BEFORE THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of

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

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

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

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

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

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

Docket No. 15-0062; 15-0071; 15-0075; 15-0078; 15-0079; and 15-0084

OIC STAFF'S RESPONSE TO MBA, BIAW, NMTA, AND CAMBIA OPPOSITION TO THE MOTION FOR SUMMARY JUDGMENT OF THE OIC STAFF

INTRODUCTION

In their Opposition to OIC Staff's Motion for Summary Judgment, the Master Builders Association, Building Industry Association, Northwest Marine Trade Association, and Cambia fail to establish standing. Appellants continue to misstate and misapprehend the OIC's authority to disapprove the 2014 large group plans sold by Regence Blue Shield to the three associations. Appellants continue to feign surprise over the effect of the 2014 group market reforms of the ACA, and Appellants continue to insist the OIC should be enforcing the old association exception to the state community rating requirement even though the ACA now replaces Washington's community rating statute with a federal community rating requirement that contains no such exception. The OIC therefore submits this brief reply.

STANDING

Appellants seek to establish that they are "aggrieved" parties entitled to demand a hearing under the Insurance Code's general hearing statute, RCW 48.04.010(1)(b), through the Declaration of Jerry Belur in support of MBA Trust, BIAW Trust, NMTA Trust and Cambia's Opposition to OIC Staff's Motion for Summary Judgment. Mr. Belur's Declaration addresses this issue in paragraph 13, page 7, with predictions that the OIC's disapproval of the 2014 Regence plans will somehow cause the rates paid by participating employers to "increase substantially," that the disapproval will "impair the AHP's ability to effectively compete for healthcare benefit business for employers falling within certain demographics," and that its "membership will be limited to an aging demographic that will not be sustainable in the long term."

It is well established that this kind of speculative assertion cannot confer standing. As stated in *KS Tacoma Holdings, LLC v. Shorelines Hearings Bd.*, 166 Wn. App. 117, 129, 272 P.3d 876 (2012):

> When a person or corporation alleges a threatened injury, as opposed to an existing injury, the person or corporation must show an immediate, concrete, and specific injury to themselves. *Trepanier*, 64 Wn. App. at 383 (citing *Roshan v. Smith*, 615 F. Supp. 901, 905 (D.D.C. 1985)). "If the injury is merely conjectural or hypothetical, there can be no standing." *Trepanier*, 64 Wn. App. at 383 (citing *United States v. Students Challenging Regulatory Agency Procedures*, 412 U.S. 669, 688-89, 93 S. Ct. 2405, 37 L. Ed. 2d 254 (1973)).

Such speculative assertions are also insufficient to defeat summary judgment. As stated in *Guile v. Ballard Cmty. Hosp.*, 70 Wn. App. 18, 25, 851 P.2d 689 (1993):

> Affidavits containing conclusory statements without adequate factual support are insufficient to defeat a motion for summary judgment.

Cambia's allegation that it is "aggrieved" is even more thinly supported. Its sole evidentiary basis appears to be the statement in paragraph 2 of the Declaration of Dale Neer In Support of the Association and Cambia's Motion for Summary Judgment that Regence is Cambia's subsidiary. Cambia is not a health care service contractor, health maintenance organization or disability insurer authorized to market health insurance in Washington. These were Regence's filings, not Cambia's. Regence has not appealed the OIC's disapproval of these plans and its time for doing so has expired. Cambia's assertion that it has standing to step into Regence's shoes because it owns Regence's stock is without legal merit. As stated in *Opportunity Christian Church v. Washington Water Power Co.*, 136 Wash. 116, 120 - 121, 238 P. 641 (1925), rejecting a claim by stockholders in a water company that they could assert company rights the company itself had not asserted:

> The argument is plausible and ingenious, but, in our opinion, to adopt it would be very dangerous and would in the long run have the effect of entirely disregarding the long-standing fundamental rules of law to the effect that a stockholder of a private corporation may not maintain a suit on behalf of the corporation to redress wrongs done to it. Business of all kinds and natures is transacted by private corporations, and the only safe rule to follow is that in all such instances the corporation is a separate entity to be controlled by its board of trustees while acting in good faith and within their power, and that it alone is the absolute owner of all of its property and rights, which may be protected and enforced only by it through its officers, and seldom, if ever, through the individual action of a stockholder, so long as the trustees act within their power and in good faith.

At any rate, the claims of all four of these appellants are barred by the specific provisions of RCW 48.44.020(2) that limit the right to demand a hearing when a group plan filing is disapproved to the health care service contractor or health maintenance organization that submitted the filing. In their opposition to the OIC Staff's Motion for Summary judgment, Appellants do not even acknowledge, let alone try to distinguish, the controlling rule that "Where general and special laws are concurrent, the special law applies to the subject matter contemplated by it to the exclusion of the general law." *State v. Becker*, 39 Wn.2d 94, 96, 234 P. (2d) 897 (1951).

Even if the appellants could create a triable issue of fact under the general hearing statute, RCW 48.04.010, as to whether or not they are aggrieved, their hearing demands here are governed by, and subject to dismissal under, the more specific provisions of RCW 48.44.020(2).

FEDERAL LAW

In their Opposition to OIC Staff's Motion for Summary Judgment, page 12, Appellants accuse the OIC staff of "labored logic" and insist that there has been no recent change in the law. Although the Affordable Care Act is not a simple statute, the logic of the OIC's position is not labored and the "recent" change is clear.

For plans with plan years commencing on or after January 1, 2014, the community rating provisions of the ACA apply. These community rating requirements are set forth in 42 USCS § 300gg as follows:

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

Per note 2 following this section "This section is effective for plan years beginning on or after January 1, 2014, as provided by § 1255 of Act March 23, 2010, P.L. 111-148, which appears as a note to this section."

Any state law provision that prevents application of the federal community rating requirements is preempted. 42 USCA § 300gg-23 provides in pertinent part as follows:

> (a) Continued applicability of State law with respect to health insurance issuers.
> (1) In general. Subject to paragraph (2) and except as provided in subsection (b), this part [42 USCS §§ 300gg et seq.] and part C [42 USCS §§ 300gg-91 et seq.] insofar as it relates to this part [42 USCS §§ 300gg et seq.] shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage **except to the extent that such standard or requirement prevents the application of a requirement of this part** [42 USCS §§ 300gg et seq.]. (Emphasis supplied.)

The application of this preemption provision is confirmed in the March 14, 2013 letter from Theresa Miller of CMS to Commissioner Kreidler advising that a state law that would "prevent application of federal law to health insurance coverage provided through an

association, and, consequently would prevent the application of the market reform provisions under the PHS Act to the Washington market" is preempted. (OIC Staff Reply to Appellants' Motion for Summary Judgment, Addendum "A," page 3.) The proposed state law Ms. Miller was addressing was a 2013 proposed bill, SB 5607 and HB 1700, that would have amended RCW 48.44.024, RCW 48.46.068, and RCW 48.21.045(3) to keep the association community rating exception alive past 2014 by adding the following language to the exception:

> (3) For plan years beginning on or after January 1, 2014, health plans provided through associations or member-governed groups are deemed large group health benefit plans, if the association or member-governed group:
> (a) Operates solely within the borders of a single state and only includes member companies that have a registered Washington state unified business identifier;
> (b) Complies with all state and federal laws applicable to fully insured large group health plans;
> (c) Does not health underwrite individuals;
> (d) Does not bar any entity from association membership based on age, health status, or claims experience; and
> (e) Offers coverage to all association members, regardless of age, health status, or claims experience.

This bill did not pass.

Prior to January 1, 2014, Washington's community rating statute, RCW 48.44.023 (HCSC version), did not prevent application of the ACA's market reform provision to the Washington market. Washington's community rating requirement therefore continued to apply as did the state exception to the state community rating requirement for employers purchasing through associations, RCW 48.44.024(2), which was enacted along with the state community rating requirement in 1995 as part of House Bill 1146.

For plan years commencing January 1, 2014 and thereafter, the ACA community rating requirements replace Washington's community rating requirements. The ACA allows no community rating exception for employers purchasing coverage through associations. For plan

years commencing on or after January 1, 2014, Washington's community rating statute, RCW 48.44.023(3), and the association exception to that statute, RCW 48.44.024(2), are therefore clearly preempted by federal law.

This proposition is confirmed by the language of the Department of Health and Human Services' rule entitled "Rate Increase Disclosure and Review: Definitions of 'Individual Market' and 'Small Group Market'" that took effect November 1, 2011, cited in the second declaration of Jim Keogh and in the rule making file for the OIC's Market Transition Rule. Although the language of this rule was modified in March of 2015, citation here is to the federal language of the rule that was in effect at the time OIC's Market Transition Rule was adopted, at the time these plans were filed, and at the time they were disapproved. The rule states at 76 FR 54979 in pertinent part as follows:

> (2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage.

The state statutory exception to Washington's community rating statute, RCW 48.44.024(2), provides just the opposite:

> 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).

Under the Supremacy Clause of the United States Constitution, the federal provisions control. The state community rating provision and its companion state community rating exception are clearly superseded by federal law for plans commencing on or after January 1, 2014.

Without RCW 48.44.024(2), Appellants' legal argument evaporates. A small member employer within the association can no longer be treated as a large employer, and the employee

benefit plan no longer exists at the member employer level. For a bona fide association that meets the ERISA "employer" definition, the association itself is now the employer. Appellants' claim that such an association must not be treated as a single employer is simply wrong as a matter of federal law.

Rating a single employee benefit plan that exists only at the true employer association level at the wrong level is not only inconsistent with the Affordable Care Act; it also results in unfair discrimination. Similar risks are treated differently and identically situated employees are charged different rates for the same benefits.

When the subgroups are created by the health carrier based on health status factors, as they undeniably were here according to Regence's filing, such a rating scheme also violates the HIPAA non-discrimination rules. It is surely no defense to argue, as Appellants do at pages 10 through 14 of their motion, that if Regence's rating scheme violates HIPAA, it must have done so even prior to January 1, 2014. Regence's rating scheme may well have violated the HIPAA non-discrimination rules even prior to the ACA under the logic of *Fossen v. Blue Cross Blue Shield of Montana, Inc.*, 744 F. Supp. 2d 1096 (D. Mont. 2010), discussed more fully at pages 16-17 of OIC Staff's Motion for Summary Judgment. Prior to January 1, 2014, however, a *Fossen* HIPAA discrimination argument would have been met in Washington with RCW 48.44.024(2), just as it was in the 2007 Spokane County Superior Court case, *Associated Indus. Of the Inland Nw. v. OIC*, cited at page 11 of Appellants' Opposition to the OIC Staff's Motion for Summary Judgment. Because the ACA has now replaced Washington's community rating statute with a federal community rating requirement that contains no such exception, RCW 48.44.024(2) no longer applies.

At pages 13 – 14 or their Opposition, Appellants seek to obfuscate the change in the law introduced by the Affordable Care Act by conflating the "bona fide association" definition in the Public Health Service Act with the ERISA definition in 42 USCS § 1002(5) of an "employer," i.e. "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." The CMS bulletin to which Appellants refer, Addendum 1 to OIC Staff's Motion for Summary Judgment, makes clear that the "bona fide association" concept has absolutely no application to the ERISA "employer" definition or to the issue in this case. Footnote 4, page 2, of the bulletin, for example, states:

> Title XXVII of the PHS Act does recognized coverage offered through "bona fide associations," but only for purposes of providing limited exceptions from its guaranteed issue and guaranteed renewability requirements. PHS Act §§ 27311; 2732b6, e); 2741(e)(1); 2742(b)(5),(e). The bona fide association concept has no other significance under the PHS Act, and, importantly, does not modify or affect the analysis of whether health insurance coverage belongs to the individual or group market.

Under the Affordable Care Act, Regence was required in 2014 to begin rating these employee welfare benefit plans as single large group plans issued to a single large employer. Regence refused to do so and filed rates that did not match its forms. The OIC had not only the legal authority, but the legal obligation under the group market reforms of the Affordable Care Act, to reject such filings.

CONCLUSION

For these reasons, in addition to those set forth in the OIC Staff's Motion for Summary Judgment and Response to Appellants' Motion for Summary Judgment, the OIC Staff

respectfully requests entry of an Order denying Appellants' Motion, granting the OIC Staff's Motion, and dismissing these hearing demands.

Dated this **3rd** day of June, 2015.

OFFICE OF INSURANCE COMMISSIONER

Charles Brown

Charles Brown
Insurance Enforcement Specialist
Office of the Insurance Commissioner

CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the state of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the state of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing OIC STAFF'S RESPONSE TO MBA, BIAW, NMTA, AND CAMBIA OPPOSITION TO THE MOTION FOR SUMMARY JUDGMENT OF THE OIC STAFF; DECLARATION OF JIM C. KEOUGH IN RESPONSE TO MBA TRUST, NMTA TRUST, BIAW TRUST, AND CAMBIA'S OPPOSITION TO OIC STAFF'S MOTION FOR SUMMARY JUDGMENT on the following individuals listed below in the manner shown:

Judge George Finkle (Ret.) Presiding Officer Office of the Insurance Commissioner kellyc@oic.wa.gov ***Via email and hand delivery***	Maren R. Norton, Attorney for Cambia Robin L. Lamer, Attorney for Cambia Karin D. Jones, Attorney for Cambia Stoel Rives, LLP 600 University St., Ste. 3600 Seattle, WA 98101 maren.norton@stoel.com robin.larmer@stoel.com karin.jones@stoel.com Renée M. Howard, Attorney for BIAW and MBA PerkinsCoie 1201 Third Ave, Suite 4900 Seattle, WA 98101-3099 RHoward@perkinscoie.com Earl J. Hereford KHBB Law 705 Second Ave., Hoge Building, Ste. 800 Seattle, WA 98104 jhereford@khbblaw.com ***Via email and by depositing in the U.S. mail via state Consolidated Mail Service with proper postage affixed to.***

Dated this **3rd** day of June, 2015, in Tumwater, Washington.

Christine M. Tribe

CHRISTINE M. TRIBE
Paralegal, Legal Affairs Division

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of

MASTER BUILDERS ASSOCIATION OF KING AND SNOHOMISH COUNTIES and MASTER BUILDERS ASSOCIATION OF KING AND SNOHOMISH COUNTIES EMPLOYEE BENEFIT GROUP INSURANCE TRUST ("MBA TRUST")
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No. 15-0079

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

Docket No. 15-0062; 15-0071; 15-0075; 15-0078; 15-0079; and 15-0084

DECLARATION OF JIM C. KEOGH IN RESPONSE TO MBA TRUST, NMTA TRUST, BIAW TRUST, AND CAMBIA'S OPPOSITION TO OIC STAFF'S MOTION FOR SUMMARY JUDGMENT

I, Jim C. Keogh, am over the age of eighteen years old. I make the following declaration based on first hand personal knowledge and am competent to testify to the facts set forth herein.

1. I am the Policy and Rules Manager for the Policy Division of the Office of the Insurance Commissioner (OIC). I have been in that position since November 2013.

2. I have been with the OIC for seven years. Prior to my current position, I was an Economic Policy Analyst for the OIC.

3. I am the OIC staff person who has been primarily responsible for evaluating the data and information available to the OIC concerning association health plans. One of the key issues I have been tasked with analyzing is the reasons for the difference in the premiums charged for health plans sold to small employers in the small group market (small group health plans) versus health plans sold to small employers through associations (association health plans).

4. Since the Mathematica report discussed in my previously submitted declaration was issued, I have monitored and analyzed continuing trends in the association health plan market. As part of my review and analysis of this issue, I have reviewed health plan filings submitted by insurance carriers that have sold large group health plans to associations, the annual statements submitted by carriers, information submitted to the Insurance Commissioner pursuant to the Legislature's authorized data call, information in the Mathematica Report, and other information provided by carriers and associations about enrollment in association health plans since the Mathematica Report was issued. Based upon this information, I believe the Declaration of Jerry Belur dated May 19, 2015, in Support of Cambia and the Associations' Opposition to OIC Staff's Motion for Summary Judgment is factually flawed.

5. For example, the points in paragraphs 4 and 5 of Mr. Belur's Declaration focus on age demographics. The 2008 data from the Mathematica study, which was the basis for my analysis of age differences between Association Health Plans and the small group market,

clearly showed that both MBA (16.7%) and BIAW (20.2%) Regence plans had a significantly smaller percentage of over-50 enrollees than found among the three major small group plan insurers at that same point in time: Regence (24.1%); Premera (27.4%); and Group Health Options (30.2%). Mr. Belur's comparison of 2014-2015 data for these three Association Health Plans to 2008 data is a badly flawed comparison. It ignores both the aging demographics in the state over this time period and the impact of the recession on both job losses and subsequent hires (primarily among younger workers). These changes are significant. For example, the MBA and BIAW lost approximately 33% of their enrollees from 2008 to 2014. During this same period the percentage of over 55 enrollees in the small group market grew from approximately 11% to 21% for the same insurance carriers cited above, strongly implying a similar or greater growth in the over 50 population in this market.

6. In paragraph 6 of his declaration, Mr. Belur asserts that the age-banded rates offered to these three associations are not gender based. However, page 8 of the Associations' original Motion for Summary Judgment cites a Regence response in Regence's SERFF filing clarifying that "New member groups place in category 0 must meet the following criteria .... (6) maintain a male percentage of 79% or greater". There is a premium difference between enrollees placed in Category 0 and those placed in Category 1 or 2. Those member groups placed in Category 0 pay 9-10% less than those placed in Category 1 and over 20% less than those placed in Category 2. Clearly gender is a part of the rate setting.

7. In paragraph 8 of his declaration, Mr. Belur compares age banding in the small group market to Regence's use of age in these filings. The comparison is misleading. Age banding in the small group market applies to individual enrollees based on the age of the individual enrollee, not to subgroups within the same plan, and the effect on an enrollee's premium occurs incrementally and gradually (typically annually). In a typical Regence small group plan, for example, the premium differential between an employee who is 50 and

someone who is 49 might be about 5%. In these association plans, which use broad age pricing "plateaus," the differential is over 80%. This differential, double the normal premium variation that a typical small group employee experiences going from age 40 to 50, creates a strong incentive for the employee and/or his or her employer to leave the coverage.

8. In paragraph 14 of his declaration, Mr. Belur incorrectly states that the OIC did not adopt the proposed Market Transition Rules in 2013 that Patrick Lennon provided his 11/5/2013 comments on. Attached hereto as Exhibit 1 is a true copy of the Rule-Making Order for the rule, and attached hereto as Exhibit 2 is a true copy of the Concise Explanatory Statement ("CES") for the rule.

9. The Rule-Making Order cites as authority for the rule, among other laws, 45 CFR 150.101(2). On page 4, the CES cites section 2 of this rule as follows:

> The U.S. Department of Health and Human Services (HHS) promulgated rules in 2011 explaining the definitions of the plans and markets to which the ACA's rating reforms apply. The final rule states that major medical coverage sold to individuals or small groups through an association is subject to the rate review system created by the ACA for rates filed in, or that take effect on or after November 1, 2011. 45 CFR 154.102[1]:
>
> "(2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5) if it were not sold through an association is subject to rate review as small group market coverage."
>
> Issuers have had over 2 years to plan for this transition to the rating requirements applicable beginning in 2014.

The footnote in this quoted section cites to Federal Register, Vol. 76, No. 172, 2011 at 54970.

This is the version of the rule that was in effect when OIC's Market Transition Rules were adopted and when the filings involved in this case were submitted and at the time they were rejected. A copy of the complete rule from the Federal Register that is cited in the Concise Explanatory Statement is attached to this Declaration as Exhibit 3.

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[1]

10. I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

SIGNED this 2 day of June, 2015 at Tumwater, Washington.

Jim C. Keogh
Policy and Rules Manager
Washington State Office of the Insurance Commissioner

EXHIBIT 1

RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Office of the Insurance Commissioner

Permanent Rule Only

Effective date of rule:
Permanent Rules
X 31 days after filing.
☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?
☐ Yes ☒ No If Yes, explain:

Purpose: The purpose of the rules is to protect consumers during the transition to health care benefit plans in the individual, small and large groups that comply with the Affordable Care Act and its implementing regulations. The rules provide ongoing market conduct guidance to issuers on required documentation related to plans designated as grandfathered, and determining which market standards apply when offering and issuing coverage to an association's membership.

Insurance Commissioner Matter No. R 2013-13

Citation of existing rules affected by this order:
Repealed:
Amended:
Suspended:

Statutory authority for adoption: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200.

Other authority : 45 CFR 150.101(2)

PERMANENT RULE (Including Expedited Rule Making)
Adopted under notice filed as WSR 13-20-141 on October 2, 2013.
Describe any changes other than editing from proposed to adopted version:

1. Additional language was added to WAC 284-170-950(2) to clarify the application of the rule to fully insured grandfathered plans.
2. WAC 284-170-950(3)(b) was amended to conform to existing federal law 45 CFR 147.170 (g) (1).
3. WAC 284-170-952(1) was amended to include the reference to the prior grandfathered plan WAC, WAC 284-170-950.
4. WAC 284-170-954(2)(a) was amended to specifically confirm that rate information is not required to be in the 90–day notice. This is a clarification, for as a practical matter, for some product withdrawal and replacement scenarios, rates are not developed at the time the notice is issued.
5. WAC 284-170-958(1) was amended to eliminate redundant references to types of large groups.
6. WAC 284-170-958(2) was amended to include a sentence explaining that an issuer must retain the documentation on which it made a determination about what market groups filing through associations belong to, and provide it to the commissioner upon request. This is a clarification requested by commenters.
7. WAC 284-170-958(4) was deleted. Because the federal standard on which the section is based still applies, this change does not result in a substantially different rule from that published, pursuant to RCW 34.05.335.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: Jim Keogh
Address: PO Box 40258
Olympia WA 98504
phone (360) 725-7056
fax (360) 586- 3109
e-mail rulescoordinator@oic.wa.gov

Date adopted:
December 11, 2013

NAME (TYPE OR PRINT)
Mike Kreidler

SIGNATURE
Mike Kreidler

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: December 11, 2013
TIME: 10:41 AM

WSR 14-01-039

(COMPLETE REVERSE SIDE)

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	4	Amended	_____	Repealed	_____
Federal rules or standards:	New	4	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

	New	_____	Amended	_____	Repealed	_____

The number of sections adopted in the agency's own initiative:

	New	6	Amended		Repealed	_____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	_____	Amended	_____	Repealed	_____

The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	6	Amended		Repealed	_____

NEW SECTION

WAC 284-170-950 Grandfathered health plan status. (1) An issuer must retain in its files all necessary documentation to support its determination that a purchaser's plan is grandfathered. The information must be sufficient to demonstrate that the issuer's determination of grandfathered status is credible. For purposes of this section, "grandfathered plan" means a health plan that meets the requirements of this section and as defined in RCW 48.43.005.

(2) An issuer's documentation supporting grandfathered plan designation must be made available to the commissioner or the U.S. Department of Health and Human Services for review and examination upon request. Beginning with the effective date of this section, for fully insured health plans designated as grandfathered, an issuer must retain the records for a period of not less than ten years. For each plan, the records supporting the issuer's determination must also be made available to participants and beneficiaries upon request.

(3) An issuer's documentation must establish for each grandfathered plan that since March 23, 2010:

(a) The plan was not amended to eliminate all or substantially all the benefits to diagnose or treat a particular condition. A list of all plan benefit amendments that eliminate benefits and the date of the amendment is the minimum level of acceptable documentation that must be available to support this criteria;

(b) The percentage of fixed amount cost-sharing percentage requirements, if applicable, for the plan were not increased when measured from March 23, 2010. A list of each cost-sharing percentage that has been in place for a grandfathered group's plan, beginning with the cost-sharing percentage on March 23, 2010, is the minimum level of acceptable documentation that must be available to support this criteria;

(c) The fixed cost-sharing requirements other than copayments did not increase by a total percentage measured from March 23, 2010, to the date of change that is more than the sum of medical inflation plus fifteen percent. A list of the fixed cost-sharing requirements other than copayments that apply to a grandfathered group's plan beginning on March 23, 2010, and a record of any increase, the date and the amount of the increase, is the minimum level of documentation that must be available to support this criteria;

(d) Copayments did not increase by an amount that exceeds the greater of:

(i) A total percentage measured from March 23, 2010, to the date of change that is more than the sum of medical inflation plus fifteen percent; or

(ii) Five dollars, adjusted annually for medical inflation measured from March 23, 2010. A record of all copayments beginning on March 23, 2010, applicable to a grandfathered group plan, and any changes in the copayment since that date is the minimum level of documentation that must be available to support this criterion.

(e) The employer's contribution rate toward any tier of coverage for any class of similarly situated individuals did not decrease by more than five percent below the contribution rate in place on March 23, 2010, expressed as a percentage of the total cost of coverage. The total cost of coverage must be determined using the methodology for determining applicable COBRA premiums. If the employer's contribution rate is based on a formula such as hours worked, a decrease of more

than five percent in the employer's contributions under the formula will cause the plan to lose grandfathered status. The issuer must retain a record of the employer's contribution rate for each tier of coverage, and any changes in that contribution rate, beginning March 23, 2010, as the minimum level of documentation that must be available to support this criteria;

(f) On or after March 23, 2010, the plan was not amended to impose an overall annual limit on the dollar value of benefits that was not in the applicable plan documents on March 23, 2010;

(g) On or after March 23, 2010, the plan was not amended to adopt an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit for all benefits that was in effect on March 23, 2010; and

(h) The plan was not amended to decrease the dollar value of the annual limit, regardless of whether the plan or health insurance coverage also imposes an overall lifetime limit on the dollar value of all benefits.

(4) In addition to documentation establishing that none of the prohibited changes described in subsection (3) of this section have occurred, an issuer must also make available to the commissioner upon request the following information for each grandfathered plan:

(a) Enrollment records of new employees and members added to the plan after March 23, 2010;

(b) Underwriting rules and guidelines applied to enrollees on or after March 23, 2010; and

(c) Proof of notification to the individual or group of its plan's grandfathered status designation for each year for which the status is claimed.

(5) A change made to a plan before March 23, 2010, but that became effective after March 23, 2010, is permitted without negating a plan's grandfathered status if the change was adopted pursuant to a legally binding contract, state insurance department filing or written plan amendment. If the plan change resulted from a merger, acquisition or similar business action where one of the principal purposes is covering new individuals from the merged or acquired group under a grandfathered health plan, the plan may not be designated as grandfathered.

(6) An issuer may delegate the administrative functions related to documenting or determining grandfathered status designation to a third party. Such delegation does not relieve the issuer of its obligation to ensure that the designation is correctly made, that replacement plans are issued in a timely and compliant manner as required by state or federal law, and that all requisite documentation is kept by the issuer.

(7) If the commissioner determines that an issuer incorrectly designated a group plan as grandfathered, the plan is nongrandfathered, and must be discontinued and replaced with a plan that complies with all relevant market requirements within thirty days. This section does not preclude additional enforcement action.

(8) An issuer must designate on its filings whether a plan is grandfathered or nongrandfathered as required by the Washington state system for electronic rate and form filing (SERFF) filing instructions.

NEW SECTION

WAC 284-170-952 Market conduct requirements related to grandfathered status. (1) An issuer may allow a group covered by grandfathered health insurance coverage to add new employees to its health benefit plan, and move employees between benefit options at open enrollment without affecting grandfathered status, as long as the group's plan does not change in any way that triggers the loss of grandfathered status as set forth in 45 C.F.R. 147.140 and WAC 284-170-950.

(2) An issuer must provide a statement in the plan materials provided to participants or beneficiaries describing the benefits provided under the plan, explaining that the group health plan believes it is a grandfathered health plan within the meaning of Section 1251 of the Affordable Care Act, and include contact information for questions and complaints that conforms to the model notice language found in 45 C.F.R. 147.140.

(3) An issuer must not restrict group eligibility to purchase a nongrandfathered plan offered through an association or member-governed group because the group is not affiliated with or does not participate in the association or member-governed group, unless the association or member-governed group meets the requirements of WAC 284-170-958(1).

(4) WAC 284-170-950 through 284-170-958 does not prohibit an issuer from discontinuing a grandfathered plan design and replacing it with a nongrandfathered plan.

(5) An issuer must not limit eligibility based on health status for either grandfathered or nongrandfathered health plans.

NEW SECTION

WAC 284-170-954 Small group coverage market transition requirements. (1) For all nongrandfathered small group plans issued and in effect prior to January 1, 2014, in 2014 issuers must replace issued nongrandfathered small group health benefit plans with health benefit plans approved by the commissioner as follows:

(a) An issuer may elect to withdraw a product pursuant to RCW 48.43.035, and discontinue each health benefit plan in force under that product on the same date, requiring groups to select a replacement plan to be effective on the date of discontinuation; or

(b) An issuer may discontinue a small group's coverage at renewal and offer the full range of plans the issuer offers in the small group market as replacement options, to take effect on the small group's renewal date. For small groups covered by nongrandfathered health benefit plans purchased based on an association or member-governed group affiliation or membership, the requirements of WAC 284-170-955 and 284-170-958 apply;

(c) If an issuer does not have a replacement plan approved by the commissioner to offer in place of the discontinued plan, the issuer must assist each enrollee in identifying a replacement option offered by another issuer.

(2) If an issuer selects the replacement option described in subsection (1)(b) of this section, the issuer must provide the small

group plan sponsor with written notice of the discontinuation and replacement options not later than ninety days before the renewal date for the small group's coverage. The commissioner may, for good cause shown, permit a shorter notice period for providing the replacement option information to a group. The written notice must contain the following information:

(a) Specific descriptions of the replacement plans for which the small group and its enrollees are eligible, both on or off the health benefit exchange. At the issuer's discretion, rate information may but is not required to be, included in the notice describing the replacement plans, provided subsequent rating information is provided with renewal;

(b) Electronic link information to the summary of benefits and explanation of coverage for each replacement plan option;

(c) Contact information to access assistance from the issuer in selecting the replacement plan option or answering enrollee questions about the replacement plans made available to them by their employer.

(3) For either replacement option set forth in subsection (1) of this section, the issuer must provide a separate written notice to each enrollee notifying the enrollee that their small group plan coverage will be discontinued and replaced. The notice must be provided not later than ninety days prior to the discontinuation and replacement date.

(4) If an issuer has electronic mail contact information for the small group plan sponsor or the enrollees, the written notice may be provided electronically. The issuer must be able to document to the commissioner's satisfaction both the content and timing of transmission. The issuer must send written notice by U.S. mail to a sponsor or enrollee for whom the electronic mail message was rejected.

(5) An issuer may offer small groups the option to voluntarily discontinue and replace their coverage prior to their renewal date.

(a) An issuer must not selectively offer early renewal to small groups, but must make this option universally available.

(b) An issuer must not alter or change a small group's renewal date to lengthen the period of time before discontinuation and replacement occurs in 2014. For example, if a small group's renewal date is March 31st of each year, the issuer may not adjust the small group's benefit year in 2013 to effect a renewal date of November 30th.

(6) This section applies to each health benefit plan that provides coverage based on receipt of claims for services, even if the coverage falls under one of the categories excepted from the definition of "health plan" as set forth in RCW 48.43.005 (26)(i) and (l). This section does not apply to a health benefit plan that provides per diem or single payment coverage based on a triggering event or diagnosis regardless of the medical necessity of the type or range of services received by an enrollee.

NEW SECTION

WAC 284-170-955 Association health plan compliance with statutory or regulatory changes. (1) An issuer offering plans through an association or member-governed group must implement all new federal or state health plan market requirements when they become effective. Re-

placement requirements for this section apply based on whether the purchaser is classified as an individual, small group, or large group purchaser. These requirements also apply to member employer groups of less than two or to individual member purchasers.

(2) An issuer providing plans of the type referenced in subsection (1) of this section must discontinue a noncompliant plan, and offer replacement plans effective on the renewal date of the master group contract for large groups, and on the group's anniversary renewal date for nongrandfathered small group and individual plans.

(3) If the association is a large group as defined in WAC 284-170-958(1), the same renewal date must apply to all participating employers and individuals, and the replacement coverage must take effect on the same date for each participant. The purchaser's anniversary date must not be used in lieu of this uniform renewal date for purposes of discontinuation and replacement of noncompliant coverage.

(4) If the association is not a large group as defined in WAC 284-170-958(1), and the master group contract and the member group do not have the same renewal date, an issuer must provide notice of the discontinuation and replacement of the plan to the affected association member group or plan sponsor, and each enrollee in the affected member group, not fewer than ninety days prior to the member's anniversary renewal date.

(5) If an issuer does not have a replacement plan approved by the commissioner to offer in place of a discontinued plan, the issuer must assist each enrollee in identifying a replacement option offered by another issuer.

(6) For purposes of this section, "purchaser" means the group or individual whose eligibility for the plan is based in whole or in part on membership in the association or member-governed group.

(7) For purposes of this section, the "anniversary renewal date" means the initial or first date on which a purchasing group's health benefit plan coverage became effective with the issuer, regardless of whether the issuer is subject to other agreements, contracts or trust documents that establish requirements related to the purchaser's coverage in addition to the health benefit plan.

(8) An issuer must not adjust the master contract renewal or anniversary date to delay or prevent application of any federal or state health plan market requirement.

NEW SECTION

WAC 284-170-958 Transition of plans purchased by association members. (1) An issuer must not offer or issue a plan to individuals or small groups through an association or member-governed group as a large group plan unless the association or member-governed group to whom the plan is issued constitutes an employer under 29 U.S.C. § 1002(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et. seq.), as amended, and the number of eligible employees is more than fifty.

(2) An issuer must make a good faith effort to ensure that any association or member-governed group to whom it issues a large group plan meets the requirements of subsection (1) of this section prior to submitting its form and rate filings to the commissioner, and prior to issuing such coverage. An issuer must maintain the documentation sup-

porting the determination and provide it to the commissioner upon request. An issuer may reasonably rely upon an opinion from the U.S. Department of Labor as reasonable proof that the requirements of 29 U.S.C. 1002(5) are met by the association or member-governed group.

(3) For plans offered to association or member-governed groups that do not meet the requirements of subsection (1) of this section, the following specific requirements apply:

(a) An issuer must treat grandfathered plans issued under those purchasing arrangements as a closed pool, and file a single case closed pool rate filing. For purposes of this section, a single case closed pool rate filing means a rate filing which includes the rates and the rate filing information only for the issuer's closed pool enrollees.

(b) For each single case closed pool rate filing, an issuer must file a certification from an officer of the issuer attesting that:

(i) The employer groups covered by the filing joined the association prior to or on March 23, 2010;

(ii) The issuer can establish with documentation in its files that none of the conditions triggering termination of grandfathered status set forth in WAC 284-170-950 or in 45 C.F.R. 2590.715-1251(g) have occurred for any plan members.

(4) For each grandfathered plan issued to an association or member governed group under subsection (3) of this section, the issuer must include the following items in its rate filing:

(a) Plan number;

(b) Identification number assigned to each employer group, including employer groups of less than two;

(c) Initial contract or certificate date;

(d) Number of employees for each employer group, pursuant to RCW 48.43.005(11);

(e) Number of enrolled employees for each employer group for the prior calendar year;

(f) Current and proposed rate schedule for each employer group; and

(g) Description of the rating methodology and rate change for each employer group.

(5) WAC 284-43-950 applies for a single case rate closed pool under this section.

NEW SECTION

WAC 284-170-959 Individual coverage market transition requirements. (1) For all nongrandfathered individual health benefit plans issued and in effect prior to January 1, 2014, during 2014 issuers must replace the plans with health benefit plans approved by the commissioner as follows:

(a) An issuer may elect to withdraw a product, pursuant to RCW 48.43.038, and discontinue each health benefit plan in force under that product on the same date, requiring selection of a replacement plan to be effective on the date of discontinuation; or

(b) An issuer may discontinue an individual's coverage and offer the full range of plans the issuer offers in the individual market as replacement options. The replacement coverage must take effect on the individual's renewal date.

(c) If an issuer does not have a replacement plan approved by the commissioner to offer in place of the discontinued plan, the issuer must assist each enrollee in identifying a replacement option offered by another issuer.

(2) If an issuer selects the replacement option described in subsection (1)(b) of this section, not fewer than ninety days before the renewal date for the coverage, the issuer must provide the individual and each enrollee under the health benefit plan with written notice of the discontinuation and replacement options. The commissioner may, for good cause shown, permit a shorter notice period for providing the replacement option information to a group. The written notice must contain the following information:

(a) Specific descriptions of the replacement plans for which the enrollees are eligible, both on or off the health benefit exchange;

(b) Electronic link information to the summary of benefits and explanation of coverage for each replacement plan option;

(c) Contact information for assistance from the issuer in selecting the replacement plan option or answering enrollee questions about the replacement plans;

(d) If a renewal date is later than January 1, 2014, the issuer's ninety day discontinuation and replacement notice must notify the individual and any other enrollees on the plan of the shortened plan year for 2014 under the replacement coverage.

(3) For either replacement option set forth in subsection (1) of this section, the issuer must provide a separate written notice to each enrollee notifying the enrollee that their existing coverage will be discontinued and replaced. The notice must be provided not later than ninety days prior to the discontinuation and replacement date.

(4) If an issuer has electronic mail contact information for the enrollees, the notice may be provided electronically. The issuer must be able to document to the commissioner's satisfaction both the content and timing of transmission. The issuer must send written notice by U.S. mail to an enrollee for whom the electronic mail message was rejected.

(5) This section applies to each health benefit plan that provides coverage based on receipt of claims for services, even if the coverage falls under one of the categories excepted from the definition of "health plan" as set forth in RCW 48.43.005 (26)(i) and (l). This section does not apply to a health benefit plan that provides per diem or single payment coverage based on a triggering event or diagnosis regardless of the medical necessity of the type or range of services received by an enrollee.

(6) Between September 1st and September 30th of each year, an issuer must provide written notice to each enrollee under an individual health benefit plan of the availability of health benefit exchange coverage, and contact information for the health benefit exchange.

EXHIBIT 2

Concise Explanatory Statement: R 2013- 13

Market Transition Rules

December 11, 2013

Prepared by: Meg L. Jones

Background

Affordable Care Act Major Market Reforms Beginning January 1, 2014, the benefit packages and rating methodology applied to health plans change based on the Affordable Care Act's requirements. The Affordable Care Act imposes different requirements on health plans based on the markets in which they are sold. The major changes apply to individual and small group plans. Certain reforms also apply to the large group market, such as bars on health status underwriting when establishing rates.

Commissioner Review of Forms and Rates Issuers file plans and rates with the Office of the Insurance Commissioner (OIC). Different standards for review and approval processes apply depending on both the market and the insurance company's licensure. In general, the Commissioner must receive a copy of every contract form and rate schedule, and modification of a contract form and rate schedule. RCW 48.18.100, WAC 284-43-920 (1). For health plans, the Commissioner reviews filings to ensure that health plans comply with applicable state and federal laws. WAC 284-43-9290 and 284-43-901. Under RCW 48.18.110, the Commissioner must disapprove policies that do not comply with title 48 RCW and the regulations adopted thereunder. WAC 284-43-125 specifically states that "health carriers shall comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits."

The small group market includes plans covering 50 or fewer employees; the large group market includes plans covering more than 50 employees.

Disability insurance issuers:	review and approval prior to use for all markets
Health care service contractors:	review and approval prior to use for individual and small group markets; filing within 30 days of signed negotiated contract for large group market, subject to review.
Health maintenance organization:	review and approval prior to use for individual and small group markets; filing within 30 days of signed negotiated contract for large group market, subject to review.

Whenever new laws are passed, health plans must be brought into compliance. If the changes are limited, usually the health plan issuer files an amendment to the coverage with the OIC, which is reviewed based on the market in which the plan is offered.

Depending on the effective date of the legal requirement, enrollees do not experience a rate change tied to the new law until their plan is renewed.

Issuers also have the right to elect to withdraw a product from the market, and must replace that product with a comparable offering. The Commissioner reviews the issuer's proposal for managing such a withdrawal, and works with the issuer to protect enrollees. *See*, RCW 48.43.035 and 48.43.038.

Some plans to not have to conform to all the 2014 market reforms. These are referred to as "grandfathered plans." Grandfathered plans are plans offered in the individual or small group market that were in effect on or before March 23, 2010, that meet specific standards related to types of coverage or cost-sharing changes in the plan design. Because state rating and benefit design requirements that were in effect before 2010 apply, the Commissioner must also confirm during the review and approval process that an issuer has correctly designated a plan as grandfathered.

2014 Market Transition For 2014, the ACA-required changes affect both plan design and rating methodology. An amendment to the plan documents would essentially look like a new health plan, and be a new health plan. Most issuers informed the OIC they planned to withdraw current products, offering approved products that were compliant with the 2014 changes. The Commissioner determined that with such a complete change in products, consumers deserved a uniform approach to the transition to 2014 so that issuers did not steer enrollees to a specific type of coverage, and so that agency resources weren't unduly consumed with company by company approvals of the projected withdrawal of product and replacement. As a result, the Commissioner proposed these rules to support that transition.

Market Specific Transition Requirements The small group market includes plans covering 50 or fewer employees; the large group market includes plans covering more than 50 employees. Some health plans are sponsored by associations for their members. Under Washington law, associations can be formed specifically for the purpose of purchasing health care coverage; associations also are categorized under federal law based on the structure of the association.

Depending on how the association health plan is structured, it is either treated for compliance purposes as a single benefit plan, or alternatively, as a funding vehicle for multiple participating employer benefit plans. The number of participants for associations that are a funding vehicle, and not a true employer association is determined separately by reference to each employer's plan. If the size of the employer is 50 or fewer employees, then the plan must comply with the small group market.

Depending on the effective date of the legal requirement, enrollees do not experience a rate change tied to the new law until their plan is renewed.

Issuers also have the right to elect to withdraw a product from the market, and must replace that product with a comparable offering. The Commissioner reviews the issuer's proposal for managing such a withdrawal, and works with the issuer to protect enrollees. *See*, RCW 48.43.035 and 48.43.038.

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Depending on how the association health plan is structured, it is either treated for compliance purposes as a single benefit plan, or alternatively, as a funding vehicle for multiple participating employer benefit plans. The number of participants for associations that are a funding vehicle, and not a true employer association is determined separately by reference to each employer's plan. If the size of the employer is 50 or fewer employees, then the plan must comply with the small group market.

Over the years, the Department of Labor (DOL) has issued rulings addressing whether a health plan covering multiple, unrelated employers (such as an association health plan) is a single benefit plan or a funding vehicle. DOL looks at the details of the health insurance arrangement, including whether the group of covered employers is a bona fide group under ERISA and has adequate control over the arrangement. There are subtleties to the DOL standards that require careful consideration for each arrangement.

Title 48 RCW establishes a safe harbor for fully insured health plans issued to association members, stating that the association is not subject to the small group market community rating laws. *See*, RCW 48.21.047, 48.44.024, and 48.46. 068. State law does not define 'association' for purposes of this exemption, but our state law does specifically permit associations to be formed solely for the purpose of purchasing health care coverage. Under federal law, such an association is not treated as a true employer (single benefit plan) association. 29 U.S.C. § 1002(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et. seq.), as amended.

The U.S. Department of Health and Human Services (HHS) promulgated rules in 2011 explaining the definitions of the plans and markets to which the ACA's rating reforms apply. The final rule states that major medical coverage sold to individuals or small groups through an association is subject to the rate review system created by the ACA for rates filed in, or that take effect on or after November 1, 2011. 45 CFR 154.102[1]:

> "(2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage."
>
> 45 CFR 154.102.

Issuers have had over 2 years to plan for this transition to the rating requirements applicable beginning in 2014.

HHS further clarified in the preamble to the rule that the rule's amendment means that state definitions no longer govern for purposes of association plan rating:

> "While the proposed rule and current final rule adopt a different policy for rate review purposes with respect to association coverage than would apply under the PHS Act for other purposes, we are amending the final rule to apply the general PHS Act policy on association coverage under the rate review regulation, as an

[1] "*Response:* In light of these comments, we are amending the definitions of "individual market" and "small group market" in this final rule to include individual and small group coverage sold through associations in the rate review process. This amendment applies to rates for association coverage that are filed, or are effective in States without filing requirements, on or after November 1, 2011." **Federal Register**, Vol. 76, No. 172, Tuesday, September 6, 2011 at 54970.

exception to the general rule that State definitions govern[2]. Accordingly, if an association is, in fact, sponsoring a group health plan subject to ERISA, the association coverage should be considered to be one group health plan and the number of employees covered by the association would determine the group size for purposes of determining whether the group health plan is sponsored by a small employer and subject to the rate review process.

In most situations involving association coverage, the group health plan will exist at the individual employer level and not at the association level, in which case the size of the individual employers in the association will determine whether the association coverage is subject to the rate review process."

Federal Register, Vol. 75, No. 172, September 6, 2011 at 54971.

True employer associations as defined by section 2791 (d)(3) of the PHS Act are not exempt from the rate review process set forth in the federal regulations issued May 23, 2011. *See*, Federal Register, Vol. 76, No. 172, September 6, 2011 at 54972[3]. Association coverage does not exist as a distinct category of health insurance under Title XXVII of the PHS Act. *See,* CMS Bulletin, *supra* (cited – footnote 3).

For coverage provided to associations and not related to employment, the federal rules apply the same reasoning to individual coverage. *See*, 45 CFR 144.103.

For all these reasons, the market transition rules also address the treatment of true employer and non-true employer association plans for purposes of the Commissioner's review of form and rate filings. Where necessary, the Commissioner will confirm with issuers that a product is properly filed and rated based on further inquiry, where the filing avers large group status for a specific association of employers. See, RCW 48.02.060.

Rule Making History

The CR-101 was published on June 5, 2013, as WSR 13-12-080. A comment period followed the publication, and remained open through July 10, 2013.

The CR-102 was published on October 2, 2013, as WSR 13-20-141. A comment period followed the publication, and remained open through November 6, 2013.

A public hearing was held on November 6, 2013 at 10:00 a.m. in Tumwater WA. The summary of that hearing is included in this Concise Explanatory Statement.

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[2] Section 2724 (a)(1) of the PHS Act provides that a state law is not preempted unless it prevents the application of a requirement of the PHS Act. Section 731 (a)(1) of ERISA has parallel language.

[3] *See* also, CMS Insurance Standards Bulletin, published September 1, 2011 (CMS Bulletin): accessed at http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.pdf

Implementation Plan

The Commissioner plans to implement this regulation through normal agency business processes, and rule-specific issuer meetings. The normal agency business processes include referencing the requirements in form and rate filing instructions, application of the regulation during market conduct oversight reviews or examinations with companies, and where an entity is non-compliant, through enforcement. Consumer protection compliance analysts will be specifically trained about the rules, and understand how the rules affect consumer rights.

Where specific compliance plans for product withdrawal and replacement are required, issuers are expected to work with the Rates and Forms division of the office. Questions about implementing the rule, or the rule development itself will be managed by the Policy & Legislative Affairs division.

Differences between the final rule and the proposed rule text (non-grammatical)

- Additional language was added to WAC 284-170-950(2) to clarify the application of the rule to fully insured grandfathered plans, in response to a comment.
- WAC 284-170-950 (3) (b) was amended to conform to existing federal law (45 CFR 147.140 (g) (1). This does not constitute a new requirement, and was a technical correction.
- WAC 284-170-952 (1) was amended to include the reference to the prior grandfathered plan WAC, WAC 284-170-950.
- WAC 284-170-954 (2)(a) was amended to specifically confirm that rate information is not required to be in the 90–day notice. This is a clarification; as a practical matter, for some product withdrawal and replacement scenarios, rates are not developed at the time the notice is issued.
- WAC 284-170-958 (1) was amended to eliminate redundant references to types of large groups.
- WAC 284-170-958 (2) was amended to include a sentence explaining that an issuer must retain the documentation on which it made a determination about what market the groups filing through associations belong to, and provide the documentation to the commissioner upon request. This is a clarification requested by commenters.
- WAC 284-170-958 (4) was deleted. Because the federal standard on which the section is based still applies, this change does not result in a substantially different rule from that published, pursuant to RCW 34.05.335.

Comments and Response

Association of Washington Business: The OIC has no authority to adopt the rules, and they should be withdrawn. Federal guidance is not a sufficient basis for adopting a rule. **Response:** The Commissioner has authority to adopt rules related to rate and form review and approval, and to implement the requirements of title 48 RCW for each type of company license, certificate of authority and registration regulated under the code.

WTIA Trust, MBA Trust: The OIC has no authority to adopt because the code does not permit regulation of association rating and does there is no provision of the code that the regulations will effectuate per RCW 48.02.060. In addition, the rules are preempted by ERISA on the basis that the regulation relates to employer sponsored health plans and not to insurance. **Response:** The rules are consistent with both state and federal law. Please see the explanation of the Commissioner's authority set forth in the background section.

The OIC has not followed the APA because there has not been a permitted notice and comment period. **Response:** The notice and comment period requirements were followed for the permanent rule making.

MBA Trust: 45 CFR 147.170 is silent about rates, and only applies to the transition of grandfathered health plans. Therefore there is no authority to adopt the regulations to enforce federal law. **Response:** 45 CFR 147.170 is one regulation being implemented. There are additional regulations being implemented, including 45 CFR 154.102. Please see analysis set forth in the background section of this document.

AWB, EPK & Associates, and MBA Trust: The emergency rules weren't justified. The reasons should be truly emergent and persuasive to the reviewing court. The findings of fact must provide an adequate basis for judicial review. *Mauzy v. Gibbs* , 44 W.App. 625, 630-32 (1986). Withdraw the emergency immediately. If not, MBA Trust will seek judicial review of all OIC actions involving the emergency rule and the proposed regulation. **Response:** The Commissioner responds to comments regarding the proposed rule text, and declines to address objections to emergency rule making that is separate from the permanent rule making.

Comments regarding WAC 284-170-950:

Premera, AWB and AHIP: 45 CFR 147.140 (a) (3) requires documentation to be retained "for as long as the plan or health	The Commissioner recognizes that issuers may not have retained records for plans related to grandfathered status for plans

insurance coverage takes the position that it is a grandfathered health plan." For plans that gave up grandfathered status in the last 3 years, they may have discarded records in the absence of this requirement, yet be penalized if on examination the requirement is not met.	that are no longer grandfathered on the dates these rules become effective. While it is a given that rules are prospective unless they state otherwise, the Commissioner inserts clarifying language regarding the effective date. The rules do not negate or prevent the implementation of the federal record keeping requirement. The rules establish the necessary time frame for record keeping supporting state review of compliance during market conduct examination or enforcement actions that may arise. Therefore the Commissioner did not eliminate the requirement from the regulation.
Regence (at public hearing) and AHIP: (3)(a) reference to 3% cost-sharing change should be "any change." AHIP cites to 45 CFR 147.140(g)(1)	The Commissioner agrees with the comment, and amends the text to conform.
Premera: delete the criteria because it is a duplicative of federal law.	The Commissioner declines to make the suggested deletion. The section explains the standards for review and the records that are, at a minimum, necessary to support designation of a plan as grandfathered.
AHIP: (a) and (b) of this section are not required by federal law. OIC should not require to prevent confusion and inconsistency.	The Commissioner declines to make the suggested deletion. The section explains the standards for review and the records that are, at a minimum, necessary to support designation of a plan as grandfathered.
AHIP: 30 days to come into compliance is not required by federal law.	The general standard is that any plan issued in the state must comply with the law. A period of time to transition a non-compliant plan to compliant is a reasonable period of time to ensure enrollees have the coverage to which they are entitled. The Commissioner declines to eliminate the standard.

Comments regarding WAC 284-170-952: no comments received.

Comments regarding 284-170-954:

AWB: Under RCW 48.43.035, guaranteed renewal is a precondition for any replacement requirement and does not apply to "change or implementation of federal or state laws that no longer permit the continued offering of such coverage." If that is the case, then there isn't a replacement requirement that attaches. Cannot rewrite the requirements of RCW 48.43.035 to require replacement coverage based on a change exempt from guaranteed renewal within the statute.	The Commissioner disagrees with AWB's analysis. The rule language permits an issuer to address bringing plans into compliance by withdrawing a noncompliant product pursuant to RCW 48.43.035, and effecting change on one date. For some issuers, this might be the easiest implementation option. Otherwise, compliant plans must be made available at renewal. The rule does not rewrite statutory requirements.
AWB: the Commissioner cannot require the issuer to help enrollees find new coverage, even if offered by another issuer. This violates a constitutional prohibition against compelling speech (first amendment). The Commissioner should explain it to people, not the issuer.	AWB misreads the regulation. Issuers are required to provide enrollees with information about the full range of choices available to them from the products the issuer offers for which the enrollees are eligible. The rule is written to preclude steering which can have discriminatory outcomes. The rule also addresses situations where an issuer may not have a replacement product. Current law requires issuers to provide enrollees with this information when a product is discontinued. The regulation does not compel speech – issuers have the flexibility to craft their guidance and provide it to enrollees so that they understand where to find coverage once their existing plan is discontinued by the issuer. Issuers have access to contact information for their insureds, and it is reasonable for the Commissioner to require that they communicate clearly with enrollees about changes in coverage. This aligns with the requirements in the discontinuation and replacement statutes as well.
Group Health: provide clarity as to whether the notice must include all	The Commissioner has permitted this flexibility as issuers proceed under the

renewal information, including actual premium rates or if carriers can send the notice and follow up with a 60 day notice with the rates.	emergency rule that will be replaced by this permanent rule. The rule is silent as to whether the rates must be included at the ninety day mark, and therefore, the issuer has the option of including this information as part of the notice or as part of the information provided as part of the 60 day notice. While the Commissioner does not believe the requested clarification is required, the Commissioner amended the proposed text as requested.
Group Health: clarify what qualifies as good cause shown to prevent a wide variety of small group plan renewal replacement option premium rate releases into the market.	The Commissioner declines to be more specific, as it is impossible to predict what situations or circumstances may arise that would justify granting a company's request for a shorter notice period. The confusion the commenter references won't occur because the good cause determination is made by the Commissioner upon request, not by the issuer.
See, AWB comment above re the Commissioner should be the one to communicate to enrollees. May also apply to this section.	See, response above.
Premera: A reasonable conclusion is that a separate notice must be sent to each subscriber and covered dependent. It is wasteful to send notices to each person when a family notice would suffice. It is inconsistent with other notice practices. Use the following language: *(3) ... The notice must be provided not later than ninety days prior to the discontinuation and replacement date; one notice sent to a subscriber or policyholder on behalf of all covered family members shall suffice to meet this requirement.*	The Commissioner declines to adopt the suggested language revision. There are sufficient situations where covered dependents do not reside at the same address, such as in families where parents are divorced or separated, or where children up to age 26 remain on their parent's policy, that a family notice runs the risk of not providing the information to all enrollees of their alternate coverage options.
Katharine Cuyle, True Benefits: is it correct that any change resulting in postponing replacement is not permissible but that an employer can change coverage in 2013 and extend their pre-2014 coverage?	The Commissioner agrees with the comment. An issuer is barred from lengthening the period of time before a group renews in 2014. Nothing prevents a group from voluntarily moving to a new plan with an issuer prior to that renewal

	date.

Comments regarding WAC 284-170-955

Premera: Make (3) and (4) subsections of (2), deleting the last phrase from (2) after the word "effective" and inserting "as follows". This clarifies that for grandfathered plans, nothing changes regarding renewal dates.	The Commissioner declines amending the regulation based on this comment. The comment appears to seek application of the concept of grandfathered plans (which is only applicable to small/individual by definition (RCW 48.43.005)) to large group plans.
Moda: Concur with Premera's comment about the timing for discontinuation and replacement. Minimize the disruption to existing associations as much as possible. (The comment does not provide a description of what is meant by "disruption").	See response above.
Premera: The restriction against rolling renewals is not set forth for grandfathered plans. If this is not correct, please advise.	The Commissioner confirms that the restriction against "rolling renewals" does not apply to grandfathered plans. The concept of grandfathered plans only applies to the individual and small group markets, however, and therefore issuers filing plans for associations as large groups that meet the definition under WAC 284-170-958 (1) must comply with the requirement in WAC 284-170-955 (3).
Premera: Make (3) and (4) subsections of (2), deleting the last phrase from (2) after the word "effective."	*See above.*
Regence: Amend with the following language: (3) If the association is a large group as defined in WAC 284-170-958(1), ~~the same renewal date~~ all applicable state and federal mandates must apply to all participating employers and individuals at the association renewal date regardless of the participating employers and individuals' anniversary date for purposes of open enrollment and rating adjustment, and the replacement mandates must take effect on the same date for each participant. A participating employer or individual may have its own renewal date for the	The Commissioner understands that past practices may differ from required practices moving forward beginning in 2014. If an association health plan is a single employer benefit plan, there can only be one single renewal date for the plan group. For this reason, the Commissioner did not amend the section based on the comment.

purpose of rating. ~~, and the replacement coverage must take effect on the same date for each participant. The purchaser's anniversary date must not be used in lieu of this uniform renewal date for purposes of discontinuation and replacement of noncompliant coverage.~~ Basis: today, associations prefer master contract renewal during low-volume months to manage volume of changes, logistics and messaging. Groups keep their own plan years independent of the association. New mandates are implemented at the association master contract renewal to all groups and members regardless of the group's anniversary date, which is usually not the master contract date.	
Regence: Please implement for 2015, not 2014, so Regence can notify groups they have 2 purchasing decisions in one year, off the regularly scheduled cycle. Renewals for 2014 have already been released under the current model.	The Commissioner determined that based on the fact that the market definitions have been in effect since 2011, delay for another year is not necessary.
Washington Farm Bureau: agree with Regence	*See response to Regence's comments.*
Regence: what constitutes a replacement offer? Does a link to the website sales section work? Do we have to include a specific product and plan?	The small group must be offered all the plans for which they're eligible in that market to choose from. This is to avoid steering, which can be discriminatory. The issuer needs to make it clear what the offerings are to choose from – something more specific than a link to the website sales section is required if there are any eligibility limitations.
Regence: do we have to offer replacement options to the employees as well? Do we have to offer the employees individual plans?	No. Employees must receive notice of the discontinuation and that replacement options will be provided to the sponsor. Employees do not need to be offered individual plans.
Premera: permit family notices, rather	The Commissioner refers the commenter to

than individual enrollee notices. (see, comment to WAC 284-170-954)	his response to the comment in reference to WAC 284-170-954, and incorporates it by reference herein.
Amerigroup/Wellpoint: does this apply to conversion plans? Asking the question in the context of grandfathered conversion plans.	The rule applies to nongrandfathered individual plans, not grandfathered, and offered through associations. Conversion plans, once issued, are treated as individual plans, and therefore would continue to renew on the date of issue to the enrollee.

Comments regarding WAC 284-170-958

Association of Washington Business (AWB): this repeals the small group exemption statutes on the basis of preemption. Preemption does not apply because of ERISA, and the Commissioner cannot treat an ERISA plan as an insurance company for the purposes of regulating as an insurance company. Citation: DOL advisory opinion letter 2005-18A to the OIC (August 1, 2005) that MEWAs are subject to premium tax and high risk pool assessments, and the state law requiring payment of the assessments is not preempted by ERISA. http://www.dol.gov/ebsa/regs/aos/ao2005-18a.html	The DOL opinion letter to the OIC (2005) that MEWAs are subject to premium tax and high risk pool assessments, and the state law requiring payment of the assessments is not preempted by ERISA. ERISA only preempts state law "to the extent that compliance with a provision of Title I [of ERISA] is an impossibility." Based on the definitions in federal rule, the preemption standard in both the ACA and ERISA, and the HHS statements regarding association rating practices under the market rules, the Commissioner does not agree with the comment.
AWB: The Commissioner must enforce state law, and wait for the legislature to repeal RCW 48.44.023, RCW 48.46.068, and RCW 48.21.047. Citation: Spokane County Superior Court case memorandum opinion – 2007 (2007-02-00592-1). Why hasn't the Commissioner asked for repeal before now? The rule materially alters the statutes.	The Commissioner disagrees that there is an obligation to ignore federal law. RCW 48.44.023, RCW 48.46.068, and RCW 48.21.047 apply to grandfathered small group health plans effective January 1, 2014. For all nongrandfathered individual and small group health plans effective January 1, 2014, 45 CFR §147.102 governs the rating.
AWB: The report filed with the legislature by Mathematica states: "For AHPs, the OIC can require prior approval of both rates and forms only for disability carriers. For all other carriers that write AHP	The Commissioner notes that the Mathematica report was filed by Mathematica, not the Office of the

business, ***the OIC has authority to require filing of rates and forms, but can review only forms, and cannot disapprove either rates or forms.***"[8] Association Health Plans and Community-Rated Small Group Health Insurance in Washington State, Final Report, September 30, 2011 (updated), "Appendix A: Summary of Statutory Authority to Regulate Health Insurance Rates and Forms," Source: Washington State Office of the Insurance Commissioner at 24. If the OIC has no authority to disapprove the rates for fully insured AHPs, then the OIC cannot impose rate requirements on them.	Insurance Commissioner. To the extent that the report makes assumptions about laws in effect prior to the date of issue, it is inapplicable to the law in effect today and as of the effective date of these regulations.
Premera: Please clarify this section in regard to MEWAs. And change the phrase from purchasing group in (1)(d) to purchaser, and cross reference to the definition in 955 (6).	The section is amended for clarity.
MBA Trust: associations are exempt from small group community rating standards, and the rules violate this legislative directive. RCW 48.44.024. The regulation only tracks the language of RCW 48.44.023, which does not apply to associations. See 2007 Spokane superior court decision, that stated that a TAA To6-07 (2006) was invalid because the OIC had no authority to require association plans to rate based on the health of the entire association group.	The Commissioner does not agree with this comment. When a true-employer large group plan is reviewed, the standard applied is found in 29 CFR Chapter XXV, Section 2590.702, which states that rules for eligibility, including continued eligibility of any individual to enroll under the terms of the plan may not be based on any of the following: (i) Health status (ii) Medical condition, including both physical and mental illnesses (iii) Claims experience (iv) Receipt of health care (v) Medical history (vi) Genetic information (vii) Evidence of insurability, including conditions arising out of acts of domestic violence (viii) Disability.
AWB: How will the reasonable proof requirement be applied? Is it unenforceable guidance? Or will it be used to disapprove rates or forms? If the latter, this impermissibly expands the OICs scope of authority beyond the provisions of the Insurance Code.	The Commissioner clarified the rule to note that the issuer must maintain the documentation. This was implied in the former language, and is a clarification.

Premera: please provide a list of alternative documentation options either as part of the rule or filing instructions. Please confirm that an opinion letter from the association's counsel will suffice.	Letter from counsel may be part of the documentation, but is not in itself sufficient. The true-employer assessment requires more than receipt of a pro forma letter without sufficient, detailed and specific analysis.
Moda: ensure issuers have flexibility with regard to the manner in which documentation of employer status is provided. Analysis from legal counsel, for example, should be sufficient.	The Commissioner provides flexibility. Please see response to Premera, above, regarding a letter from counsel.
Master Builders Association Trust (MBA): the provision adopts community rating for the large group market, and is not required under the ACA. See, 42 USC 300gg (a)(5), which only applies the requirement to large groups sold on the Exchange.	The Commissioner disagrees. Community rating does not apply to the large group market.
Premera: the overly broad documentation requirement comments re 950, above, apply here. Are these retroactive?	The requirements are not retroactive. If there are current plans designated as grandfathered, then under federal law the issuer should have access to or have the requisite documentation in place, as such documentation must be kept while grandfathered status is claimed.
Premera: clarify these standards to ensure understanding of the implications of when an association plan no longer meets large group plan requirements. Place emphasis on the changed and shortened notice to small groups of renewal documentation.	The Commissioner declines to restate the entire small group market renewal process in this rule set, on the basis that issuers must be compliant, and explain requirements to their enrollees for renewal.
Earle J. Hereford, of Kutscher, Hereford & Bertrand for Northwest Marine Trade Association: NMTA currently offers coverage to employees through the Master Builders Association Trust. The OIC determined the MBA trust didn't meet DOL standards, and so NMTA set up a trust that meets DOL standards for the 2014 benefit year. Joins in the objections of the MBA trust to the rule, and opposes the rules on the basis that WAC 284-170-958 (4) requires community rating for large	The Commissioner disagrees that the proposed subsection establishes community rating to the large group market.

groups. Strike (4) from the regulation.	
EPK & Associates: If the OIC adopts this requirement (WAC 284-170-958 (4)), make it effective for the 2015 benefit year. The MBA Trust acted in reliance on the emergency rules in place after 6/28/13 in establishing its rates and benefits for the 1380 groups currently renewing, based on the OIC's statements in 2012. MBA Trust can't revise renewals to comply with the language for 2014. Cite: Letter of 9/25/12 from Commissioner Kreidler to Master Builders Association trustees that the MBA Trust is a bona fide group.	The Commissioner determined that the section does not need to be in the set of adopted regulations.
WTIA Trust: Do not adopt either 955 or 958, because of the effect of (4) on the true employer trust, such as WTIA. Nothing in the ACA or Washington law bars individual health underwriting or health questionnaires when rating large groups. WTIA doesn't use them. The OIC language imposes the rating requirements of the small group market and does not recognize the small group rating exemption for associations as a large group that exists in current state law. Current quotes for 1/1/14 applied rating methodologies that the rule would now make non-compliant. Can't withdraw and re-rate groups. Suggest that they be made effective for 2015 plan year.	The Commissioner disagrees. Please refer to analysis above regarding the Health Insurance Portability and Accountability Act (HIPAA) prohibitions against discrimination toward participants and beneficiaries based on health status.
Premera: other than the prohibition against health status, this section is overly broad and restrictive. Such rating restrictions are not applicable to the large group market, and associations should not be singled out for such prohibitions. Revise it to read: "An issuer must not use data or information relating to health status from a specific employer to establish rates for that group purchaser." Delete the remainder of the subsection (4).	The Commissioner deleted the section.
Regence: Revise to permit application of other rating factors at the plan level. Don't impose community rating. Significant market disruption will occur if the rule is adopted for the 2014 benefit year, as quotes have already been issued.	The Commissioner deleted the section.

Suggested revision: (4) An issuer must rate a large group plan issued through an association that meets the definition of subsection (1)(c) of this section based primarily on the overall experience of the entire association~~, and apply rating factors uniformly to each purchasing entity in the association.~~ (a) To determine the rate of a purchasing entity in the association, an issuer may use any rating factor permitted by federal or state law including, but not limited to, demographics, age, employer contribution amounts, participation factors, group size, industry segment, duration with issuer, and market competitive factors . An issuer must not use individualized data or information from a specific group purchaser of the association's health benefit plan to establish rates for that group purchaser. "Data or information" as used in this section refers to ~~specifically includes~~ specific ~~employer~~ individual information regarding employee as ~~group size~~, health status~~,~~ and claims experience~~, participation requirements, and number of employees under COBRA status~~. An issuer must apply any permitted rating factor uniformly to each purchasing entity in the association. ~~Composite rating may not be used to set rates for a large group as described under this subsection unless the composite rates are applied uniformly across the entire large group. For purposes of this section, "composite rating" means the averaged rate issued to a group using the group's demographically specific rating factors.~~	
Mary L. Stoll, on behalf of Washington State Rural Hospital Insurance Trust: Trust is a Premera group, a VEBA under IRS regulations, and has been in business since 2006, operating a MEWA as defined by ERISA Section 3 (40)(A), and is regulated by the OIC. The trust is a bona fide association under DOL regulation. The change in underwriting standards for true employer associations is invalid based on RCW 48.44.024, which provides an exemption for employers purchasing through associations from community rating. The rule will go into effect on November 8, 2013. This is too short a time frame for the OIC to review and respond to all comments.	The Commissioner agrees that the November 8, 2013 adoption date did not provide sufficient time to consider the comments in full. The Commissioner notes that the date is a statement of the earliest possible date of adoption, not the adoption or effective date of the rule. The rule is not adopted until an order adopting the rule is issued. RCW 48.44.024 (2) states "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)."
Regence: delete (f) above on the basis that, for grandfathered plans, the rates are not available at the rate filing of the master contract renewal because they do not have a common renewal date. These are new requirements, imposed at the individual group level, and are an undue burden to continue grandfathered status.	The Commissioner deleted the section.

Comments regarding WAC 284-170-959 – none received.

Hearing Summary

The Commissioner delegated the responsibility to preside over the hearing to staff. Meg Jones presided. The hearing began at 10:04 a.m. on November 6, 2013, and ended at 10:34 a.m. The following testimony was offered. Because testimony did not differ from the written comments received, the applicable Commissioner's response for the written comment on the subject applies to the comments received at hearing.

J. Beher, of Bellevue Washington testified on behalf of the Master Builders Association Trust (MBA), providing a chronology of the rule making, explaining that the MBA covers 1,380 employer groups - a total of 42,000 subscribers – and relied on the rule version issued in June, 2013 to provide renewal quotes to those groups. The significant changes in the two rules affect the rating practices used to quote the groups. He asserted that the rules will cause market disruption as a result, and that the MBA does not believe the Commissioner has authority to adopt the regulations. If adopted, he urged an effective date after January 1, 2014.

Chris Bandoli testified on behalf of Regence, referencing the detailed comment letter submitted. He agreed with the MBA comments offered, and asked that the Commissioner delay the effective date until January 1, 2015.

Waltraut Lehman testified on behalf of Premera, citing their written comments as well. Her testimony highlighted the key points in the written testimony as their objections to the level of documentation for grandfathered plans, providing 90-day notice to each enrollee in a household being burdensome, asking for more explicit guidance related to rolling renewals vs. single master contract date application, and the rating standards for

true-employer groups. Premera agrees health status is not a permitted rating factor but believes rating in relation to the other factors is permitted.

Randy Ray from WAHIT testified that the rule is causing employers to cancel policies. He testified as to his opinion related to the marketplace options for small employers being limited, and noted that he believed getting a Department of Labor letter was costly for associations. No specific data was cited in support of the latter contention.

Kris Tefft, counsel for Association of Washington Business reiterated the contents of the written comments as well in relation to the process, the substance and the market impact of the regulations. Mr. Tefft believed the process was not meaningful or transparent. He did not assert that the notice and comment period required by the Administrative Procedures Act was not followed.

Hamilton Emery from Regence testified that the reference in WAC 284-170-950 (3)(b) should not be limited to a change of greater than 3%, but should reference "any change" in cost sharing as disqualifying a plan's grandfathered status designation.

EXHIBIT 3

*76 FR 54969, **

FEDERAL REGISTER

Vol. 76, No. 172

Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Centers for Medicare & Medicaid Services (CMS)

Center for Consumer Information and Insurance Oversight

45 CFR Part 154

[CMS-9999-F]

RIN 0938-AR26

Rate Increase Disclosure and Review: Definitions of "Individual Market" and "Small Group Market"

View PDF of Federal Register Print Version

76 FR 54969

DATE: Tuesday, September 6, 2011

ACTION: Final rule.

SUMMARY: This final rule amends a May 23, 2011, final rule entitled "Rate Increase Disclosure and Review". The final rule provided that, for purposes of rate review only, definitions of "individual market" and "small group market" under State rate filing laws would govern even if those definitions departed from the definitions that otherwise apply under title XXVII of the Public Health Service Act (PHS Act). The preamble to the final rule requested comments on whether this policy should apply in cases in which State rate filing law definitions of "individual market" and "small group market" exclude association insurance policies that would be included in these definitions for other purposes under the PHS Act. In response to comments, this final rule amends the definitions of "individual market" and "small group market" that apply for rate review purposes to include coverage sold to individuals and small groups through associations even if the State does not include such coverage in its definitions of individual and small group market. This final rule also updates standards for health insurance issuers regarding disclosure and review of unreasonable premium increases under section 2794 of the Public Health Service Act.

DATES: *Effective date.* This rule is effective on November 1, 2011.

FOR FURTHER INFORMATION CONTACT: Sally McCarty, (301) 492-4489 (or by e-mail: *ratereview@hhs.gov*).

SUPPLEMENTARY INFORMATION: The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (Pub. L. 111-152) was enacted on March 30, 2010. In this preamble, we refer to the two statutes collectively as the Affordable Care Act. The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group

health plans and health insurance issuers in the group and individual markets.

Section 1003 of the Affordable Care Act adds a new section 2794 of the PHS Act, which directs the Secretary of the Department of Health and Human Services (the Secretary), in conjunction with the States, to establish a process for the annual review of "unreasonable increases in premiums for health insurance coverage." The statute provides that health insurance issuers must submit to the Secretary and the applicable State justifications for unreasonable premium increases prior to the implementation of the increases. Section 2794 of the PHS Act does not apply to grandfathered health insurance coverage, nor does it apply to self-funded plans.

On December 23, 2010, we published a Notice of Proposed Rulemaking to implement section 2794. Among other things, because of unique characteristics of State rate review and for purposes of administrative efficiency, we proposed to adopt definitions of the individual and small group markets that would defer to definitions set forth in State rate filing laws. We did not discuss in the proposed rule, or anticipate, how association policies would be treated under the proposal. Regardless, we received a number of comments objecting to the definitions as they would apply to association plans. On May 23, 2011, we published a final rule with comment period (76 FR 29964), in which we specifically solicited further comments on amending the definitions of "individual market" and "small group market" in § 154.102 to include coverage sold to individuals and small groups through associations in all cases.

We received 30 comments in the comment period. Commenters included the National Association of Insurance Commissioners (NAIC); a State insurance regulator; many consumer and public interest organizations; associations sponsoring insurance plans for their individual and employer members; health care providers; health insurance issuers and related trade associations (collectively, "industry"); and others. After consideration of the comments, we are amending the May 23, 2011 final rule to provide 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.

II. Provisions of the May 23, 2011 Final Rule With Comment and Responses to Comments

In the May 23, 2011 final rule, we solicited comments regarding whether to amend the definitions of "individual market" and "small group market" in § 154.102 to include coverage sold to individuals and small groups through associations in the rate review process, even if the State excludes such coverage from its definitions of individual and small group market coverage. Additionally, we solicited comments to address the following questions:

1. Do States currently review rate increases for association and out-of-State trust coverage sold to individuals and small groups, regardless of whether the policies are situsted in or outside of their States?

2. How many rate filings do States receive for association and out-of-State trust coverage?

3. How prevalent are association and out-of-State trust coverage arrangements? What percentage of individual market and small group market business is sold through associations and out-of-State trusts?

4. In which States is association and out-of-State trust coverage commonly purchased by individuals and small groups? Where are out-of-State trusts typically situated?

5. Why do some individuals and small employers purchase coverage through associations and out-of-State trusts rather than through the traditional markets? Are there particular groups of individuals or types of small employers that typically purchase coverage through associations and out-of-State trusts? What organizations (other than issuers) typically sponsor, endorse, or market association and out-of-State trust arrangements?

6. How do rate increases for association and out-of-State trust coverage sold to individuals and small groups compare to rate increases in the traditional market? What explains the differences (if any) between rate increases for association and out-of-State trust coverage and traditional market coverage?

Comment: Most commenters, including State regulators, consumer advocates, the insurance industry representatives, and three affected associations, supported including individual and small group association coverage in the definitions of "individual market" and "small group market" in § 154.102, even where such coverage was not included in those definitions under State rate filing laws, so that more individuals and small employers would benefit from rate review. According to comments from consumer advocates and some of the affected associations, if association coverage was not included in the rate review rule, the association coverage market would be treated differently from traditional markets in some States, and consumers in these plans would not benefit from the Affordable Care Act's rate review process. State regulators and consumer advocates noted that, in the past, State law exceptions for association health plans had allowed them to avoid market reforms such as guaranteed issue and community rating and permitted them to "cherry pick" individuals and groups with favorable risk profiles. A State regulator also noted that exempting coverage sold through the associations from the regulatory process leads to a concentration of poorer risk in non-association coverage in community rating States. Based on past State experience with association coverage exceptions, the NAIC advised against allowing exceptions for association coverage under the market definitions of § 154.102. Moreover, consumer advocates and one issuer emphasized the importance of having consistent standards across association health plans and the rest of the market to ensure that issuers competed on a level playing field.

Many comments also discussed the importance of encouraging States to regulate association plans in the same way as the traditional market. Several consumer advocates and State insurance officials cited a study n1 concluding that two-thirds of the States regulate associations differently from other plans in the same market and about one-half of the

States entirely or partially exempt national associations from State regulation. In States where associations are not regulated, this differential treatment gives residents little recourse if their association health plan changes its terms of coverage, denies claims, or completely ceases operation. One consumer advocate further highlighted that individuals and small businesses often buy health plans through associations with little knowledge of the protections that they do or do not have in these plans. In addition, the consumer noted that many States cede the regulatory and oversight roles to other States when an association is headquartered elsewhere, allowing association health plans to operate without as much oversight as plans in the traditional market. This can result in different consumers in the same State being subject to different levels of protections depending on whether the coverage is sold through an association and also on where the association is sitused.

n1 Mila Kofman, Kevin Lucia, Eliza Banget, Karen Politz, "Association Health Plans: What's All the Fuss About?" *Health Affairs*, Vol. 25, No. 6, 2006.

While most comments were in favor of including association coverage in the rate review process even where State rate filing laws did not include such coverage in definitions of individual market and small group market, CMS received five comments that opposed changing the current policy under § 154.102. Four of these comments came from associations, and one comment came from an association professional membership organization. Three associations discussed the history of associations in their State and indicated that their State treats association health plans as large group plans not subject to individual or small group requirements for all purposes, not just rate review. These associations expressed concern about potential logistical and administrative burdens for association plans were they to be regulated as small group market coverage at the State and Federal levels. (We note that even if we were not making this amendment to the final rate review rule, this State practice would differ from longstanding guidance on the treatment of association coverage for all other purposes under title XXVII of the PHS Act.) In addition, all five commenters asserted that, because association health plans have a larger insurance pool, they should not be regulated the same as plans and policies in individual and small group markets. However, a regulator from the same State as three of the associations opined that successful implementation of the Affordable Care Act depended on having a stable health insurance market, which could be jeopardized if issuers could avoid the various individual and small group market requirements by offering coverage through associations.

Response: In light of these comments, we are amending the definitions of "individual market" and "small group market" in this final rule to include individual and small group coverage sold through associations in the rate review process. This amendment applies to rates for association coverage that are filed, or are effective in States without filing requirements, on or after November 1, 2011. The majority of commenters supported extending the rate review rule to include such association coverage; no commenter offered a persuasive reason why associations should be treated differently in connection with the review of rate increases than they are treated generally under the PHS Act. To the extent that issuers set premiums for members within an association differently based on their own health status or other factors, these association members are essentially purchasing individual or small group coverage and should not be treated differently than other individuals or small groups not buying coverage through an association. Further, excluding individual and small group coverage sold through associations from the rate review process creates an unlevel playing field between issuers that sell coverage through associations and those that do not. Lastly, excluding association coverage from the rate review process raises the risk of creating incentives that could lead to adverse selection. We note that nothing in this amended rule prevents individuals and employers from enjoying the benefits of belonging to an association and obtaining health insurance coverage as a benefit of their association membership.

All other requirements in title XXVII of the PHS Act (for example, section 2718's medical loss ratio requirements) are governed by the individual and small group market definitions in section 2791 of the PHS Act. Under section 2791's definitions, individuals and employers who purchase health insurance coverage through associations generally have been and continue to be entitled to the same rights and protections as those who purchase coverage in the individual and group markets. CMS Insurance Standards Bulletin 02-02 (August 2002) stated that "the test for determining whether health insurance coverage offered through an association is group market coverage or individual market coverage, for purposes of [PHS Act] title XXVII, is the same test as that applied to health insurance offered directly to employers or individuals."

The decision to propose somewhat different definitions of individual and small group market for the purposes of rate review was based on the discretion under section 2794 of the PHS Act to specify which markets are subject to this rate review rule, and our desire to minimize disruption for the States and enable as many of them as possible to have Effective Rate Review Programs. In proposing to follow State filing law definitions, we did not take into account the substantial difference this could make with respect to association coverage in States with filing law definitions of individual market and small group market that exclude association coverage. n2 However, we are amending the regulation to make clear that for purposes of rate review, the treatment of association coverage is identical to how it is treated for other title XXVII requirements, so that individuals and small employers who purchase coverage through an association have the same set of protections they would receive if they had purchased coverage outside of an association. We note that in amending these definitions, we do not change the role offered to States to conduct Effective Rate Review Programs under the final rule which aims to minimize disruption of State rate review processes.

n2 As noted above, there is a long, consistent history of how associations have been treated with respect to the requirements added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, prior to enactment of the Affordable Care Act, none of those requirements related to rate review, and for HIPAA purposes it was irrelevant how a State defined its markets for rate review purposes. Therefore we were not familiar with the possible ramifications for associations.

Comment: A trade association noted that section 3(5) of the Employee Retirement Income Security Act (ERISA) defines

the term "employer" so that an association of employers could be deemed an "employer" sponsoring a group health plan under some circumstances. In such a case, the commenter recommended that the association coverage should be treated as one group health plan for purposes of the rate review process.

Response: As indicated by the commenter, the market definitions in section 2791 of the PHS Act are derived from definitions of employer and employee welfare benefit plan in ERISA section 3. While the proposed rule and current final rule adopt a different policy for rate review purposes with respect to association coverage than would apply under the PHS Act for other purposes, we are amending the final rule to apply the general PHS Act policy on association coverage under the rate review regulation, as an exception to the general rule that State definitions govern. Accordingly, if an association is, in fact, sponsoring a group health plan subject to ERISA, the association coverage should be considered to be one group health plan and the number of employees covered by the association would determine the group size for purposes of determining whether the group health plan is sponsored by a small employer and subject to the rate review process.

In most situations involving association coverage, the group health plan will exist at the individual employer level and not at the association level, in which case the size of the individual employers in the association will determine whether the association coverage is subject to the rate review process. The Department of Labor (DOL) has jurisdiction over ERISA group health plans and, for private sector entities, the determination of whether the group health plan exists at the association level or the employer level is made under ERISA. DOL has prepared a booklet in an effort to address questions that have been raised under ERISA concerning "multiple employer welfare arrangements." This booklet may assist stakeholders in identifying situations where an ERISA group health plan may exist at the association level. See DOL MEWA Guide (*http://www.dol.gov/ebsa/Publications/mewas.html*). Several DOL Advisory Opinions may also be helpful. *See* DOL Advisory Opinions 2001-04A (*http://www.dol.gov/ebsa/regs/aos/ao2001-04a.html*); 2008-07A (*http://www.dol.gov/ebsa/regs/aos/ao2008-07a.html*) and 2003-13A (*http://www.dol.gov/ebsa/regs/aos/ao2003-13a.html*). For example, in DOL Advisory Opinion 2008-07A, DOL stated:

"A determination whether there is a bona fide employer group or association for this ERISA purpose must be made on the basis of all the facts and circumstances involved. Among the factors considered are the following: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as employers; and who actually controls and directs the activities and operations of the benefit program. The employers that participate in a benefit program must, directly or indirectly, exercise control over the program, both in form and in substance, in order to act as a bona fide employer group or association with respect to the program.

The definition of employee welfare benefit plan' in ERISA is grounded on the premise that the person or group that maintains the plan is tied to the employers and employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits."

For more information, State regulators and other stakeholders can contact the Department of Labor's Employee Benefits Security Administration.

Comment: An association advised that a group policy for an association is issued to a trust in the State where the trust is domiciled and certificates are issued to insured parties who may reside in other States. In such a case, the association indicated that if the State where the trust is domiciled has a rate review process, that State should be responsible for the rate review of the entire program and should apply the same rating principles to the entire association, thus making it easier for compliance. Consumer advocates and a health insurance issuer, on the other hand, advised that rate increases of all individual and small group coverage sold in a State should be reviewed by that State, regardless of where the association is domiciled, to ensure that the individuals and employers in the State are protected by their local insurance department.

Response: A State's ability to review rate increases of coverage sold through associations domiciled in another State is dependent solely upon State law. Accordingly, it will be up to each individual State to determine whether its laws provide the authority to review proposed rate increases of individual and small group health insurance coverage sold through associations domiciled in another State. It should be noted that the rate review process set forth in the May 23, 2011 final rule sets standards so that the reporting and review process is similar in all States which should decrease the burden of having to file a rate increase in multiple States.

Comment: One insurance issuer commented that CMS should keep bona fide associations out of the rate review process because the bona fide association marketplace operates much like the large group market, in that trustees of associations are sophisticated purchasers who exercise their fiduciary responsibility to their members. This commenter therefore felt that, to prevent an undue burden on the rate review process, bona fide associations should be regulated differently from non-bona fide associations. An association indicated that, if bona fide association individual and small group coverage were included in the rate review process, it would subject the affected insurance premiums to review by as many as 40 different States.

Response: Although the PHS Act recognizes bona fide associations as defined by section 2791(d)(3) n3 of the PHS Act and currently exempts them from guaranteed renewability of coverage and guaranteed availability of coverage, individual and small group coverage provided through bona fide associations are subject to every other provision and protection of title XXVII of the PHS Act without exception. Therefore, the rate review process applies to individual and small group coverage provided through bona fide associations and non-bona fide associations. It should be noted that the rate review process set forth in the May 23, 2011 rule sets standards so that the reporting and review process is similar in all States

which should decrease the burden of having to file a rate increase in multiple States.

n3 *Bona fide association* means, with respect to health insurance coverage offered in a State, an association that meets the following conditions: (1) Has been actively in existence for at least 5 years. (2) Has been formed and maintained in good faith for purposes other than obtaining insurance. (3) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee). (4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member). (5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association. (6) Meets any additional requirements that may be imposed under State law.

Comments: Consumer advocates commented that States should be required to review an issuer's premium-rate increases on individuals and small groups purchasing insurance through an association or out-of-State trust as a condition of having an Effective Rate Review Program. These commenters also suggested that, to the extent possible, adequate regulation of associations should be a factor in awarding Cycle II grants of the Health Insurance Rate Review Program.

Response: A State that meets the criteria for an Effective Rate Review Program, as outlined in § 154.301 will be determined to have Effective Rate Review Programs; with this amendment, this review will apply to rate increases of association coverage sold directly to individuals and small groups in that State. A State's status as an Effective Rate Review Program State in other market segments will not be affected by its status as it relates to the effective review of association coverage rate increases. For purposes of this determination, we will not take into account whether the State where an association plan has its situs reviews the rates. In order to be an Effective Rate Review Program State for association coverage, a State will have to meet the criteria specified in § 154.301(a) and (b) for review of rate filings in its State for association coverage. If a State fails to meet the criteria for association coverage, CMS will review the rate filings above the threshold for the association coverage in that State.

The Cycle II funding opportunity announcement (FOA) was posted in February of this year and applications were due August 15, 2011. In order to be eligible for an award under Cycle II, for either Phase I or II awards, a State must be able to demonstrate at the time of application that it already meets the criteria for an Effective Rate Review Program, or that with the funding resources from the grant it can achieve an Effective Rate Review Program.

To the extent that association coverage is one product type in which a State can be effective or not, it is a consideration, but effective review of association coverage is not a requirement for a Cycle II grant.

III. Provisions of This Final Rule

This final rule amends the definition of "individual market" and "small group market" in § 154.102 as follows:

We amended the definition of "individual market" to include coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association. We also amended the definition of "small group market" to include coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association. This approach follows the definition that applies for other PHS Act purposes (under which an association itself will only be considered to be a group health plan if it complies with and is regulated under ERISA).

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

. The need for the information collection and its usefulness in carrying out the proper functions of our agency.

. The accuracy of our estimate of the information collection burden.

. The quality, utility, and clarity of the information to be collected.

. Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The Collection of Information Requirements associated with the May 23, 2011 final rule were approved under OMB control number 0938-1141, with an expiration date of August 31, 2014. In the May 23, 2011 final rule, we solicited comments on whether individual and small group coverage sold through associations should be included in the rate review process. At that time, we did not include an estimate of the number of rate review filings of association coverage for the burden estimates in the PRA section of the final rule. We are now amending the burden estimates in the PRA section to reflect the additional number of filings resulting from amending this final rule.

As indicated in RIA section below, we estimate that 229 additional rate filings will be subject to the rate review process as a result of including individual and small group coverage sold through associations in the process. This increases the

total number of filings subject to review from 974 to 1,203. All other estimates, including number of respondents and burden per response, have not changed from the final rule. Accordingly, the language from the PRA section of the May 2011 final rule is incorporated in this final rule and the changes in the estimates are reflected in the Revised Table A, with revised numbers highlighted in bold.

Revised Table A – Estimated Annual Burden

Regulation Section(s)	OMB Control No.	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($)	Total Labor Cost of Reporting ($)	Total Capital/ Maintenance Costs ($)	Total Cost ($)
§154.210 ICRs Regarding State Determinations	0938-New	35	**801**	0.33	**264**	200	**52,800**	0	**52,800**
§§154.215, and 154.220, ICRs Regarding the Rate Review Preliminary Justification Form	0938-New	417	**1,203**	11	**13,233**	200	**2,646,600**	0	**2,646,600**
§154.230 ICRs Regarding the Final Justification	0938-New	417	**1,203**	0.5	**601**	200	**120,200**	0	**120,200**
§154.230 ICRs Regarding the Final Notification	0938-New	417	**1,203**	0.5	**601**	200	**120,200**	0	**120,200**
Total		452	**4,410**		**14,699**		**2,939,800**		**2,939,800**

V. Response to Comments

Because of the large number of public comments we receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. A discussion of the comments we received is included in the preamble of this document.

VI. Regulatory Impact Analysis

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

A. Summary

In the regulatory impact analysis (RIA) for the May 23, 2011 final rule, we discussed the proposal to amend the definitions of individual and small group markets in order for individual and small group coverage sold through associations to be subject to rate review. Although we did not include the burden of including coverage sold through associations in the final numbers for the PRA package or the RIA, an estimate was provided in the RIA for the purpose of soliciting comments on the potential burden of including individual and small group coverage sold through associations in the rate review process.

We reviewed data submitted by health insurance issuers to the NAIC and estimated that there would be 986 filings annually that would have to be submitted for individual or small group coverage sold through associations. We in turn applied the factors for non-grandfathered coverage (0.42) and filings above the 10 percent threshold (0.45), which resulted in a total of 186 additional filings that would be subject to rate review. We further estimated that 34 percent of these filings would occur in States that require prior approval before a rate increase can be implemented, in which case the rate filings are already subject to review by a State. This resulted in a final estimate of 123 additional filings above the 10 percent threshold occurring if coverage sold through associations were subject to the rate review process.

In response to our solicitation of comments on the association issue, we received from the NAIC a survey of State

regulators in which the following question was asked: "How many such rate filings does your State receive for association and out-of-State trust coverage?" Thirty-two States responded to the survey and 14 States provided estimates that totaled 440 rate filings for association coverage on an annual basis. Most of these estimates did not distinguish between the individual and small group markets. One State indicated that no rate filings were received from associations, and the other 17 indicated that they did not track association rate filings. This data was provided by State regulators who review rate filings, as opposed to the prior data that was provided by health insurance issuers. Since State regulators are positioned to review the rate filings of all the issuers in their States, we chose to use the State data for the purpose of updating the burden estimates in this RIA. Extrapolating the 440 number from 14 States to 50 States provides an estimate of 1,570 rate filings annually for association coverage in the individual and small group markets. Using the percentages from the final rule numbers (76% small group market, 24 percent individual market), this breaks out to 377 additional filings in the individual market and 1,193 filings in the small group market. Applying the factors for non-grandfathered coverage and filings above the 10 percent threshold results in a mid range estimate of 229 additional filings being subject to rate review.

Since this final rule directs that individual and small group coverage sold through associations be included in the rate review process, we are amending the burden estimates in the RIA to reflect the additional number of filings. The estimated number of affected entities, the burden estimates for the start-up costs and the amount of time to review each rate filing do not change from what was estimated in the RIA for the May 23, 2011 final rule. Accordingly, the RIA from the May 23, 2011 final rule is incorporated into this final rule with the only the changes being the additional number of filings discussed here and in the Federalism Statement in section D. All ranges of filing estimates were increased by 1,570, the estimated number of rate filings for association coverage, as explained above. This results in the number of 2011 filings in Table 3 for the low range estimate being increased from 6,121 to 7,691; the mid range was increased from 6,733 to 8,303; and the high range from 7,343 to 8,913. In the tables, the amended numbers are highlighted in bold.

B. Estimated Number of Rate Filings

This section of the regulatory impact assessment provides estimates of the number of filings that would be subject to review under this final rule. Below we are revising Table 3, Table 4, and Table 5 of the May 23, 2011 final rule (see 76 FR 29980 through 29982) to read as follows:

Revised Table 3: Estimated Number of Filings Subject to Review

		Individual	Small Group	Total
Estimated number of filings for 2011				
Low Range		**1772**	**5,919**	**7,691**
Mid Range		**1,948**	**6,355**	**8,303**
High Range		**2,123**	**6,790**	**8,913**
Percent of filings subject to review (non-grandfathered)				
Low Range		40%	20%	
Mid Range		54%	30%	
High Range		67%	42%	
Number of filings subject to review				
Low Range		**709**	**1184**	**1,893**
Mid Range		**1,052**	**1,906**	**2,958**
High Range		**1,422**	**2,852**	**4,274**
Estimated percentage of filings meeting or exceeding threshold				
Low Range		50%	20%	
Mid Range		60%	30%	
High Range		70%	40%	
Estimated number of filings meeting or exceeding threshold				
Low Range		**354**	**236**	**590**
Mid Range		**631**	**572**	**1,203**
High Range		**995**	**1,141**	**2,136**

C. Estimated Administrative Costs Related to Rate Review Provisions

Revised Table 4: Estimated Costs for Reporting, Record Retention, and Website Notification (Actual Dollars)

Description	Total Number of Issuers	Total Number of Reports	Estimated Total Hours (1)	Estimated Average Cost Per Hour (2)	Estimated Total Cost	Estimated Average Cost Per Issuer	Estimated Average Cost Per Report
LOW RANGE ASSUMPTIONS							
One-Time Costs	417	590	52,125	$200	$10,425,000	$25,000	$17,669
Ongoing Costs	417	590	2,808	$200	$561,600	$1,347	$952
Total Year One Costs	417	590	54,933	$200	$10,986,600	$26,347	$18,621
MID RANGE ASSUMPTIONS							
One-Time Costs	417	1,203	62,550	$200	$12,510,000	$30,000	$10,399
Ongoing Costs	417	1,203	14,699	$200	$2,939,800	$7,050	$2,444
Total Year One Costs	417	1,203	77,249	$200	$15,449,800	$37,050	$12,843
HIGH RANGE ASSUMPTIONS							
One-Time Costs	417	2,136	72,975	$200	$14,595,000	$35,000	$6,833
Ongoing Costs	417	2,136	27,568	$200	$5,513,600	$13,222	$2,581
Total Year One Costs	417	2,136	100,543	$200	$20,108,600	$48,222	$9,414

Notes: Estimated costs are stated in 2010 dollars.
(1) Estimated number of one-time start up hours and annual ongoing hours.
(2) Actuary salary/fee.
(3) Estimated Costs to the States and Federal Government Related to Rate Review Provisions.

Revised Table 5: Estimated Actuarial Rates

Estimated Actuarial Rates			
	Low	Mid	High
Principal Actuaries	$340.00	$350.00	$360.00
Support Actuaries	$200.00	$234.00	$275.00
Actuarial Analyst	$120.00	$150.00	$180.00
Administrative Support	$80.00	$100.00	$120.00
Estimated Time to Complete Average Review	Average Time Required		
Principal Actuaries	4.25	5.50	6.75
Support Actuaries	8.50	9.50	11.00
Actuarial Analyst	12.00	14.00	15.00
Administrative Support	9.00	9.50	12.00
Actuarial Staff Hours	24.75	29.00	32.75
Total Staff Hours	33.75	38.5	44.75
	Low	Mid	High
Estimated Cost per Review	$5,305	$7,198	$9,595
Number of Rate Reviews	165	396	769
Total Expected Contracting Cost	$875,325	$2,850,408	$7,378,555

1. Estimated Costs to States

CMS recognizes that States have significant experience reviewing rate increases. As discussed earlier in this preamble, most States have existing Effective Rate Review Programs that will meet the requirements of this regulation. Rate review

grants provided by CMS are expected to increase the effectiveness of State rate review processes, but they are not a direct measure of the cost of this regulation.

CMS estimates that the cost impact on States will be small because most States currently conduct rate review. For these States, the incremental costs and requirements of this regulation will be minimal. Some States do not already have a rate review process or have a process that applies to only a portion of the individual and small group markets that this regulation addresses. In these States, the implementation costs to develop Effective Rate Review Processes at the State level can be offset by the rate review grants provided by CMS. For States not currently conducting effective rate review, HHS will conduct the review.

States with Effective Rate Review Programs will be required to report on their rate review activities to the Secretary. CMS believes that this reporting requirement will involve minimal cost. CMS estimates that reporting information from the State to CMS will require approximately 20 minutes per filing. Based on an actuary's fee of $ 200 per hour, CMS estimates an average cost per filing of $ 66. Including association coverage, the estimated cost of reporting the two-thirds of filings meeting or exceeding the 10 percent threshold (801), which are reviewed by States, is $ 52,866.

D. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. In CMS' view, while the requirements proposed in this final rule would not impose substantial direct costs on State and local governments, this final rule has federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining the reasonableness of rate increases for coverage that State-licensed health insurance issuers offer in the individual and small group markets.

CMS recognizes that there are federalism implications with regard to CMS' evaluation of Effective Rate Review Programs and its subsequent review of rate increases. Under Subpart C of this final rule, CMS outlines those criteria that States would have to meet in order to be deemed to have an Effective Rate Review Program. If CMS determines that a State does not meet those criteria, then CMS would review a rate increase subject to review to determine whether it is unreasonable. If a State does meet the criteria, then CMS would adopt that State's determination of whether a rate increase is unreasonable.

As indicated earlier in this preamble, we received comments from consumer advocates and State insurance officials citing a study concluding that two-thirds of the States regulate associations differently from other plans in the individual and small group market and about one-half of the States entirely or partially exempt coverage sold through national associations from State regulation. In States where individual and small group coverage sold through associations is not subject to the rate review process, we indicate in this preamble that CMS will review the rate filings for such coverage that meet the threshold. We also state that the fact that a State may not review rate filings of association coverage will not be considered in determining whether that State has an effective rate review program.

States would continue to apply State law requirements regarding rate and policy filings. State rate review processes that are similar to the Federal requirements likely would be deemed effective and satisfy the requirements under this final rule. Accordingly, States have latitude to impose requirements with respect to health insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, CMS has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners (NAIC), participating in a NAIC workgroup on rate reviews and consulting with State insurance officials on an individual basis.

Throughout the process of developing this final rule, CMS has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform protections to consumers in every State. By doing so, it is CMS' view that it has complied with the requirements of Executive Order 13132. Under the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, CMS certifies that the Center for Consumer Information and Insurance Oversight has complied with the requirements of Executive Order 13132 for the attached final rule in a meaningful and timely manner.

List of Subjects in 45 CFR Part 154

Administrative practice and procedure, Claims, Health care, Health insurance, Health plans, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR Subtitle A, Subchapter B, by amending part 154 as follows:

PART 154--HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

1. The authority citation for part 154 continues to read as follows:

Authority: Section 2794 of the Public Health Service Act (42 U.S.C. 300gg-94).

Subpart A--General Provisions

2. In § 154.102, revise the definitions of "individual market" and "small group market" to read as follows:

§ 154.102 Definitions.

* * * * *

Individual market has the meaning given the term under the applicable State's rate filing laws, except that:

(1) Where State law does not define the term, it has the meaning given in section 2791(e)(1)(A) of the PHS Act; and

(2) Coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association is subject to rate review as individual market coverage.

* * * * *

Small group market has the meaning given under the applicable State's rate filing laws, except that:

(1) Where State law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act; provided, however, that for the purpose of this definition, "50" employees applies in place of "100" employees in the definition of "small employer" under section 2791(e)(4); and

(2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage.

* * * * *

Dated: August 16, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: August 29, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2011-22663 Filed 9-1-11; 11:15 am]

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(2) Coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association is subject to rate review as individual market coverage.

* * * * *

Small group market has the meaning given under the applicable State's rate filing laws, except that:

(1) Where State law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act; provided, however, that for the purpose of this definition, "50" employees applies in place of "100" employees in **[*54977]** the definition of "small employer" under section 2791(e)(4); and

(2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage.

* * * * *

Dated: August 16, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: August 29, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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