with respect to NMTA Trust.

[18] *See* 66 Fed. Reg. 1421 (Jan. 8, 2001). In fact, the substance of what is now 26 C.F.R. § 54.9802-1(c)(1) was present in former 26 C.F.R. § 54.9802-1(b)(1) since at least 1997.

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

Dated this 6th day of May, 2015.

PERKINS COIE LLP

Renee M. Howard, WSBA # 38644
1201 Third Avenue, Suite 4900
Seattle, WA 98101
Phone: (206) 359-8000
Facsimile: (206) 359-9000
rhoward@perkinscoie.com
Attorney for Master Builders Association of King and Snohomish Counties, et al. and Building Industry Association of Washington Health Insurance Trust

STOEL RIVES LLP

with email authority from:

Maren R. Norton, WSBA # 35435
600 University Street, Suite 3600
Seattle, WA 98101
Phone: (206) 624-0900
Facsimile: (206) 386-7500
maren.norton@stoel.com
Attorney for Cambia Health Solutions (Cambia 1, Cambia 2 and Cambia 3)

KUTSCHER HEREFORD BERTRAM BURKART PLLC

with email authority from:

Earle J. Hereford, WSBA # 5188
705 Second Avenue, Suite 800
Seattle, WA 98104
Phone: (206) 382-4414
Facsimile: (206) 382-4412
jhereford@khbblaw.com
Attorney for Northwest Marine Trade Association and Northwest Marine Trade Association Health Trust

CERTIFICATE OF SERVICE

I, Sherri Wyatt, certify under penalty of perjury under the laws of the State of Washington that, on May 6, 2015, I caused the foregoing document to be served on the persons listed below in the manner shown:

Judge George Finkle (Ret.)
Presiding Officer
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
Email: kellyc@oic.wa.gov

Via email and U.S. Mail

Mike Kreidler, Insurance Commissioner
Email: mikek@oic.wa.gov
James T. Odiorne, J.D., CPA, Chief Deputy Insurance Commissioner
Email: jameso@oic.wa.gov
Molly Nollette, Deputy Commissioner, Rates and Forms Division
Email: mollyn@oic.wa.gov
AnnaLisa Gellermann, Deputy Commissioner, Legal Affairs Division
Email: annalisag@oic.wa.gov
Charles Brown, Sr., Insurance Enforcement Specialist, Legal Affairs Division
Email: charlesb@oic.wa.gov
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255

Via email and U.S. Mail

Sherri Wyatt, Legal Secretary
PERKINS COIE LLP

37923-0005/LEGAL125919182.1

Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099
Phone: 206.359.8000
Fax: 206.359.9000

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OLYMPIA OFFICE:
INSURANCE BUILDING
P.O. BOX 40258
OLYMPIA, WA 98504-0258
Phone: (360) 725-7000

OFFICE OF
INSURANCE COMMISSIONER

May 14, 2010

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
Attention: DHHS–2010-PRR
Baltimore MD 21244-8010

Re: Request for Information and Comments regarding Section 2794 of the Public Health Services Act, as set forth in 45 CFR Parts 146 and 148: **Premium Rate Review Process**

Dear Madame Secretary:

Thank you for the opportunity to comment on the U.S. Department of Health and Human Services' (HHS) planned regulatory activity associated with section 1003 of the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, regarding premium rate review, published April 14, 2010 in the *Federal Register*. Washington State's comments provide information about the review process we use, and analysis regarding improvements to the current rate review process, including expanding our authority to review and approve large group and association health plan rates, in addition to commending to you the comments being submitted by the National Association of Insurance Commissioners (NAIC).

Responses to Information Requests

1. Overview of Washington State's Premium Rate Review Process

Washington State's premium rate review process is market specific. The Washington State Office of the Insurance Commissioner (OIC) licenses disability insurers, health care service contractors, and health maintenance organizations. The agency also has more limited oversight of discount health plans and plans offered by entities not falling into one of the three licensure categories. Issuers who are licensed entities must file rates for OIC review for all plans offered in the individual and small group market. The OIC reviews rates for plans issued by disability insurers in the large group and association

health plan market, but does not review rates for those markets for health care service contractor or health maintenance organization health plans.

Rate review is an iterative process. Some filings contain very few documents; others are quite complex, and issuers may file in several submissions over a period of time. After an initial review, OIC staff often request revision and resubmission from issuers. As a result, the OIC often reviews rate filings multiple times, and the final allowed rate is quite different from the one contained in the initial filing. Our data does not classify this as "disapproval" or disallowance of a filing. Under our iterative approach, issuers change approximately 20% of proposed rates, in addition to those that we formally disallow; the net regulatory effect is a more reasonable rate.

In 2009, the OIC handled approximately 2000 rate filings for review in the health care category. These included long term care, Medicare Supplement, vision plan, individual and group dental filings, and conversion plan filings in addition to individual and group medical filings. Excluding dental, vision, long term care, and those filings we received that were not reviewed for rates, the OIC reviewed 885 health care filings, with 37 withdrawals and 22 disapprovals.

The OIC also uses information collected through annual and quarterly statements filed by issuers to understand the potential impact and actual experience on an issuer's financial condition. Issuers file annual statements each March through the National Association of Insurance Commissioners; the OIC receives those annual filings and also requires quarterly information.

2. Market Specific Information

a. Individual Market The Commissioner's rate review authority for the individual market expires January 1, 2012. The Commissioner will ask the legislature to extend and enhance that authority during the 2011 Session, which begins in January.

Currently, individual market issuers must file their proposed rates, and wait 60 days before using them. During this 60-day period, OIC staff reviews the individual market filing, and determines whether the proposed premium is "reasonable in relation to the benefits provided." Issuers have the burden of proof, and must provide justification for all proposed rates, whether the rate decreases or increases. This ensures not only that premium is fair in relation to the cost of services and their delivery, but also that insurers

are not placing their solvency at risk in an effort to capture market share by using artificially low rates to set premium. Such a practice only results in an issuer increasing rates later to "catch up."

If the agency does not deny the proposed premium rate within the 60-day period, it is deemed approved and may be used. Issuers may request an administrative hearing when a filing is disallowed or may re-file their premium proposal.

Requirements Individual market rates are established using an adjusted community rating system. Issuers may only adjust rates based on:

- Family composition
- Age (3.75:1)
- Geography
- Tenure and
- Wellness program use

An issuer's entire individual health plan medical experience is pooled for rating purposes. *See,* Revised Code of Washington (RCW) 48.44.023.

Washington State's retrospective minimum loss ratio (MLR) requirement for the individual market is 74%, less premium tax. Premium tax is 2% for domestic carriers. If an issuer does not achieve the required MLR, the company pays a remittance to the Washington State Health Insurance Pool (WSHIP), the state's high risk pool. Plan participants do not receive rebates.

Documentation Issuers submit the following documentation to the OIC to support premium filings:

- An actuarially sound estimate of incurred claims. Experience data, assumptions, and justification for the issuer's projected incurred claims must be provided in a manner consistent with the issuer's rate-making methodology and incorporate the following elements:
    - A brief description of the issuer's methodology

- The number of subscribers for each month or quarter of the experience period
- Earned premium for each month or quarter of the experience period
- The adjusted earned premium for each month or quarter of the experience period
- Claims data for each month or quarter of the experience period
- Documentation and justification for any adjustments made to the claims experience data
- Documents and justification of the factors and methods used to forecast incurred claims

- An actuarially sound estimate of prudently incurred expenses for non claims expenses. Experience data, assumptions and justifications must be provided by the issuer as follows:

    - A breakdown of the issuer's expenses allocated or assigned to the plans included in the filing for the experience period or for the period corresponding to the most recent "annual statement" schedule "Underwriting and Investment Exhibit, part (3), Analysis of Expenses."

- An actuarially sound provision for contribution to surplus, contingency charges or risk charges.
- An actuarially sound estimate of forecasted investment earnings.
- Adjustment of the base rate for adjusted community rating.
- A certification by a member of the American Academy of Actuaries, or other person approved by the Commissioner, that the adjusted community rate charged can be reasonably expected to result in a MLR that meets or exceeds the MLR standard of 74%, minus the applicable premium tax rate.

Medical trending is also considered in the rate review process for the individual market. Washington State does not impose one standard for calculating medical trending. Each issuer submits the estimate of medical trend with their justification and method for reaching the estimate as part of the rate filing. Qualified actuaries at the OIC validate or reject the issuer's approach and conclusions. *See*, Washington Administrative Code (WAC) 284-43-930 through WAC 284-43-945.

b. Small Group Market Regulation of small group market rates mirrors the individual market with one major difference. While the OIC reviews all individual plan rate filings, unless a waiting period is triggered issuers may use their proposed small group plan rate after filing without waiting for approval. *See,* RCW 48.44.023. The issuer triggers a waiting period if the small group plan's annual rate adjustments vary by up to plus or minus four percentage points from the overall adjustment of the carrier's small group pool. The agency must review these filings within 60-days. Issuers must not use the new rate to set premium during that time frame.

Issuers for the small group market must file the same documentation that is filed for individual market plans regarding proposed rates, and they must pool their health plan medical experience in the same way, and use the same adjusted community rating system.

3. Commissioner's Recommendations Regarding the Secretary's Regulations

a. Manage the Risk of Market Destabilization The best risk management tools available to mitigate the risk of market destabilization are: (1) state regulator authority to review rates in *every* market and (2) state regulator authority to disallow those rates. The review process must permit regulators to evaluate a variety of factors that make sense given their state marketplace. Washington State supports an approach where the federal standards are a federal floor for rate review.

Authority to regulate a market is the first safeguard against market destabilization. For example, between 2000 and 2008, the OIC did not have the authority to review rates in the individual market. It is possible that during that period of time some carriers instituted higher than needed premiums, and that some arbitrarily lowered premiums to gain greater market share (and then raised rates considerably in subsequent years). Both practices are unfair to consumers and dangerous to the solvency of the issuers in the market. In most markets, with Washington State being no exception, the consumers in the individual or small group markets are the most vulnerable. These markets have traditionally been unstable and have seen significant fluctuation in rate increases and benefit decreases over the past decade.

HHS' regulations and process can set standards that help state regulators prevent potential market destabilization. The standards should address both the specific requirements and the general scope of material to review when evaluating a rate.

Example: MLR Standards For example, when a regulator increases the minimum or medical loss ratio requirement, at a certain point, the pressure to achieve the MLR causes the plan to cut administrative costs, at a point unique to each issuer. The OIC evaluates an issuer's management of administrative costs closely, because it is a key performance indicator to evaluate the risk of market destabilization.

Currently, regulators collect information annually about administrative costs through the cost-containment subtotals provided on annual statements. These statements are filed with the NAIC and the state. These filings aggregate this information at a level that does not include the data by plan. This means we do not have credible data at present to project whether the PPACA's inclusion of health care quality costs in premium development will offset the potential impact of the PPACA's use of an 80% and 85% medical loss ratio threshold. Not only is it important in establishing a rate review process to aggregate the data on actual experience at the right level, but the definitions used for the prospective data classifying administrative and medical expenses are critical. Without carefully drawn standards, issuers will be able to reclassify administrative expenses as medical expenses, and artificially increase MLR to meet the federal standard without achieving the actual goal of the legislation.

Our state's experience demonstrates that where the MLR is set has an impact on volatile markets. Note that in Washington, we refer to minimum, not medical loss ratio, and the calculation is performed differently under our regulations than under Section 1001 of the PPACA. However, the role of the MLR for the rate review process is the same regardless of the definition.

Depending on the way it is applied when reviewing the rate, the outcome differs. For the combined segments of the individual, small group and large group markets, Washington's average MLR is 84%. But within just the individual and small group markets, Washington's current average MLR is 74%. These calculations are based on the current state MLR equation, which divides the incurred health care costs by earned premiums; if the MLR calculation adjusts the earned premium in accordance with Section 2718 of the PPACA to account for cost such as taxes and regulatory fees paid, then the current average MLR for Washington's markets rises significantly.

The individual and small group markets in Washington State are dominated by non-profit issuers. Issuers rate those markets using community rating. At the 74% level, we have seen significant migration in less than a decade from the small group market to association health plans, which are not community rated. In part, this is because association health plan rates are not subject to the same rate standards as the individual and small group markets. The result: a high risk of small market destabilization.

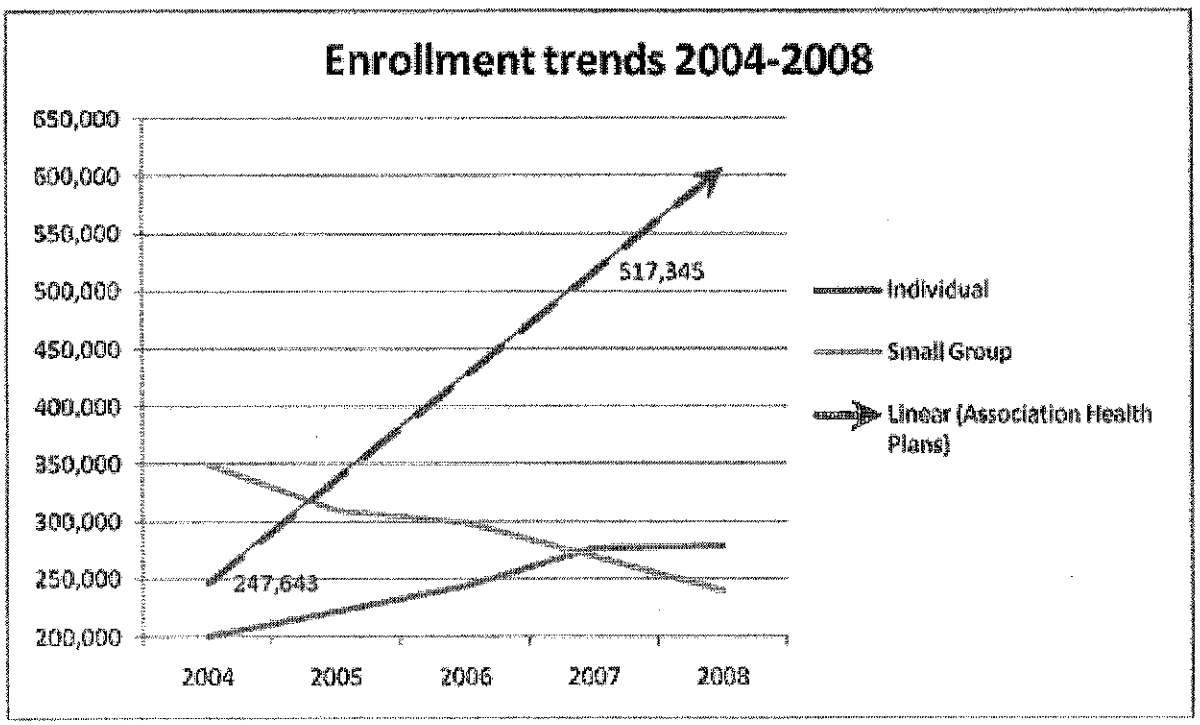


Figure 1. Enrollment by Market Data Source: Office of the Insurance Commissioner market surveys and filed annual reports

b. Authority to Review Across All Markets Our rates do not compare favorably to other States for the large group market, in comparison to the rates for our individual and small group markets. We do not have authority to review large group rates, other than for disability insurers. We interpret our statutory requirements as treating association health plans as large groups. States where rates do not compare as favorably to Washington's in the individual and small group markets typically do not have rate review authority that matches or exceeds ours. As discussed below, the Commissioner needs additional authority to review rates that includes setting a required, meaningful level of aggregation for reporting issuer administrative costs by plan, and authority to consider overall issuer financial performance as affected by the proposed rate.

c. Offer Grant Support to States that Currently Review Rates While the PPACA requires the Secretary's and/or the relevant state's review of "unreasonable" rates, the law gives neither the Secretary nor the states specific authority to approve or deny rate requests. To support achieving reasonable rates on a national basis, each state therefore must have a rate review process that includes authority to review and approve or disallow rates in place. Without this authority, the Secretary is unlikely to achieve the legislation's goal of achieving a healthy and fair consumer health plan marketplace. The grant process can be used to encourage the alignment of State and federal premium rate review processes.

We urge the Secretary to design the grant award process to advance meaningful rate review by state regulators. For states without a regulatory framework for rate review in place, a grant is the encouragement they need to take on rate regulation at the state level. For Washington State, grant support requirements crafted to address these considerations aid our effort – and our need – to renew Commissioner rate review authority in the individual market, and to obtain additional authority over rates for all markets at a 'best practices' level.

The PPACA adds large group and association health plan rate review to the OIC rate review work load. We estimate that the number of filings that we must review will materially increase, creating a significant fiscal impact. For this reason, I recommend that the HHS grant structure include requirements that a state recipient must have, or enact within a certain period of time, (1) the authority to review all rate requests for reasonableness in relation to the benefits provided, and (2) the authority to approve or disallow them within a certain period of time. The "federal floor" approach works best if all states review rates and have the authority to approve or disallow them. Grant support should demand a higher standard than the floor.

d. Expand permitted rate justification factors This higher standard must include factors broader than those currently reviewed in Washington State for the individual and small group markets, and large group disability insurance markets. In reviewing rates, regulators must evaluate the overall finances of the issuer, including consideration of factors like surplus, investment incomes, and the issuer's performance and experience in the large group market.

Greater public disclosure of rate justification illuminates practices that provide consumers with affordable coverage choices and those that don't. This makes the marketplace more stable and healthier as long as consumers understand the meaning of the information presented. We intend to ask for greater public disclosure as part of our legislative request to renew premium rate review authority for the individual market.

4. Defining "Unreasonable" Increases in Premium

a. Current State Regulation of Rates The OIC currently reviews all rate filings in the individual and small group markets. Those markets represent only a small percentage of the total number of plans and covered lives in Washington State. Consumers in all markets have been ill-served by the limits on the Commissioner's authority to review large group and association health plan market rates in Washington.

b. Recommendations It is important HHS regulations do not promote ongoing patchwork rate review authority as this will further fragment the insurance marketplace in states. Through the regulatory framework established for the PPACA, the Secretary can promote rate review of all markets outside the Exchange by the states, as well as rate review for the Exchange on behalf of the Secretary. Occurring at either the national or state level, the opportunity to review rates on an annual basis allows a thoughtful determination of what is acceptable, and helps tag any financial solvency challenges for the issuer.

For that reason, we recommend that each state first review all rates for plans issued in the state and that a state regulator's disallowance serve as the trigger for a further assessment of the issuer's justification by the Secretary. This avoids the confusion caused when a state's approval of a rate increase results in a premium deemed "unreasonable" under the Secretary's criteria. For this reason, distinguishing between a "reasonable" rate and an "unreasonable" premium is also important.

Washington State defines a rate as unreasonable when excessive in comparison to the benefits offered in the plan, or creating an unreasonable risk to financial solvency. There are, of course, many ways of defining "unreasonable." If a consumer cannot afford a premium based on their resources, even though it is based on an actuarially justified rate, that premium is unreasonable to them. A premium may seem unreasonable if the rate supporting it did not evaluate whether administrative resources were directed to customer

service or executive compensation. In both cases, the "unreasonable" premium is based on a "reasonable" rate. When developing the regulations, the standards for rate review must tie to the policy goals embodied in the concept of a reasonable premium. With that in mind, please consider the following when defining what triggers review of a premium by HHS:

a) We urge the Secretary to define "unreasonable" at an accessible level, one that makes it more likely than not that an HHS review is triggered.

b) Do not limit the factors for justification to just one number or circumstance. For example, an issuer meeting the PPACA MLR standard might still have an unreasonable premium if administrative costs are unreasonably allocated to executive compensation, in preference to paying for adequate customer service. Rate review should assess this. Rather than list the factors again here, we defer to the NAIC's comments.

c) One of the multiple factors should be sufficient to trigger HHS review.

d) Require the issuer requesting the rate change to have the burden of proof for justification. Clarify whether regulators are justified in interpreting the PPACA to mean that a rate increase is unreasonable unless certain criteria, as defined in regulation, are present.

e) Require issuers to account for changes to the cost-sharing components as benefit changes for purposes of explaining whether a rate increase is warranted. Washington State does this, and we believe consumers have benefitted.

f) The overarching regulatory consideration must be whether the rate is reasonable in relation to the benefits. This is evaluated by comparing the issuer's past experience overall and for the specific plan being rated, in comparison to the benefits offered and being changed.

g) One factor making a rate unreasonable is whether the issuer can meet the obligation to pay claims, even if a dramatic or unexpected event occurs, such as an epidemic or natural disaster. The documents required for rate review must address the overall finances of an issuer, for if reviewed on a regular basis, potential problems are identified before they arise, ensuring a more stable insurance market.

5. Exchange Participation

The following comments pertain only to the HHS framework for Exchange participation based on issuer rate filing experience. The PPACA precludes participation if an issuer's past rates are "excessive." In this context, we recommend defining "excessive" to mean rates that, from the regulator's perspective, are not warranted based on the combination of factors used to calculate the rate, because they result in an artificially higher base for premium than would an alternative, reasonable methodology.

The regulatory framework to support such a definition should be grounded on state rate review. The most elegant approach to regulating Exchange participation is by limiting participation to issuers:

(1) Who are licensed in the relevant state,
(2) Whose Exchange plan meets the PPACA's 'qualified health plan' standards, and
(3) Whose other plan rates have been reviewed by the state regulator.

Issuers transacting business in Washington State establish reasonableness if they provide actuarially sound estimates as explained by contributions to surplus, contingency charges or risk charges, forecasted investment earnings related to claim reserves, and incurred claims associated with the filings for the renewal period including managed care cost savings estimates. *See,* WAC 284-43-915. The OIC evaluates whether the methodology and estimates are reasonable based on a review of the documentation. Under the PPACA, there seems to be a presumption that rates are "unreasonable" if there is an increase, and justification must follow. This can mean that a decrease in rates -- which may or may not be reasonable from the standpoint of issuer solvency considerations – is not evaluated. This places Exchange plans at risk.

To address this risk, I urge the Secretary to make the first predicate for Exchange participation the requirement that all of an issuer's plans meet state *rate* review standards, whether offered in or outside of the Exchange. For Exchange plans, the Essential Health Benefits requirements will make it easier to compare the basis for rates since there will be a similar basic program design across plans. If this approach is used, then HHS, through the contracted Exchange, excludes an issuer with any pattern or practice of excessive or unjustified rates in the state from participation in the Exchange, regardless of the market.

This eliminates the need for two "tracks" of regulation, and means that the Secretary need not make a determination of whether a pattern or practice of excessive or unjustified *premium* increases exists. We recommend that the Secretary's review and determination of excessive premium serve as a second –tier basis for issuer participation in a state-based Exchange.

Thank you for your review and consideration of these comments. If you have any questions, please contact Mary Clogston, Deputy Commissioner for Policy and Legislative Affairs at 360-725-7037 or marycl@oic.wa.gov.

Sincerely,

Mike Kreidler

Mike Kreidler
Insurance Commissioner

Association Health Plans and Community-Rated Small Group Health Insurance in Washington State

Final Report

September 30, 2011(Updated)

Deborah Chollet
Jessica Nysenbaum
Allison Barrett
Eric Morris
Mathematica Policy Research

James Matthisen
The Mosier Group

This report was developed pursuant to a contract with the Office of the Insurance Commissioner.

Contract Number: 1122

Mathematica Reference Number:
06928.500

Project Officer:
Meg L. Jones
Policy & Rules Manager
Policy & Legislative Affairs Division
Office of the Insurance Commissioner
360-725-7170

Submitted by:
Mathematica Policy Research
600 Maryland Avenue SW
Suite 550
Washington, DC 20024-2512
Telephone: (202) 484-9220
Facsimile: (202) 863-1763
Project Director: Deborah Chollet

Association Health Plans and Community-Rated Small Group Health Insurance in Washington State

Final Report

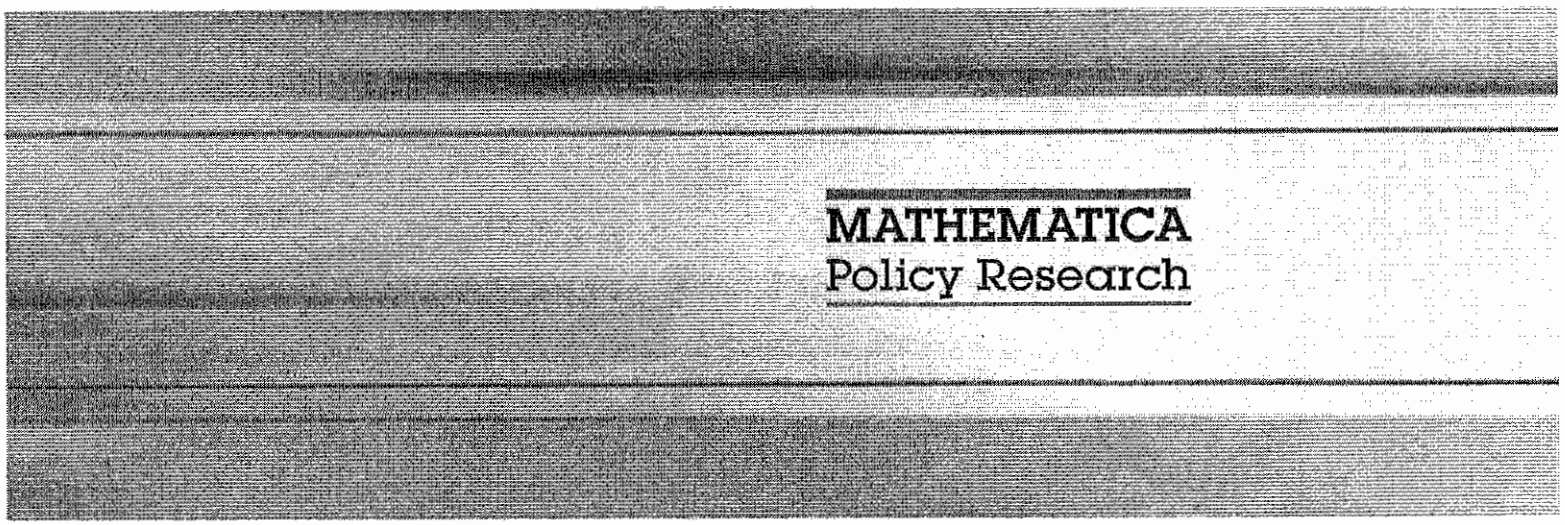
September 30, 2011(Updated*)

Deborah Chollet
Jessica Nysenbaum
Allison Barrett
Eric Morris
Mathematica Policy Research

James Matthisen
The Mosier Group

This report was developed pursuant to a contract with the Office of the Insurance Commissioner.

*Figure 4 is updated in this copy of the final report.



ACKNOWLEDGEMENTS

The authors greatly appreciate the contributions made by staff at the Office of the Insurance Commissioner (OIC). Meg Jones and Jim Keogh provided invaluable guidance and support throughout the process, supplied and directed us to key public data reports, offered carefully prepared and documented estimates to update the survey data, and contributed thoughtful comments on the draft reports. Their considerable efforts are evident throughout the report. We are grateful also to John Haworth and others at OIC who reviewed and commented on the final draft report.

In addition, we are grateful to Linda Melton and her colleagues Will Treinen and Barry Peters at Treinen and Associates, as well as Peter Thomas at Seattle Excel Experts, for preparing the database. The study could not have been accomplished without their strong experience, meticulous work, and thorough professionalism.

Finally, we would like to acknowledge Donna Dorsey at Mathematica Policy Research, who produced the draft and final manuscripts with characteristic skill and good humor.

CONTENTS

TABLES

FIGURES

EXECUTIVE SUMMARY

Washington State has a robust association health plan (AHP) market. Unlike many other states, Washington statute recognizes associations formed for the purpose of insurance. As a result, associations in Washington have been formed on several bases: within industry groups, across industry groups, and as creations of insurance carriers. While most AHPs offer coverage to small groups (with 50 or fewer employees), larger groups account for a growing share of AHP enrollment.

Washington State regulates AHPs as large group plans, specifically exempting them from small group rating and approval requirements. Since 1995, carriers have been able to offer "experience rated" premiums to small employers that buy AHP coverage, taking into consideration each employer's claims experience and the aggregated health history of its employees. Carriers may also use other rate factors to rate AHP coverage—such as gender and nonstandard age brackets for rate differentiation—that are prohibited in the community-rated small group market.

The asymmetric regulation of AHPs and small groups offers substantial opportunity for carriers to select risk. By rating coverage strategically and denying employers where the associations' own rules may permit, carriers can separate the risk pools for AHPs and other employer groups and can isolate high-cost small groups in community-rated coverage. As a result, premiums in the community-rated small group market might be higher for the same benefit design, discouraging some employers from offering coverage at all and driving others to offer less coverage (with more limited benefits and greater cost sharing) than they might if premiums were lower.

This report offers an analysis of the information that carriers provided in response to a data call issued by the Office of the Insurance Commissioner (OIC) as authorized in legislation amending ESBH 1714(2011), as well as other information that carriers reported in regular filings to the OIC and the U.S. Department of Labor.

Enrollment in AHPs and Large Group or Community-Rated Small Group Plans

In 2008, approximately 491,300 Washington State residents were enrolled in AHP plans, including 227,000 enrolled through small employers and 264,300 enrolled through large employers. AHP enrollees accounted for more than one-third of total insured group coverage—16 percent in small groups with AHP coverage and 18 percent in large groups with AHP coverage. Nearly half of all insured small group enrollees (48 percent) were in AHP plans.

Small group enrollees in AHP plans predominantly included those in relatively large small groups—that is, groups of 11 to 50 workers, versus 2 to 10 workers. In 2008, these larger small groups accounted for 64 percent of total small-group enrollment in AHPs, and the smallest groups—with 2 to 10 workers—accounted for 36 percent. In contrast, larger small groups accounted for 48 percent of the community-rated small group market, while the smallest groups accounted for 52 percent.

Trends in Enrollment

From 2005 to 2008, enrollment in AHPs increased 11 percent, while enrollment in either large group or community-rated small group insurance decreased nearly 12 percent—driving an overall decline in group coverage during this period. Most of this change occurred between 2007 and 2008, when the number of enrollees in AHPs increased 6 percent and the number of enrollees in large group or community-rated small group plans decreased nearly 11 percent.

From 2005 to 2008, large-group AHP enrollment increased much faster than small-group AHP enrollment. Large-group AHP enrollment increased more than 16 percent, while small-group AHP enrollment grew 4.5 percent. However, enrollment in both non-AHP large group and community-rated small group plans decreased faster than the increase in AHP enrollment. As a result, 87,000 fewer residents (-5.2 percent) were enrolled in any insured group coverage in 2008 than in 2005. In small groups, 67,500 fewer workers and dependents were covered overall, with 76,900 fewer workers and dependents covered in community-rated small group plans.

Corresponding to the growth in AHP enrollment, the number of carriers that wrote AHP business in Washington State increased from 11 in 2005 to 16 in 2008, as some carriers began insuring AHPs and others withdrew. In addition, the median size of AHPs grew 8 percent as associations with 500 or more enrollees became more prevalent. In 2008, AHPs with 500 or more enrollees accounted 42 percent of all AHPs.

The increase in the median size of AHPs from 2005 to 2008 coincided with an increase in the average size of AHP small groups and a decrease in the average size of small groups insured in the community-rated small group market. Even in 2005, the smallest groups accounted for a smaller share of AHP enrollment than enrollment in the community-rated small group market; by 2008, they accounted for an even lower proportion of AHP small group enrollment and a higher proportion of community-rated small group enrollment. In 2008, about 35 percent of AHP small-group enrollees were in groups with fewer than 10 lives, with 21 percent in the smallest groups of 2 to 5. In contrast, 50 percent of community-rated small group enrollees were in groups with fewer than 10 lives, with 27 percent in the smallest groups.

Premiums and Medical Cost

Because carriers have ample opportunity to segment risk between AHPs and community-rated small group market, it is widely supposed that small groups with AHP coverage pay lower premiums than are available to community-rated small groups. Indeed, in 2008, AHP small groups appear to have paid premiums that were substantially lower than community-rated small group premiums. On average, small groups in AHP plans paid about $246 per member month, compared with $316 per member per month in community-rated small group coverage. Adjusted for age, AHP small group premiums remained lower than community-rated small group premiums; other adjustments—for gender, location, benefit design, or burden of illness—were not possible with available data.

It is possible that much lower unadjusted average premiums for AHP small groups were related to generally narrower benefit designs (with, for example, lower limits on covered benefits or much higher cost sharing) than were available in the community-rated small group market. However, it seems more likely that lower average AHP premiums reflected better risk selection as well as the larger average size of AHP small groups compared with community-rated small groups.

From 2005 to 2008, premiums increased at a faster average rate for AHP small groups than for community-rated small groups, but remained lower for AHP small groups in all years. In both AHPs and community-rated small group plans, medical cost (defined as carrier payments for incurred claims) increased faster than premiums, but it increased fastest for small groups in AHPs.

The faster growth of average medical cost increased insurers' average medical loss ratios (calculated as total medical cost divided by total premiums) for both large and small groups in AHPs, as well as for community-rated small groups. However, in all years, the medical loss ratio for small groups in AHPs exceeded that in community-rated small groups, consistent with the larger

average size of AHP small groups. By 2008, the average medical loss ratio for small and large groups in AHPs had risen to 0.87, compared with 0.84 for community-rated small groups.

Medical Underwriting

Many carriers reported using health factors or claims experience to rate AHP coverage, having each applicant complete a standard health questionnaire (not requiring a physical exam) and reviewing claims histories to adjust rates at renewal. In 2008, health status was used to set rates in nearly half of all AHPs (48 percent), affecting 60 percent of AHP enrollees. Claims experience was used to set rates in nearly two-thirds of AHPs, affecting 87 percent of AHP enrollees. Just 6 percent of AHP enrollees were in a plan that used neither health factors nor claims experience to rate coverage. The number of AHPs that rated on health factors or claims experience (or both) increased from 75 in 2005 to 95 in 2008, and the number of AHP enrollees affected by these practices increased 26 percent.

Average premiums rose faster for enrollees in AHPs subject to rating on health status or claims experience, but the medical loss ratio on these plans increased much less than in AHPs where the carrier did not medically underwrite premiums. From 2005 to 2008, the average loss ratio for plans where carriers used health factors or claims experience to rate coverage increased just 4 percent. In AHPs where carriers did not medically underwrite premiums, the average medical loss ratio increased 16 percent.

Update to 2010

Carriers in Washington State reported lower levels of enrollment in AHPs and in community-rated small group plans in 2010 than in 2008. In 2010, estimated enrollment in AHPs was 2.5 percent less than in 2008, while enrollment in large group and community-rated small group plans dropped 11 percent. Overall, more than 35 percent of insured residents were enrolled in AHPs in 2010, compared with 33 percent in 2008.

A subset of carriers (representing 94 percent of total insured enrollment and 70 percent of AHP small group enrollment in 2008) reported more detailed information about the size of enrolled groups in both years. For these carriers, the change in enrollment from 2008 to 2010 was significant in at least two ways. First, while total enrollment dropped 11 percent, the loss of enrollment was concentrated in the large group and community-rated small group markets, not in AHPs—as also occurred from 2005 to 2008. Second, small group enrollment in AHPs increased 5 percent, while enrollment in every other category—AHP large groups, non-AHP large groups, and community-rated small groups—declined. In 2010, AHPs accounted for nearly half of these carriers' total small group enrollment (49 percent), compared with 39 percent in 2008.

As in 2008, average premiums for AHP small groups ($278) were substantially lower than for community-rated small groups ($382) in 2010, and may have increased much less since 2008. While comparison of AHP and community-rated small group premiums is complicated by the different calculations possible for 2008 and 2010, it appears that average premiums increased 6 percent for AHP small groups, compared with 21 percent for community-rated small groups.

Future Monitoring

Federal health reforms seem likely to transform the regulatory landscape for AHPs in Washington State and in other states that currently allow AHPs to operate under regulation that is different from the traditional market. For purposes of rate review and reporting, new federal rules include individual and small employer policies sold through associations in the rate review process—even if, as in Washington State, they are otherwise excluded from individual and small group market rules. Also with respect to the implementation of federal reform more broadly, federal regulators have expressed their view that the size of each individual employer participating in an AHP will determine whether the employer's coverage is subject to the small group or the large group rules. In addition, federal reform will redefine small groups as employer groups with 2 to 100 employees (versus the current definition of 2 to 50), potentially expanding the reach of small group market rules in AHPs as well as in the traditional market.

If embraced in Washington State, these changes could obviate many of the concerns that underlie this study. To the extent that AHP small groups are subject to the same regulations that govern the community-rated small group market, the ability of AHPs to segment risk in ways that would imperil the community-rated market is very limited. However, if Washington State wishes to continue to monitor the relationship of AHPs to the large group and community-rated small group market in coming years, more information is needed than either ESBH 1714(2011) authorized for this study or is obtained under other current reporting requirements. In particular, to understand whether AHPs are segmenting risk in ways that might destabilize the large group community-rated small group markets, it will be necessary to know in greater detail how carriers are rating AHPs—specifically, which rate factors they use, the impact on rates offered to AHP large and small groups, differences in plan designs, and the relative burden of illness in AHP large and small groups compared with that in non-AHP large groups and community-rated small groups.

In addition, to be useful to policymakers, this information must:

- Clearly include, and separately categorize, information about individuals and groups of one;
- Specifically name the AHP that is covered to allow verification of the reported data against other reporting and earlier survey information; and
- Identify which AHPs are insurer-sponsored, versus those initiated by public employer groups or private employer groups.

Finally, the information must be much more current than was required for this study, which looks back eight years and captures information only as recently as 2008.

Some of the information that is needed to understand the relationship between AHPs and the large group and community-rated small group markets will potentially be easier to obtain in future years due to efforts already underway in Washington State. For example, as of March 2011, health carriers are required to file a Revised Additional Data Statement reporting information about AHP enrollment, premiums, and medical cost for small and large groups—although, because life and disability carriers (which insured more than 15 percent of AHP enrollees in 2010) are not required to report, the information currently obtained is very incomplete. Other information needed to understand how the cost experience of AHPs differs from that in the large group and community-rated small group market might be obtained in the context of federal reforms or in parallel efforts (such as the development of an all-payer claims database) that Washington State might consider.

INTRODUCTION

Washington State has a robust association health plan (AHP) market. Unlike many other states, Washington allows associations to form for the purpose of insurance. As a result, associations in Washington have been formed on several bases: within industry groups (such as the Washington Education Association (WEA)), across industry groups (such as the Associated Employers Health and Welfare Trust), and as creations of insurance carriers (such as the Washington Alliance for Healthcare Insurance Trust (WAHIT)). While most AHPs offer coverage to small groups (with 50 or fewer employees), larger groups account for a large and growing share of AHP enrollment.

Washington State regulates AHPs as large group plans, specifically exempting them from small group community rating requirements.[1] Since 1995, carriers have been able to offer "experience rated" premiums to small employers that buy AHP coverage, taking into consideration each employer's claims experience and the aggregated health history of its employees.[2] Carriers may also use other rate factors to rate AHP coverage—such as gender and nonstandard age brackets for rate differentiation—that are prohibited in the community-rated small group market. One managing general agent publicly attributes the "exceptional growth" of AHPs to regulation "which favors in many ways, member controlled Association or Trust Plans over community rated medical plans" in Washington State.[3]

The definitions of the individual and group insurance markets set out in new federal rules implementing the ACA differ from the current definitions that some states, including Washington State, use to exempt AHPs.[4] In particular, the final rules governing rate review and reporting provide

[1] Because the statutory authority of Washington State agencies to regulate health plans is dependent on the type of plan, it is complex and uneven. A summary chart of the authority of, respectively, the Washington State Office of the Insurance Commissioner and the U.S. Department of Health and Human Services to oversee rates and forms is provided in Appendix A.

[2] The question of whether AHPs can rate coverage to individual employer groups based on each group's health status or claims experience was raised in 2007, when the OIC issued Technical Assistance Advisory TAA-06-07 indicating that association rates must be based on the claims experience of the entire association membership and that any rating by an association based on the health information of an individual member employer was prohibited. Two associations challenged this approach to regulating the rating practices of associations. In finding for the plaintiffs, the Spokane County Superior Court noted that Washington's statutes provide an exemption for associations from the community rating laws but do not address how the association plan should be rated. In her 2007 ruling, the Judge noted that the rating approach desired by the OIC was a policy change that should be specified by the Legislature, not the agency. On August 29, 2007, the OIC permanently withdrew the advisory.

[3] The website goes on to note that "the ability to factor industry, gender and geographical location when establishing new business rates is allowed by current regulation of member controlled Associations" and that, due to these factors, AHPs can offer "exceptionally high quality medical coverage at competitive premiums for qualifying employer groups." (See: http://www.thompsonspears.net/, accessed September 23, 2011.)

[4] Final federal rules clarifying the status of AHPs under ACA provisions regarding rate review and reporting were issued on September 6, 2011 (see: Federal Register Vol. 76, No. 172 available at: http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22663.pdf, accessed September 20, 2011). While the September 6 final rule federal pertains only to specific rate review and reporting requirements, CMS has indicated its view that, for the broader purpose of implementing the ACA, "in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not the association-of-employers level. In these situations the size of each individual employer participating in the association determines whether the employer's coverage is subject for the small group or the large group rules." (See: CMS Insurance Standards Bulletin Series, September 1, 2011, available at: http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.pdf, accessed September 20, 2011).

that "individual and small employer policies sold through associations will be included in the rate review process, even if a State otherwise excludes such coverage from its definitions of individual and small group market coverage." While these federal rules apply uniformly to small groups whether insured through AHPs or in the small group market, the states retain broad regulatory authority to regulate insurance products if not otherwise specified in federal law. Thus, the new federal rules do not alter Washington State's exception for AHPs with respect to either community rating or the use of rate factors that are prohibited for community-rated small groups.

The inclusion of AHPs in the federal reasonable rate review requirements means that Washington carriers that issue non-grandfathered plans to association members must file a rate justification with the U.S. Department of Health and Human Services (HHS) if a rate increase greater than 10 percent is proposed. However, Washington State's current statutory exemption of AHPs from state-level rate review means that HHS will review AHP rates, even though for purposes of this rule Washington is deemed an effective rate review state for individual and small group plans.

The asymmetric regulation of AHPs and small groups offers ample opportunity for carriers and AHPs to select favorable risk. By rating coverage strategically and denying employers where the associations' own rules may permit, carriers have the opportunity to separate the risk pools for AHP and other employer groups and isolate high-cost small groups in the community-rated market. As a result, premiums for community-rated small groups might be higher for the same benefit design, discouraging some employers from offering coverage at all and driving others to offer less coverage (with more limited benefits and greater cost sharing) than they might if premiums were lower.

In 2005, the Office of the Insurance Commissioner (OIC) conducted a survey of carriers that wrote association health plans. This survey found that approximately 248,000 Washington residents were enrolled in AHPs. In addition, roughly one-quarter of these enrollees were in plans that used member employers' health information to determine rates.

In March 2010, Washington State enacted ESBH 1714(2011), requiring insurance carriers in the state to report the volume of business they wrote, respectively, for associations and community-rated small groups in calendar years 2005 through 2008. Carriers were asked to provide information about each association plan that they wrote—including the size of employers that participated in the association plan; the number and age distribution of resident enrollees; the dollar values of premiums and medical cost; and the use of health factors or claims experience in issuing coverage to an association member, setting premiums, or both. Carriers were asked also to report the same information for their small group business, aggregated across all small groups that they covered.

Twenty-seven carriers responded to the data call—representing nearly all of the group health insurance written in Washington State. Most carriers that responded reported both AHP and community-rated small group business. The information that carriers reported was amassed in a database and checked to confirm that required information was reported, the information reported for each AHP and aggregated small group line was internally consistent, and responses were within feasible ranges. Several carriers were asked to resubmit information to correct apparent data quality problems, and the database (including carriers' original and resubmitted data for nearly all AHPs) was closed on August 31, 2011.

This report offers an analysis of the information that carriers provided in response to the data call, as well as information that carriers reported in regular filing. The latter included: (1) the carriers' annual statements reporting both company-level information and information about, respectively, individual and group health insurance business written in Washington State; (2) supplemental reports

to the OIC that report member-owned and other individual, small group, and large group business in Washington State; and (3) information reported to the federal Department of Labor by self-insured employer trusts.[5]

The report is organized in six sections. Section A offers a snapshot of the AHP and community-rated small group insurance markets in Washington State in 2008. In Section B, changes in the size and composition of these markets from 2005 to 2008 are reported.

Section C offers an analysis of AHP premiums and medical cost, compared with premiums and medical cost in the community-rated small group market. We adjust both measures for the age distribution of covered workers to partially account for the relative burden of illness in AHPs versus the community-rated small group market. However, because carriers were not required to report information about the gender and geographic location of enrollees, the scope of covered benefits, level of cost sharing, or the incidence of medical conditions, we were unable to adjust for the factors that likely drive most of any difference in premiums and medical cost.

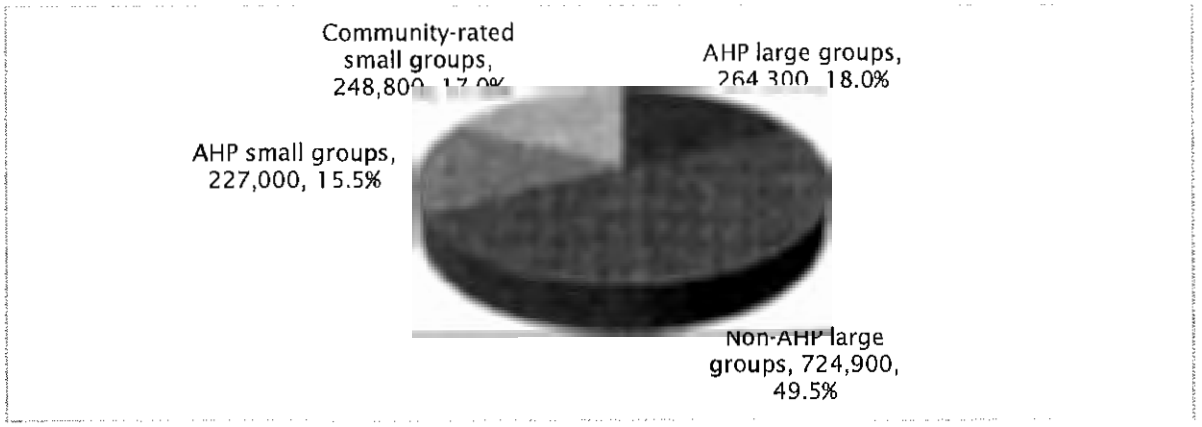
In Section D, the information that carriers reported about their use of health status and claims experience in setting premiums for AHP members is presented, and we consider differences in average premiums and medical cost that correspond to these practices. In Section E, we use carriers' 2011 additional data statements and estimates prepared by the OIC to update the survey-based analysis, comparing enrollment in AHPs and the community-rated small group market in 2008 and 2010, as well as the change in average premiums and medical cost. Finally, issues related to ongoing monitoring of AHPs are discussed in Section F.

A. Enrollment in AHPs and Large Group or Community-Rated Small Group Plans

In 2008, approximately 491,300 Washington State residents were enrolled in AHP plans, including 227,000 enrolled through small employers (defined as groups of 2 to 50 employees) and 264,300 enrolled through large employers (defined as groups of more than 50 employees) (Figure 1). AHP enrollees accounted for more than one-third of total insured group coverage—16 percent in small groups with AHP coverage and 18 percent in large groups with AHP coverage. Nearly half of all insured small group enrollees (48 percent) and 27 percent of large group enrollees were in AHPs. (Figure 2).

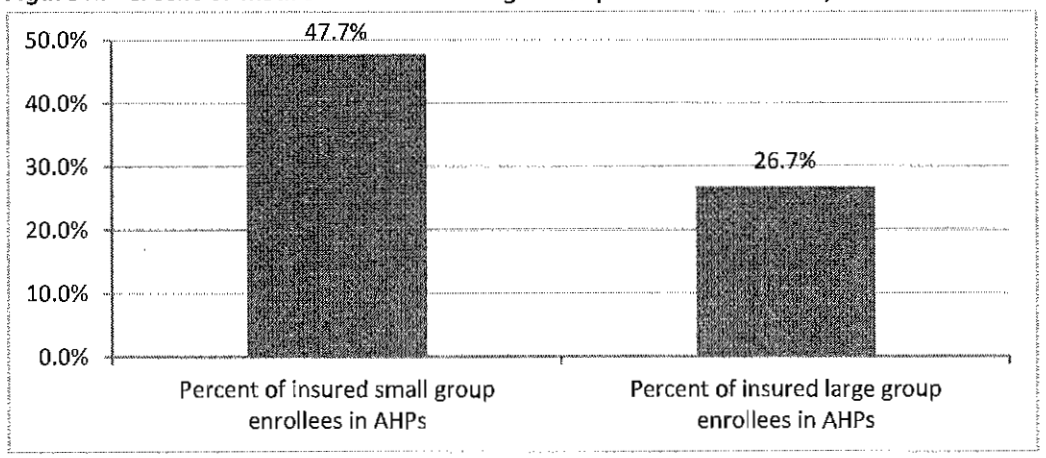
[5] Technical Appendix B provides more information on the data sources and methods used in this report.

Figure 1. Number and Percent of Enrollees in AHPs or in Large Group or Community-Rated Small Group Plans, 2008



Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey and 2008 annual carrier statements.

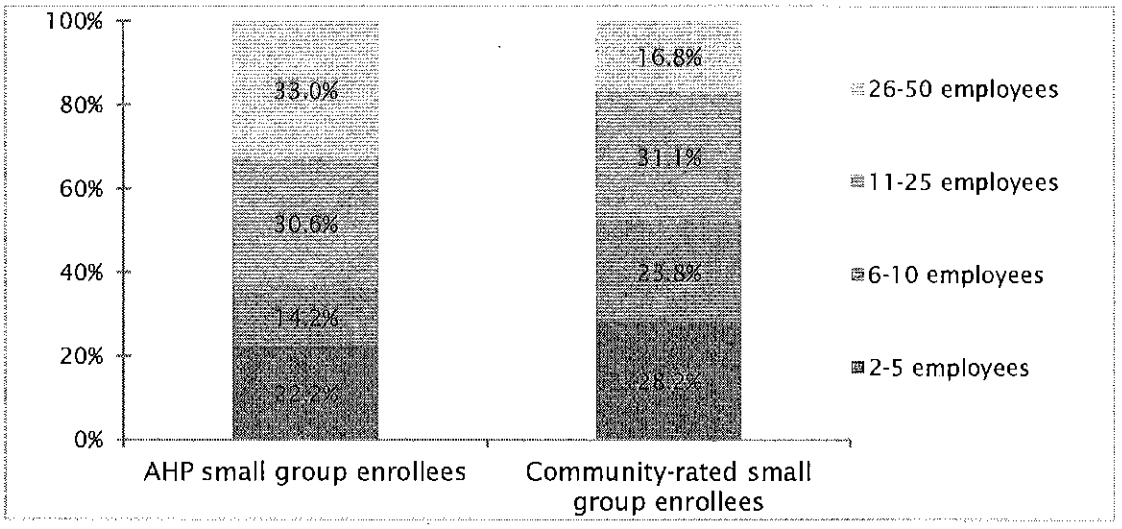
Figure 2. Percent of Insured Small- and Large-Group Enrollees in AHPs, 2008



Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Small group enrollees in AHPs predominantly included those in relatively large small groups—that is, groups of 11 to 50 workers, versus 2 to 10 workers.[6] In 2008, these larger small groups accounted for 64 percent of total small-group enrollment in AHPs, and the smallest groups—with 2 to 10 workers—accounted for 36 percent (Figure 3). In contrast, larger small groups accounted for 48 percent of the community-rated small group market, while the smallest groups accounted for 52 percent.

Figure 3. Distribution of Small-Group Enrollees in AHP and Community Rated Small Group Plans by Group Size, 2008



Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: Enrollees in AHP and non-AHP large-groups are not shown.

[6] ESBH 1714(2011) authorized the OIC to call for information on enrollment in firm sizes with 2 or more employees. Consequently, it is unclear whether carriers reported enrollment of groups of one at all, or whether they might have included either individuals or groups of one in the smallest firm size category. At least two carriers in Washington State, the Mega Life and Health Insurance Company, and Midwest National Life Insurance Company of Tennessee, explicitly market to groups of one. Enacted in 2010, S.B. 6538 clarified the definition of a group of one to be "a self-employed individual or sole proprietor who must also: (a) have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year." (See: http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Law%202010/6538-S.SL.pdf, accessed September 20, 2011.)

Among all AHP enrollees in 2008, 42 percent were in employer groups of 100 or more employees (Table 1). Twelve percent were enrolled through employer groups with 51 to 100 employees, which the federal Patient Protection and Affordable Care Act (ACA) will redefine as small groups.[7] Had this redefinition been in place in 2008, it would have categorized 58 percent of total AHP enrollment as small groups—suggesting that about half of AHP enrollees in Washington State might be drawn from the community-rated small group market when the redefinition of small groups becomes effective.

Table 1. Distribution of Enrollees in AHPs or Community-Rated Small Groups by Group Size, 2008

	AHPs		Community-rated small groups	
	Number of enrollees (in thousands)	Percent of enrollees	Number of enrollees (in thousands)	Percent of enrollees
Total	491.3	100.00%	248.8	100.00%
Small Employer Groups	227.0	46.3%	240.9	96.8%
2-5 employees	50.4	10.3%	68.0	27.3%
6-10 employees	32.2	6.6%	57.4	23.1%
11-25 employees	69.4	14.1%	75.0	30.1%
26-50 employees	75.0	15.3%	40.5	16.3%
Large Employer Groups	264.3	53.8%	7.9	3.1%
51-100 employees	57.0	11.6%	7.1	2.8%
100+ employees	207.3	42.2%	0.8	0.3%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

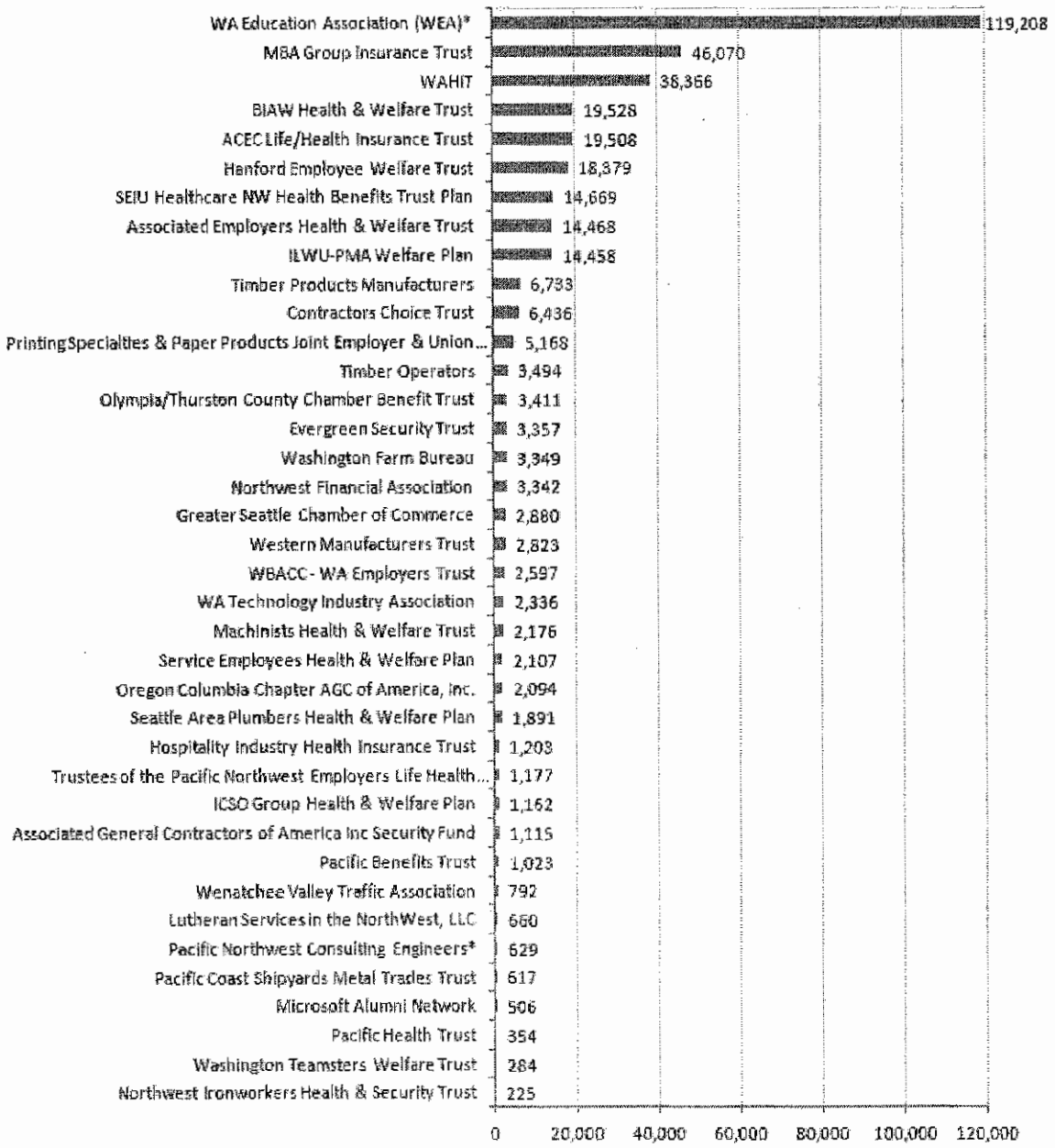
Figure 4 displays many of the AHPs that enroll small and large groups in Washington State based on public reporting to the U.S. Department of Labor. These AHPs, accounting for approximately three fourths of total AHP enrollment in Washington State in 2010, ranged from those with more than 100,000 lives to those with only a few hundred lives. By far the largest AHP, insured by Premera, was the Washington Education Association (WEA). WEA bad more than 119,000 health plan enrollees in 2010 and accounted for as much as a third of total AHP enrollment. The next largest association plan was the Master Builders Association (MBA) Group Insurance Trust with approximately 46,000 enrollees, followed by the Washington Alliance for Healthcare Insurance Trust (WAHIT), a Premera-created AHP with more than 38,000 enrollees. One of the AHPs reported in Figure 4—the Timber Products Manufacturers, with about 6,700 enrollees—was self-insured.

Relatively few carriers write most AHP coverage in Washington State. In 2008, Premera and Regence wrote nearly three-fourths of all AHP business in the state. Premera accounted for 42 percent of total insured AHP enrollment and 47 percent of AHP premiums (Table 2). Regence accounted for 34 percent of insured AHP enrollment and 33 percent of AHP premiums. Group Health and Aetna also wrote significant AHP business, but respectively, accounted for just 7 percent and less than 4 percent of insured AHP enrollment. Other carriers—including Kaiser, United

[7] States may adopt this expanded small-group definition in 2014, but must adopt it for all plan years starting in 2017.

Healthcare, and another 10 carriers—collectively covered about 13 percent insured AHP enrollees and wrote about 12 percent of AHP premiums.

Figure 4. Selected AHPs by Number of Enrollees, 2009-2011



Source: Mathematica Policy Research. WEA enrollment is derived from Premera's SIMBA filing (November 12, 2010). For all other associations, enrollment is reported in the association's Form 5500, submitted to the U.S. Dept. of Labor.

Notes: This figure has been updated to reflect a software correction. All data are for fiscal years beginning in calendar 2009 unless otherwise noted: *indicates enrollment in the fiscal year beginning in calendar year 2010. When reported plan enrollment exceeded reported association enrollment at the beginning and end of the year by more than 30 percent, plan enrollment was estimated as average association enrollment during the year.

Table 2. Distribution of AHP Enrollees and Total Premiums by Major Carrier, 2008

	Total AHP enrollees		Total AHP premiums	
	Number (thousands)	Percent	Dollars (millions)	Percent
Total	491.4	100.0%	$1,739.6	100.0%
Premera	208.7	42.5%	824.4	47.4%
Regence	168.0	34.2%	578.2	33.2%
Group Health	34.3	7.0%	124.1	7.1%
Aetna	16.9	3.4%	4.8	0.3%
Kaiser	0.8	0.2%	0.3	0.0%
All other AHP carriers (n=11)	62.6	12.7%	207.8	11.9%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Premera companies include Premera Blue Cross and Lifewise Health Plan of Washington. Regence companies include Asuris Northwest Health, Regence BlueShield, Regence BlueShield of Idaho, Regence Blue Shield of Oregon, Regence Health Maintenance of Oregon, and Regence Life and Health Insurance Company. Group Health companies include Group Health Options, KPS, and Group Health Cooperative.

Regence and Premera also write most community-rated small group coverage in Washington State—in 2008, nearly 84 percent (Table 3). Regence covered 57 percent of all community-rated small group enrollees in 2008, and Premera covered 26 percent. Group Health and Kaiser also wrote significant community-rated small group business (respectively covering 10 percent and 4 percent of community-rated small group enrollees), while Aetna and another 11 carriers collectively covered less than 2 percent.

Table 3. Distribution of Community-Rated Small Group Enrollees and Total Premiums by Major Carrier, 2008

	Total enrollees		Total premiums	
	Number (thousands)	Percent	Dollars (millions)	Percent
Total	248.8	100.0%	943.8	100.0%
Regence	143.1	57.5%	585.4	62.0%
Premera	64.5	25.9%	213.1	22.6%
Group Health	25.9	10.4%	90.0	9.5%
Kaiser	10.7	4.3%	38.6	4.1%
Aetna	0.1	0.1%	0.6	0.1%
All other community-rated small group carriers (n=11)	4.5	1.8%	16.1	1.7%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Premera companies include Premera Blue Cross and Lifewise Health Plan of Washington. Regence companies include Asuris Northwest Health, Regence BlueShield, Regence BlueShield of Idaho, Regence Blue Shield of Oregon, Regence Health Maintenance of Oregon, and Regence Life and Health Insurance Company. Group Health companies include Group Health Options, KPS, and Group Health Cooperative.

B. Trends in Enrollment

From 2005 to 2008, enrollment in AHPs increased 11 percent, while enrollment in the large group and community rated small group market decreased nearly 12 percent—driving an overall decline in group coverage during this period (Table 4). The largest change in the market occurred between 2007 and 2008, when the number of enrollees in AHPs increased 6 percent and the number of enrollees in large group and community-rated small group plans decreased nearly 11 percent.

Table 4. Number of Enrollees in AHPs or in Large Group or Community-Rated Small Group Plans, 2005-2008

	All insured large and small groups enrollees	AHP large and small group enrollees	Non-AHP large group and community-rated small group enrollees
Enrollment (in thousands)			
2005	1,546.1	441.3	1,104.8
2006	1,557.5	476.4	1,081.2
2007	1,550.7	462.8	1,088.0
2008	1,465.0	491.4	973.6
Percent change, 2005-2008	-5.2%	11.3%	-11.9%
2005-2006	0.7%	7.9%	-2.1%
2006-2007	-0.4%	-2.8%	0.6%
2007-2008	-5.5%	6.2%	-10.5%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: A small number of carriers were unable to report the number of AHP enrollees in 2005, but did report enrollees in other years. In these cases, 2005 enrollment was estimated by extrapolating from enrollment in 2006-2008.

From 2005 to 2008, AHP enrollment increased among both small and large groups. Small group AHP enrollment increased 4.5 percent—from 208,200 in 2005 to 217,700 in 2008 (Table 5). Large group AHP enrollment increased more than 16 percent—from 212,800 in 2005 to 247,500 in 2008.

However, enrollment in both non-AHP large groups and community-small groups declined faster than the increase in AHP enrollment. As a result, 87,000 fewer residents (-5.2 percent) were enrolled in any insured group coverage in 2008 than in 2005 (Figure 4). In small groups, 67,500 fewer workers and dependents were covered in insured plans overall, with 76,900 fewer workers and dependents covered in community-rated small group plans. In large groups, 19,500 fewer workers and dependents were covered in insured plans overall, with 54,300 fewer workers and dependents covered in non-AHP large group plans.

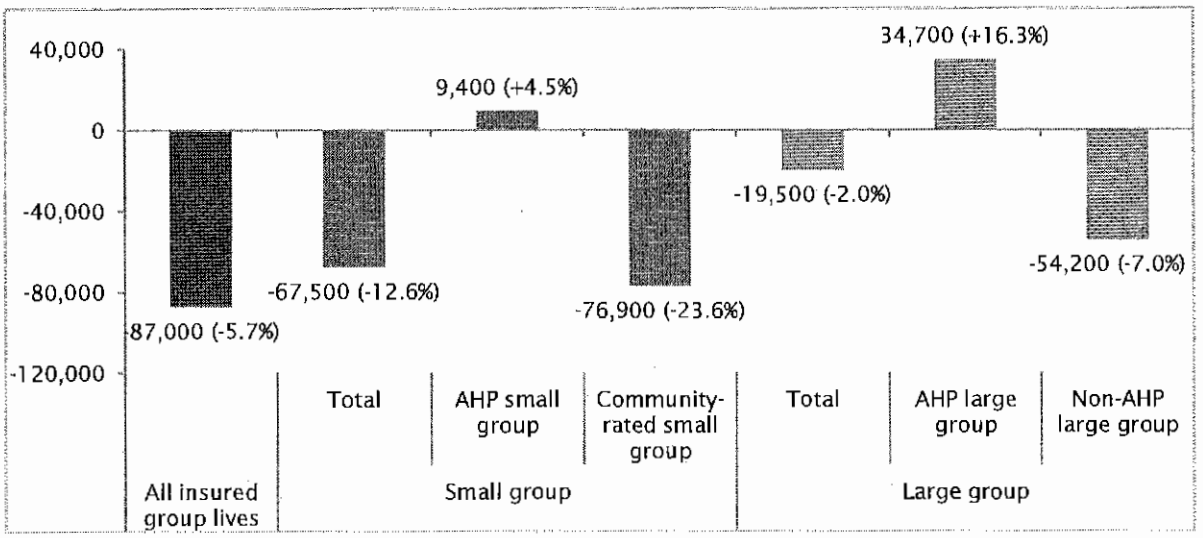
Table 5. Number of Small- and Large-Group Enrollees in AHPs or in Large Group or Community-Rated Small Group Plans and Percent Change, 2005-2008

	AHP small group enrollees	Community-rated small group enrollees	AHP large group enrollees	Non-AHP large group enrollees
Enrollment (in thousands)				
2005	208.2	325.7	212.8	779.1
2006	213.5	305.6	236.3	775.5
2007	212.3	280.7	236.9	807.2
2008	217.7	248.8	247.5	724.9
Percent change, 2005-2008	4.5%	-23.6%	16.3%	-7.0%
2005-2006	2.5%	-6.2%	11.0%	-0.5%
2006-2007	-0.6%	-8.1%	0.3%	4.1%
2007-2008	2.5%	-11.4%	4.5%	-10.2%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: A small number of carriers were unable to report the number of AHP enrollees in 2005. The tabulations in this table exclude those plans in all years.

Figure 5. Change in Enrollment in AHPs and Large Group or Community-Rated Small Group Plans, 2005-2008



Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: A small number of carriers were unable to report the number of AHP enrollees in 2005. A small number of carriers were unable to report the number of AHP enrollees in 2005. The tabulations in this figure exclude those plans in all years.

Corresponding to the growth in AHP enrollment, the number of carriers that wrote AHP business in Washington State increased from 11 in 2005 to 16 in 2008 (Table 6), as some carriers began insuring AHPs and others withdrew (data not shown). In addition, the number of AHPs increased from 135 in 2005 to 139 in 2008, having risen to as many as 145 AHPs in 2006. From 2005 to 2008, the median size of AHPs grew 8 percent—from 219 to 236 enrollees—as associations with 500 or more enrollees became more prevalent. In 2008, AHPs with 500 or more enrollees accounted 42 percent of all AHPs, compared with 36 percent in 2005.

Table 6. Number of AHP Carriers, Number of AHPs, and AHP Enrollment, 2005-2008

	Number of carriers writing AHP business[a]	Number of AHPs	Median enrollees per AHP	Percent of AHPs			
				2-50 enrollees	51-99 enrollees	100-499 enrollees	500+ enrollees
2005	11	135	219	32.6%	5.9%	25.2%	36.3%
2006	15	145	247	33.8%	2.8%	23.4%	40.0%
2007	15	141	214	34.0%	5.7%	22.7%	37.6%
2008	16	139	236	30.2%	6.5%	20.9%	42.4%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: A small number of carriers were unable to report the number of AHP enrollees in 2005, but did report enrollees in other years. In these cases, 2005 enrollment was estimated by extrapolating from enrollment in 2006-2008.

[a] Carriers owned by a common parent are combined. Parent companies include Premera, Regence, Group Health, Aetna, Health Net, and United Healthcare.

The increase in the median size of AHPs from 2005 to 2008 coincided with an increase in the average size of small groups in AHPs and a decrease in the average size of community-rated small groups. Even in 2005, a lower share of AHP enrollment was in the smallest groups, compared with enrollment in the community-rated small group market. Groups with fewer than 10 lives accounted for 44 percent of AHP small-group enrollment, with 32 percent in the smallest groups (with 2 to 5 lives) (Table 7). In contrast, 45 percent of community-rated small group enrollment was in groups with fewer than 10 lives, with 25 percent in the smallest groups.

Table 7. Group Size Distribution of Small-Group Enrollment in AHPs and Community-Rated Small Group Plans, 2005-2008

	Total small group enrollees (thousands)	Percent of small-group enrollees in groups of:			
		2-5	6-10	11-25	25-50
AHPs					
2005	208.2	32.3%	11.3%	29.6%	26.8%
2006	213.5	27.9%	12.9%	29.1%	30.1%
2007	212.3	24.3%	13.1%	30.2%	32.4%
2008	217.7	20.8%	13.8%	31.2%	34.1%
Community-rated small groups					
2005	325.7	24.6%	20.2%	28.3%	19.8%
2006	305.6	25.0%	21.0%	29.2%	18.6%
2007	280.7	25.9%	22.5%	30.4%	17.2%
2008	248.8	27.3%	23.1%	30.1%	16.3%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Plans that did not report enrollment in 2005 are excluded from this table. As a result, change in the small and large group markets does not sum to total change. In addition, AHPs and community-rated small group plans for which enrollment by group size were not reported are included in the "total enrollees "column but not in other columns.

By 2008, very small groups accounted for an even lower proportion of AHP small group enrollment and a higher proportion of community-rated small group enrollment. About 34 percent

of AHP small-group enrollees were in groups with fewer than 10 lives, with 21 percent in the smallest groups of 2 to 5. In contrast, 50 percent of community-rated small-group enrollees were in groups with fewer than 10 lives, with 27 percent in the smallest groups.

C. Premiums and Medical Cost

Because carriers are able to use pricing to segment risk between the AHP and community-rated small group market, it is widely supposed that AHP small groups pay lower premiums than are available to community-rated small groups. In this section, we explore these differences, although the analysis is substantially hindered by the highly aggregated nature of the data insurers were asked to report. In particular, carriers were not asked to report differences in premiums and medical cost within either AHPs or the community-rated small group market. Therefore, to the degree that carriers vary premiums by group size, we are unable to account for that variation.[8]

Attempting to work around this weakness in available data, we look at two alternative measures of average small group premiums and medical cost in AHPs: (1) the weighted average across all AHPs that included small groups (in effect assuming that each is the same across small and large groups in the same AHP); and (2) the average in "small group-focused AHPs", where more than 50 percent of total enrollment was in small groups. Both are compared to average premiums and medical cost in the community-rated small group market. We further adjust premiums and medical cost for the minor differences in the reported average age of insured employees. However, we were unable to adjust either measure for other major sources of differences in premiums and medical costs that ultimately were more important than the minor differences in enrollee age. These other sources include not only the smaller average size of groups in the community-rated small group market compared with those in AHPs, but also the prevalent benefit designs and the relative burden of illness in AHP small groups and community-rated small groups, and differences in gender, industry, geographic location, or other factors that carriers might use set AHP premiums.

Unadjusted Average Premiums and Medical Cost

In 2008, AHP small groups appear to have paid premiums that were, on average, substantially lower than community-rated small group premiums. This difference is apparent, whether looking at the weighted average premium in AHPs that included small groups or the average premium in small group-focused AHPs. On average, small groups in AHP plans paid $246-$247 per member month for coverage, compared with $316 per member per month in community-rated small group coverage (Table 8). In contrast, large groups in AHPs paid average premiums ($340-$366) that were higher than community-rated small-group premiums—likely reflecting broader benefits, lower cost sharing, or both in AHPs that included predominantly large groups.

It is possible that the much lower average AHP small group premiums were related to narrower benefit design (with, for example, lower limits on covered benefits or higher cost sharing) than were available to community-rated small groups. However, it seems more likely that AHP benefits were at least competitive with those in the community-rated small group market, and that lower AHP

[8] In addition, carriers were not asked to report association membership fees; those amounts, if any, may not be reflected in the AHP premium data.

premiums reflected better risk selection as well as the larger average size of AHP small groups compared with community-rated small groups.

Table 8. Unadjusted Premiums and Medical Cost for Community-Rated Small Groups, and AHP Small and Large Employer-Focused Groups, 2005-2008

	Community-rated small groups	AHP small groups, average across large and small groups in the AHP	AHP large groups, average across large and small groups in the AHP	Average in small group-focused AHPs	Average in large group-focused AHPs
Average earned premiums					
2005	$275	$204	$272	$206	$285
2006	$282	$215	$291	$217	$306
2007	$294	$233	$315	$234	$336
2008	$316	$246	$340	$247	$366
Annual change					
2005-2006	2.5%	5.3%	6.9%	5.5%	7.3%
2006-2007	4.2%	8.3%	8.3%	7.7%	9.7%
2007-2008	7.6%	5.5%	7.9%	5.5%	8.9%
2005-2008 average	4.8%	6.4%	7.7%	6.2%	8.6%
Average medical cost					
2005	$207	$158	$235	$160	$251
2006	$223	$178	$248	$181	$260
2007	$242	$193	$272	$193	$293
2008	$267	$214	$296	$215	$319
Annual change					
2005-2006	7.4%	13.0%	5.3%	13.4%	4.0%
2006-2007	8.7%	8.3%	9.9%	6.8%	12.6%
2007-2008	10.1%	11.1%	8.8%	11.3%	8.6%
2005-2008 average	8.8%	10.8%	8.0%	10.5%	8.4%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Plans not reporting enrollment in 2005 are excluded in all years. Premiums and medical cost for small and large groups enrolled in AHPs are calculated as the weighted average per member per month for all groups in an AHP that included small and large groups, respectively. Small group-focused AHPs are AHPs where more than half of the members were in groups of 2-50 employees. Large group-focused AHPs are AHPs where more than half of the members were in groups with more than 50 employees. Medical cost is defined as carrier payments for incurred claims.

From 2005 to 2008, average premiums increased at a faster rate for AHP small groups than for community-rated small groups, but remained lower for AHP small groups in all years. In the last year of this period, from 2007 to 2008, average AHP small group premiums increased more slowly (6 percent) than community-rated small-group premiums (8 percent), while AHP large group premiums increased somewhat faster (8 to 9 percent).

In both AHPs and community-rated small group plans, medical cost—defined as carrier payments for incurred claims—increased faster than premiums, but it increased fastest for AHP small groups. From 2005 to 2008, average medical cost increased at an average annual rate of 11 percent in AHP small groups, compared with 9 percent in community-rated small groups and 8 percent in AHP large groups.

The faster growth of average medical cost increased insurers' average medical loss ratios (calculated as total medical cost divided by total medical premiums) for both large and small groups in AHPs, as well as for community-rated small groups. However, in all years, the medical loss ratio for small groups in AHPs exceeded that for community-rated small groups. By 2008, the average medical loss ratio for small and large groups in AHPs had risen to 0.87, compared with 0.84 for community-rated small groups (Table 9).[9]

Table 9. Unadjusted Weighted Average Medical Loss Ratios for AHP Small Groups, Community-Rated Small Groups, and AHP Large Groups, 2005-2008

	AHP small groups	Community-rated small groups	AHP large groups
2005	0.772	0.754	0.865
2006	0.827	0.791	0.852
2007	0.828	0.825	0.865
2008	0.872	0.844	0.872

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: Plans not reporting enrollment in 2005 are excluded in all years. Premiums and medical cost for small and large groups enrolled in AHPs are calculated as the weighted average per member per month for all groups within an AHP that includes small and groups, respectively. Medical loss ratios are calculated as medical cost per premium dollar; medical cost is defined as carrier payments for incurred claims. Medical loss ratios for non-AHP large-group plans are not shown.

Age-Adjusted Premiums and Medical Cost

The results of age-adjusting premiums and medical cost are reported in Table 10. Two aspects of this analysis are noteworthy. First, the average age of enrollees in each segment of the insured market—AHP small groups, community-rated small groups, and AHP large groups—is similar and quite young, ranging from 34 to 36 years of age in all years. Compared with community-rated small groups, AHP enrollees (in either small or large groups) were slightly younger in all years. Moreover, from 2005 to 2008 the average age in AHP small and large groups declined more (-1.3 percent and -1.1 percent, respectively) than that in community-rated small groups (-0.9 percent). Nevertheless, the differences (apparent in the age-related expected cost adjustment factor) were small.

Second, adjusted only for age, both premiums and medical cost for AHP small groups increased faster than for community-rated small groups—a result that might well not hold if more detailed analysis of benefit designs, in particular, had been possible. Relative to AHP large groups, age-adjusted premiums for AHP small groups grew more slowly, but age-adjusted medical cost grew faster. The anomalous character of these results relative to the more intuitive patterns we observed without adjustment strongly suggests that much more detailed information—such as the gender and geographic location of enrollees, benefit design and cost sharing, and the relative burden of illness—

[9] The higher medical loss ratio for AHP small groups is consistent with the larger average size of AHP small groups compared with community-rated small groups. Indeed, calculated for the smallest AHP small groups (with 2 to 25 lives), the medical loss ratio in 2008 was 0.83, compared with 0.92 among AHP groups with 26 to 100 lives (data not shown).

is needed to understand relative premiums and medical cost in AHPs and in non-AHP large group and community-rated small group plans.

Table 10. Age-Adjusted Premiums and Medical Cost for AHP Small Groups, AHP Large Groups, and Community-Rated Small Groups, 2005-2008

	Enrollees (in thousands)	Average age	Age-related expected cost adjustment factor	Adjusted medical cost per member per month	Adjusted premiums per member per month
AHP small groups					
2005	207.6	34.47	0.98	160	208
2006	221.5	34.64	0.98	180	219
2007	220.0	34.13	0.97	198	240
2008	229.9	33.98	0.97	219	252
Percent change 2005-2008	10.7%	-1.4%	-1.0%	36.9%	21.2%
Average annual change	2.6%	-0.4%	-0.3%	8.2%	4.9%
AHP large groups					
2005	237.8	34.91	1.00	218	251
2006	245.9	35.25	1.02	241	284
2007	228.6	34.75	1.01	281	325
2008	253.2	34.52	1.01	293	335
Percent change 2005-2008	6.5%	-1.1%	1.0%	34.4%	33.5%
Average annual change	1.6%	-0.3%	0.2%	7.7%	7.5%
Community-rated small groups					
2005	325.7	35.95	1.00	208	276
2006	305.6	36.48	1.02	218	276
2007	280.7	35.51	1.01	239	290
2008	248.8	35.64	1.01	265	313
Percent change 2005-2008	-23.6%	-0.9%	1.0%	27.4%	13.4%
Average annual change	-6.5%	-0.2%	0.2%	6.2%	3.2%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: Medical cost is defined as carrier payments for incurred claims.

D. Medical Underwriting

Many carriers reported using health factors or claims experience to rate AHP coverage, having each applicant complete a standard health questionnaire (not requiring a physical exam) and reviewing claims histories to adjust rates at renewal. In 2008, health status was used to set rates in nearly half of all AHPs (48 percent), affecting 60 percent of AHP enrollees. Claims experience was used to set rates in nearly two-thirds of AHPs, affecting 87 percent of AHP enrollees (Table 11). Just 6 percent of AHP enrollees were in a plan that used neither health factors nor claims experience to rate coverage.

In AHPs that were rated based on either health factors or claims experience, average medical cost was much higher ($270 to $274 per member per month) than in those that used neither to set rates ($130). However, the very low average premium among AHPs that used neither health status or claims experience to rate coverage was driven by just a few large plans in this category, and may reflect plan designs with higher cost sharing than was common in either AHPs or the community-rated small group market.

Table 11. Use of Health Factors or Claims Experience to Set AHP Premiums, 2008

	Number of AHPs	Percent of AHPs	Number of enrollees (thousands)	Percent of AHP enrollees	Medical cost per member per month
All AHPs	138	100.0%	491.4	100.0%	$257
Health factors used	66	47.8%	294.1	59.8%	$274
Claims experience used	87	63.0%	427.2	86.9%	$270
Neither health factors nor claims experience used	43	31.2%	29.0	5.9%	$130

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Medical cost is defined as carrier payments for incurred claims. Because some carriers reported using both health factors and claims experience to rate coverage, percentages may not add to 100%.

The number of AHPs that rated on health factors or claims experience increased from 75 in 2005 to 95 in 2008, and the number of AHP enrollees affected by these practices increased 26 percent (Table 12). While average premiums rose faster for enrollees in AHPs subject to rating on health status or claims experience, the medical loss ratio in these plans increased much less than in AHPs where the carrier did not medically underwrite premiums. From 2005 to 2008, the average loss ratio in AHPs where carriers used health factors or claims experience to rate coverage increased just 4 percent (from 0.836 to 0.873). In AHPs where carriers did not medically underwrite premiums, the average medical loss ratio increased 16 percent.

Table 12. Number of Plans, Average Premiums, and Medical Loss Ratios in AHPs That Use Health Factors or Claims Experience to Set Premiums and Percent Change, 2005-2008

	Number of plans	Number of enrollees (thousands)	Premiums per member per month	Average medical loss ratio
Carrier uses health factors or claims experience to rate association members				
2005	75	367.9	$254	0.836
2006	97	435.1	$266	0.840
2007	97	429.1	$292	0.849
2008	95	462.3	$304	0.873
Percent change, 2005-2008	26.7%	25.7%	19.8%	4.3%
Carrier does not use health factors or claims experience to rate association members				
2005	59	73.3	$156	0.749
2006	47	41.3	$135	0.770
2007	43	33.7	$145	0.803
2008	43	29.0	$149	0.870
Percent change, 2005-2008	-27.1%	-60.4%	-4.7%	16.2%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: Medical loss ratios are calculated as medical cost per premium dollar; medical cost is defined as carrier payments for incurred claims.

E. Update to 2010

Responding to new reporting requirements in March 2011, carriers in Washington State reported lower levels of enrollment in either AHPs or in community-rated small group plans in 2010 than they had reported for 2008, in response to the OIC data call. While inferences drawn from comparison of separate data sources should always be considered with caution, the data reported for 2010 appear to indicate a continuation of some trends observed from 2005 to 2008. These changes occurred in the context of a significant drop in total insured group coverage, which in all states has been an important result of the economic recession.

In 2010, estimated enrollment in AHPs was 2.5 percent less than in 2008, while enrollment in non-AHP large group and community-rated small group plans had dropped nearly 11 percent (Table 13). Overall, about 35 percent of insured residents were enrolled in AHPs, compared with 33 percent in 2008.

Table 13. Enrollment in AHPs and Large Group or Community-Rated Small Group Plans and Percent Change, 2008 and 2010 (estimated)

	Total insured coverage	AHP large and small groups	Non-AHP large groups and community-rated small groups
Enrollment (in thousands)			
2008	1,465.0	491.3	973.7
2010	1,348.5	479.2	839.3
Percent change 2008-2010	-8.0%	-2.5%	-10.7%
Percent of enrollees			
2008	100.0%	33.5%	66.5%
2010	100.0%	35.5%	64.5%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey, carrier information reported in the revised additional data statement, and OIC estimates. Non-AHP large-group enrollment includes PEBB enrollees.

Table 14 provides estimates of the change in small- and large-group enrollment, respectively, in AHP and large group or community-rated small group coverage for a subset of carriers that reported information about the size of enrolled groups to the OIC in the March 2011 Revised Additional Data Statement. These carriers represented about 94 percent of total enrollment in insured health plans, 84 percent of total AHP enrollment, and 70 percent of AHP small group enrollment in 2008.[10]

For these carriers, the change in enrollment from 2008 to 2010 was significant in at least two ways. First, while their total enrollment dropped 11 percent, the loss of enrollment was concentrated in non-AHP large group and community rated small group plans, not in AHPs—as also occurred

[10] The relatively low proportion of AHP small group enrollees that these carriers represent reflects the impact of exempting life and disability carriers (including United HealthCare, Aetna, Mega Life and Health Insurance Company, Health Net Life Insurance Company, the National Life Insurance Company of Tennessee, and others) from filing the Additional Data Statement in March 2011.

from 2005 to 2008. As a result, AHP enrollment accounted for 34 percent of their total business in 2010, compared with 30 percent in 2008.

Table 14. Selected Carriers' Enrollment in AHP and Large Group and Community-Rated Small Group Plans by Group Size, and Percent Change, 2008 and 2010

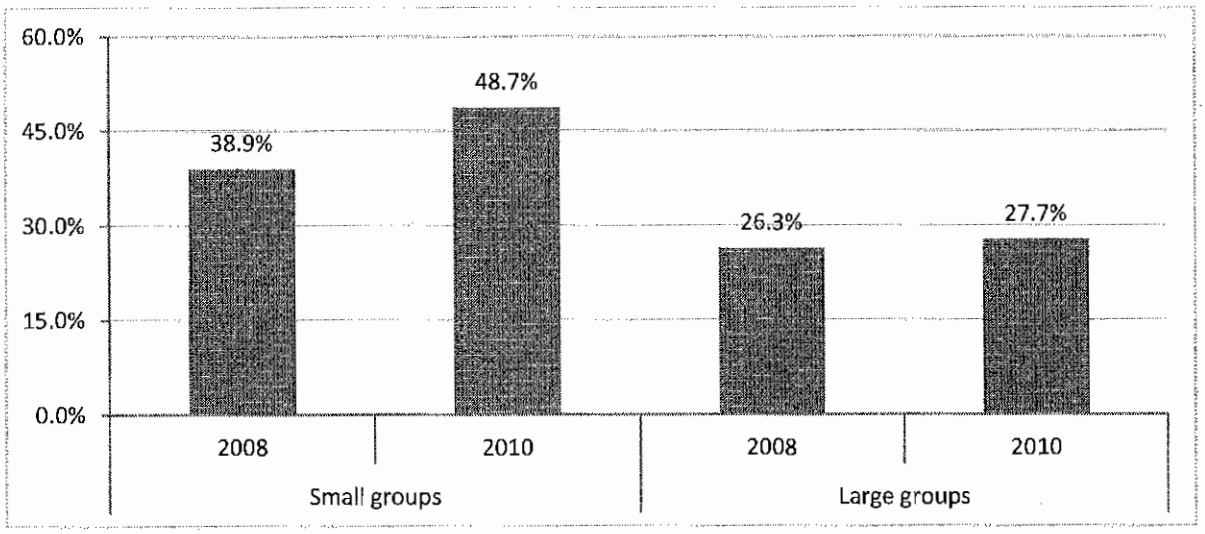
		AHP coverage			Non-AHP coverage		
	Total	Total	Small groups	Large groups	Total	Community-rated small groups	Non-AHP large groups
Enrollment (in thousands)							
All carriers, 2008	1,464.9	491.2	227.0	264.3	973.6	248.8	724.9
Selected carriers							
2008	1,380.0	413.7	156.3	257.4	966.3	245.0	721.3
2010	1,221.4	409.0	164.1	245.0	812.4	173.2	639.1
Percent change	-11.5%	-1.1%	5.0%	-4.8%	-15.9%	-29.3%	-11.4%
Percent of enrollees							
All carriers, 2008	100.0%	33.5%	15.5%	18.0%	66.5%	17.0%	49.5%
Selected carriers							
2008	100.0%	30.0%	11.3%	18.6%	70.0%	17.8%	52.3%
2010	100.0%	33.6%	13.4%	20.1%	66.5%	14.2%	52.3%
Percent of enrollees by source of coverage							
All carriers, 2008	---	100.0%	46.2%	53.8%	100.0%	25.6%	74.4%
Selected carriers							
2008	---	100.0%	37.8%	62.2%	100.0%	25.4%	74.6%
2010	---	100.0%	40.1%	59.9%	100.0%	21.3%	78.7%

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey and carrier information reported in the revised additional data statement.

Note: Selected carriers are those that reported 2010 enrollment in March 2011. These carriers are Asuris Northwest Health, Group Health Cooperative, Group Health Options, KPS Health Plans, Kaiser Foundation Health Plans of the Northwest, Lifewise Health Plan of Washington, PacifiCare of Washington, Premera Blue Cross, Regence Blue Shield, Timber Products Manufacturers Association, Western Grocers Employee Benefit Trust, Providence Health Plans, Regence Blue Shield of Idaho, Regence Blue Shield of Oregon, and Health Net Health Plan of Oregon. Non-AHP large-group enrollment includes PEBB enrollees.

Second, small group enrollment in AHPs increased 5 percent, while enrollment in every other category—AHP large groups, non-AHP large groups, and community-rated small groups—declined. In 2010, AHPs accounted for nearly half of these carriers' total small group enrollment (49 percent), compared with 39 percent in 2008 (Figure 6). AHPs also accounted for a greater share of their large group business in 2010 (28 percent) than in 2008 (26 percent).

Figure 6. Selected Carriers' AHP Enrollment as a Percent of their Total Small and Large Group Enrollment, 2008 and 2010



Source: Mathematica Policy Research analysis of carrier survey data for 2008 and carrier information reported in the revised additional data statement.

Note: Selected carriers are those that reported 2010 enrollment in March 2011. These carriers are Asuris Northwest Health, Group Health Cooperative, Group Health Options, KPS Health Plans, Kaiser Foundation Health Plans of the Northwest, Lifewise Health Plan of Washington, PacifiCare of Washington, Premera Blue Cross, Regence Blue Shield, Timber Products Manufacturers Association, Western Grocers Employee Benefit Trust, Providence Health Plans, Regence Blue Shield of Idaho, Regence Blue Shield of Oregon, and Health Net Health Plan of Oregon. Non-AHP large-group enrollment includes PEBB enrollees.

As in 2008, Premera and Regence were the largest AHP carriers in 2010, followed by Group Health. Premera insured 45 percent of AHP enrollees in 2010, compared with 42 percent in 2008 (Table 15). Group Health companies also reported greater AHP enrollment in 2010, and accounted for a larger share of total AHP enrollment (9 percent) than in 2008 (7 percent). In contrast, the Regence companies that reported detailed enrollment data in March 2011 had lower AHP enrollment, and accounted for a somewhat smaller share of all AHP enrollees in 2010 (29 percent) than in 2008 (33 percent).

Table 15. Total AHP and Community-Rated Small-Group Enrollment by Carrier, 2008 and 2010 (estimated)

	2008				2010			
	AHP (thousands)	Percent of total AHP	Community-rated small group (thousands)	Percent of total community-rated small group	AHP (thousands)	Percent of total AHP	Community-rated small group (thousands)	Percent of total community-rated small group
Total	491.4	100.0%	248.8	100.0%	479.2	100.0%	173.2	100.0%
Premera Blue Cross	208.7	42.5%	64.5	25.9%	216.5	45.2%	12.4	7.2%
Regence	164.7	33.5%	143.1	57.5%	141.3	29.5%	113.6	65.6%
Group Health	34.3	7.0%	25.9	10.4%	45.1	9.4%	34.6	20.0%
All other carriers	84.0	17.1%	15.3	6.1%	77.8	16.2%	12.6	7.3%

Source: Mathematica Policy Research analysis of carrier survey data for 2008, carrier information reported in the revised additional data statement, and OIC estimates. Non-AHP large-group enrollment includes PEBB enrollees.

Notes: In this table, Regence includes Asuris Northwest Health, Regence Blue Shield, Regence Blue Shield of Idaho, and Regence Blue Shield of Oregon, but excludes Regence Health Maintenance of Oregon and Regence Life and Health Insurance Company in both 2008 and 2010. Premera includes Premera Blue Cross and Lifewise Health Plan of Washington. Group Health includes Group Health Cooperative, Group Health Options, and KPS Health Plans.

In contrast to its growing AHP enrollment, Premera appeared to shed most of its community-rated small group business from 2008 to 2010. Having reported 64,500 community-rated small-group enrollees in 2008, it reported just 12,400 in 2010. Regence also reported many fewer community-rated small-group enrollees in 2010 (113,600) than in 2008 (143,100), but ultimately held a much larger share of the community-rated small group market (66 percent, compared with 58 percent in 2008). In contrast to both Premera and Regence, Group Health reported greater community-rated small group enrollment in 2010. In 2010, Group Health accounted for 20 percent of the community-rated small group market, compared with 10 percent in 2008.

Table 16 presents average monthly premiums and medical cost in AHP small and large groups among carriers that reported in March 2011. As in 2008, average premiums for AHP small groups in 2010 ($278) were substantially lower than for community-rated small groups ($382), and may have increased much less since 2008. While comparison of AHP and community-rated small group premiums is complicated by the different calculations possible for 2008 and 2010, it appears that average premiums increased 6 percent for AHP small groups, compared with 21 percent for community-rated small groups.[11]

[11] In 2010, carriers reported separately the premiums earned and medical costs incurred by small and large groups within each AHP. In contrast, the OIC data call asked carriers to report total premium earned and medical costs incurred by AHP in 2008, for enrolled groups of all sizes, and it was necessary to calculate average premiums and medical costs for 2008 across small and large groups in the same AHP. Because actual AHP small group premiums and medical costs may have been higher than the average within an AHP (due to the inclusion of larger groups in the

Table 16. Selected Carriers' Average Premiums, Medical Cost, and Medical Loss Ratios for AHP Large and Small Groups and Community-Rated Small-Groups, 2008 and 2010

	AHP small groups	AHP large groups	Community-rated small groups
Average premiums per member per month			
All carriers, 2008	$247	$337	$316
Selected carriers			
2008	$262	$338	$317
2010	$278	$381	$382
Percent change 2008-2010[a]	6.2%	12.7%	20.8%
Average medical cost per member per month			
All carriers, 2008	$214	$294	$267
Selected carriers			
2008	$224	$295	$267
2010	$244	$343	$315
Percent change 2008-2010[a]	9.0%	16.6%	18.0%
Average medical loss ratio			
All carriers, 2008	0.868	0.875	0.844
Selected carriers			
2008[a]	0.854	0.872	0.844
2010	0.877	0.903	0.824

Source: Mathematica Policy Research analysis of carrier survey data for 2008 and carrier information reported in the revised additional data statement.

Notes: Selected carriers are those that reported 2010 enrollment in March 2011. These carriers are Asuris Northwest Health, Group Health Cooperative, Group Health Options, KPS Health Plans, Kaiser Foundation Health Plans of the Northwest, Lifewise Health Plan of Washington, PacifiCare of Washington, Premera Blue Cross, Regence Blue Shield, Timber Products Manufacturers Association, Western Grocers Employee Benefit Trust, Providence Health Plans, Regence of Blue Shield Idaho, Regence Blue Shield of Oregon, and Health Net Health Plan of Oregon. Because the average premium and medical cost estimates are rounded, the reported percent changes and medical loss ratios may differ slightly from those calculated directly from the table.

[a] 2008 estimates are the AHP-wide weighted average among AHPs that include small groups, while 2010 values were reported for small and large groups separately. Consequently, the percentage change estimates may be overstated for AHP small groups and understated for AHP large groups for the same benefit design, and the implied change in the medical loss ratios for both AHP small groups and AHP large groups may be overstated.

(continued)

calculation), the percentage change calculations for AHP small groups may be overstated for the same benefit design. Alternatively, if AHP small groups systematically bought lower-benefit options than AHP large groups, the percentage change may be overstated. Conversely, the calculated change for AHP large groups may be conservative for the same benefit design, or potentially overstated if AHP large groups systematically enrolled in higher-benefit options.

In 2010, the average medical loss ratio was 0.88 among AHP small groups and 0.82 for community-rated small groups. These compare with the federal minimum medical loss ratio of 0.85, applicable to the community-rated small group market as of January 1, 2011.

F. Future Monitoring

AHPs are a significant source of coverage in Washington State. Because Washington State allows associations to be formed for the purpose of insurance and exempts them from small group market rules, there is ample opportunity for either carriers or the AHPs themselves to select relatively low-risk employer groups into AHPs and leave higher-risk groups in the large group or community-rated small group markets.

However, federal health reforms seem likely to transform the regulatory landscape for AHPs in Washington State and in other states that currently allow AHPs to operate under regulation that is different from the traditional market. First, for purposes of rate review and reporting, new federal rules include individual and small employer policies sold through associations in the rate review process—even if, as in Washington State, they are otherwise excluded from individual and small group market rules. Second, with respect to the implementation of federal reform more broadly, federal regulators have expressed their view that the size of each individual employer participating in the association will determine whether the employer's coverage is subject to the small group or the large group rules. Finally, federal reform will redefine small groups as employer groups with 2 to 100 employees (versus the current definition of 2 to 50), potentially expanding the reach of small group market rules in AHPs as well as their reach into the current large group market.

If embraced in Washington State, these changes could obviate many of the concerns that underlie this study. To the extent that AHP small groups are subject to the same regulations that govern the community-rated small group market, the ability of AHPs to segment risk in ways that would imperil the community-rated market is very limited. In states that have long regulated AHPs at the participating employer level (for example, Colorado, Massachusetts, and New Jersey), AHPs are believed to be an insignificant component of the small group market; future analysis of data reported nationally for the first time in 2011 may well bear out that perception.

If Washington State wishes to continue to monitor the relationship of AHPs to the large group and community-rated small group markets in coming years, more information is needed than either ESBH 1714(2011) authorized for this study or is obtained under other reporting requirements. In particular, to understand whether AHPs are segmenting risk in ways that might destabilize the large group community-rated small group markets, it will be necessary to know in greater detail how carriers are rating AHPs—specifically, which rate factors they use, the impact on rates offered to AHP large and small groups, differences in plan designs, and the relative burden of illness in AHP large and small groups compared with that in non-AHP large groups and community-rated small groups. In addition, to be useful to policymakers, this information must:

- Clearly include, and separately categorize, information about individuals and groups of one;
- Specifically name the AHP that is covered to allow verification of the reported data against other reporting and earlier survey information; and
- Identify which AHPs are insurer-sponsored, versus those initiated by public employer groups or private employer groups.

Finally, the information must be much more current than was required for this study, which looks back eight years and captures information only as recently as 2008.

Some of the information that is needed to understand the relationship between AHPs and the large group and community-rated small group markets will potentially be easier to obtain in future years due to efforts already underway in Washington State. For example, as of March 2011, health carriers are required to file a Revised Additional Data Statement, reporting information about AHP enrollment, premiums, and medical cost for small and large groups, respectively. However, because life and disability carriers are not required to report, the information currently obtained is very incomplete. The OIC estimates that the life and disability insurers that were exempted from reporting in 2011 accounted for more than 15 percent of AHP enrollees in 2010.

Other information needed to understand how AHPs differ from the large group and community-rated small group markets might be obtained in the context of federal reforms, or in parallel efforts that many other states have undertaken and that Washington State might consider. For example, differences in benefit design might be captured by requiring carriers to use the standard actuarial rules to determine plan tiers in the health insurance exchange, extended to all plans offered to AHPs and community-rated small groups. In addition, an all-payer claims database (such as many other states are assembling) could be extremely useful for understanding the relative burden of illness in AHPs and the large and community-rated small group markets, if carriers are further required to provide coding that links individual identification codes to policy identification codes. As in other states, such a database could also be useful in understanding many other aspects of health care delivery, costs, and financing in Washington State.

APPENDIX A: SUMMARY OF STATUTORY AUTHORITY TO REGULATE HEALTH INSURANCE RATES AND FORMS

The statutory authority of the OIC to review carriers' rates and forms varies by both the type of carrier and the type of plan. For health carriers (called health care service contractors, or HCSCs) and HMOs, the OIC has authority to require carriers to file rates and forms, require prior approval of forms for small groups, and disapprove rates.

For AHPs, the OIC can require prior approval of both rates and forms only for disability carriers. For all other carriers that write AHP business, the OIC has authority to require filing of rates and forms, but can review only forms, and cannot disapprove either rates or forms.

Under federal rules issued September 6, 2011, HHS will review non-disability carriers' AHP small-group rates in Washington State, as well as MEWA small-group rates.

Table A.1. Rate and Form Review Authority in Washington State, Effective 2011

	Washington State Office of the Insurance Commissioner (OIC)					U.S. Department of Health and Human Services (HHS)
Carrier and plan type	Prior Approval (group sizes 1-50)	File, review, and possible disapproval	File and review	File and use	Use	Review (group sizes 2-50)
HMOs – community rated	Forms	Rates				
Health Care Service Contractors (HCSCs) – community rated	Forms	Rates				
Disability carriers, including AHPs	Rates Forms					
Non-disability carriers, including AHPs			Forms	Rates		Rates
MEWAs					Forms	Rates

Source: Washington State Office of the Insurance Commissioner.

APPENDIX B: DATA AND METHODS

A. Data

The analysis in this report relies on data reported to the Washington Office of the Insurance Commissioner (OIC) and the federal Department of Labor. Each data source is described below.

- **Data reported to the Office of the Insurance Commissioner in compliance with ESBH 1714(2011).** In 2010, 37 carriers that wrote AHP or small group business in Washington State between 2005 and 2008 responded to a request for information issued by the Washington OIC as authorized by ESBH 1714(2011). Carriers were asked to provide information about each association plan that they wrote—including the number and size of employers that participated in the plans; the number and age distribution of resident employees or individuals enrolled in the plans; the dollar values of premiums and medical cost; and the use of health factors or claims experience in issuing coverage, setting premiums, or both. In addition, they were asked to report the same information for their community-rated small group business as a whole.

- **Annual Statement: Exhibit of Premiums, Enrollment and Utilization (2005-2008).** The OIC provided annual statements for each carrier that filed as a comprehensive health insurance company and reported business in Washington. Information about the number of members and member months, health premiums earned, and the claims incurred in each year for group plans was extracted from the Exhibit of Premiums, Enrollment and Utilization for 2005-2008 (rows 6, 15, and 18).

- **Additional Data Statement Filing.** The OIC also provided the Additional Data Statement Form for the Year Ending December 31, 2010 for all carriers, other than life and disability carriers, that wrote community-rated small group or AHP coverage in Washington. Information on net premium income, claims incurred (total hospital and medical), and total members at the end of the current year were extracted for small group contracts, and large group contracts.

- **Form 5500, Annual Return/Report of Employee Benefit Plan.** The OIC provided links to Form 5500 information submitted to the U.S. Department of Labor reporting the number of people enrolled in association plans in 2009, 2010, and 2011 and the insured or self-insured status of the plans.

- **State Insurance Management & Business Application (SIMBA).** Created to provide a tool for OIC staff to complete the day to day business of the agency, SIMBA is used to collect and manage data related to licensing of producers and companies, cases and orders submitted against companies and/or producers; revenue received from licensees (taxes, licensing fees, etc); rates and forms filings. SIMBA consists of an internal component used by OIC staff and an online component used by OIC customers. The OIC estimates of life and disability carriers' AHP enrollment in 2010 were based on the carriers' April 2011 NAIC filing (which reported their national AHP and MEWA business) cross-referenced to SIMBA.

B. Methods

1. Data cleaning and verification

The information that carriers reported in response to the OIC data call as authorized by ESBH 1714(2011) was amassed in a database and checked to confirm that the required information was reported, the information reported for each AHP and aggregated small group line was consistent, and responses were within feasible ranges. Premiums per member month were analyzed, and extreme outlier lines of data (specifically, reporting premiums of less than $100 or greater than $2,000 per member month) were excluded from the analysis. Mathematica confirmed the stability of the reported trends by reproducing the calculations, eliminating all years of data for any AHP where at least one year of data was excluded as an outlier; this analysis confirmed that the elimination of outliers did not skew the reported results.

Most carriers reported the number of members enrolled during the year, and the distribution of those members by group size. However, for a small number of association plans, carriers were unable to report 2005 enrollment. When reporting trends in total AHP enrollment over time, Mathematica estimated 2005 enrollment for those plans by extrapolating from reported 2006-2008 enrollment. However, because the data were insufficient to estimate small and large group enrollment for these plans, they were excluded in all years for analyses of enrollment change by group size. AHPs not reporting 2005 enrollment were dropped from analyses of average premiums and medical cost only in the 2005.

All plans reported in the data call were classified into the following analysis categories:

- **Carrier.** Carriers commonly owned by a single company were combined under the parent company for the purpose of counting the number of carriers writing AHP or other large group or community-rated small group business over time. Six companies (Asuris Northwest Health, Regence BlueShield, Regence Life And Health Insurance Company, Regence BlueShield of Idaho, Regence Blue Shield of Oregon, and Regence Health Maintenance of Oregon) were classified as Regence. Three companies (Group Health Cooperative, Group Health Options, and KPS Health Plans) were classified as Group Health" Aetna, UnitedHealthcare, and HealthNet each reported two separate lines of business that were combined under their respective parent names.
- **Number of small-group and large-group enrollees.** Within each plan, the number of enrollees in group sizes of 2 to 50 were summed to arrive at total small-group enrollees, and the number in group sizes of 51 or more were summed to arrive at total large-group enrollees.
- **Small group or large group focus.** Association health plans were classified as being small group or large group focused if more than 50 percent of their enrollment was comprised of small groups (size 2 to 50) or large groups (sized 51 and above), respectively.
- **AHP size.** Association health plans were categorized into size class using total enrollment, including both small and large group enrollees.
- **Large group enrollment, premiums, and medical cost** were estimated as total group enrollment, earned premiums, and incurred claims reported in each year on the 2005-

2008 Annual Statements minus the small group and association plan numbers reported in the OIC data call.

2. Describing Trends in the AHP and Small Group Market

From the data call database, we calculated trends in enrollment, annual incurred claims, and annual net earned premiums for the AHP and community-rated small group market. We also calculated the share of the small group market that enrolled in AHPs and community-rated plans. In addition, data from carriers' annual statements for 2008 were used to assess the size of the non-AHP large group market in Washington state.

In addition, we analyzed the distribution of enrollees in the AHP and small group market based on employer size (2-5, 6-10, 11-25, 26-50, 51-100, 100+). Lastly, we analyzed data reported on the percentage of enrollees for whom plan rates were adjusted for health factor or claims experience reasons. Carriers also reported if they deny coverage based on health factors. However, as only one carrier in one year (2007) reported denying a limited number of plans we did not include analysis of this data.

3. Age Adjustment

To develop the adjustment factors to compare premiums and claims, four cost-by-age tables were developed and then simplified and blended into the following unisex age factors:

<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
1	1.25	1.5	1.7	1.85	1.85	2.25	2.75	3.5	4.25	6

Member-weighted averages were used to develop a relative cost factor for the entire study population and for each sub-population studied. The weighted average cost factor for the full population was 2.023.

4. Analysis of 2010 Data

To assess changes in the market from 2008 to 2010, per member per month premiums, medical loses, and carriers' shares of the AHP and other large group and community-rated small group market were calculated using data from the OIC data call database (for 2008) and carriers' additional data statement fillings (for 2010). In addition, OIC provided estimates of 2010 AHP and other large group and community-rated small group enrollment for life and disability carriers that are not required to file the additional data statement.

MATHEMATICA
Policy Research

www.mathematica-mpr.com

Improving public well-being by conducting high-quality, objective research and surveys

Princeton, NJ ■ Ann Arbor, MI ■ Cambridge, MA ■ Chicago, IL ■ Oakland, CA ■ Washington, DC