BEFORE THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

IN THE MATTERS OF:

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

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

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

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

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

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

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

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

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I. INTRODUCTION

The Office of the Insurance Commissioner ("OIC") moves for summary judgment as to its January 15, 2015 disapprovals (the "Disapprovals") of the 2014 rate filings (the "Filings") of Master Builders Association of King and Snohomish Counties and Master Builders Association of King and Snohomish Counties Employee Benefit Group Insurance Trust (collectively "MBA Trust"), Building Industry Association of Washington Health Insurance Trust ("BIAW Trust"), and Northwest Marine Trade Association and Northwest Marine Trade Association Health Trust (collectively "NMTA Trust"). But nowhere in the OIC Staff's Motion for Summary Judgment ("OIC's Motion") does the OIC point to the elusive "new" law supporting its abrupt change in position regarding the ability of association health plans to set rates at the Participating Employer[1] level. Rather, the OIC vaguely asserts that the Affordable Care Act ("ACA") suddenly mandated that association health plans cannot do so, without citing any provision of the ACA that so provides. The OIC's Disapprovals are without basis in state or federal law, and MBA Trust, BIAW Trust, and NMTA Trust, and their issuer, Cambia Health Solutions ("Cambia"), respectfully request that they be reversed as a matter of law.

II. BACKGROUND

MBA Trust, BIAW Trust, and NMTA Trust (collectively, the "AHPs"), and Cambia incorporate the discussion from the "Background" section of their Motion for Summary Judgment as if set forth in full herein.

III. STANDARD OF DECISION

Summary judgment in an administrative proceeding is appropriate "if the written record shows that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." WAC 10-08-135; *see also Stewart v. State Dep't of Soc. &*

[1] Capitalized terms not defined herein have the meaning assigned to them in the Motion for Summary Judgment filed by MBA Trust, BIAW Trust, NMTA Trust, and Cambia.

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Health Servs., 162 Wn. App. 266, 270, 252 P.3d 920 (2011). All facts are viewed "in the light most favorable to the nonmoving party." *Granton v. Wash. State Lottery Comm'n*, 143 Wn. App. 225, 230, 177 P.3d 745 (2008).

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

IV. ARGUMENT

A. The AHPs and Cambia Have Standing to Challenge the OIC's Decisions

Contrary to the OIC's assertion, the AHPs and Cambia have standing to demand this hearing. RCW 48.04.010(1)(b) provides:

> Except under RCW 48.13.475,[2] upon written demand for a hearing made by any person aggrieved by any act, threatened act, or failure of the commissioner to act, if such failure is deemed an act under any provision of this code, or by any report, promulgation, or order of the commissioner other than an order on a hearing of which such person was given actual notice or at which such person appeared as a party, or order pursuant to the order on such hearing.

(Emphases added). The three AHPs and Cambia are each aggrieved by an act of the Commissioner; as such, each has standing under the only standing provision applicable here: the above-quoted RCW 48.04.010(1)(b).

The OIC argues that only a carrier has standing to challenge the Disapprovals. But that is not what RCW 48.04.010(1)(b) provides. Had the Legislature intended to limit demands for a hearing to carriers, it could have done so. Instead, it provided that "any person aggrieved by any act" of the OIC has the right to be heard. RCW 48.04.010(1)(b) (emphases added).

[2] RCW 48.13.475 pertains to the safeguarding of securities and is inapplicable here.

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1. RCW 48.44.020(2) and RCW 48.46.060(3) Do Not Limit the AHPs' Right to a Hearing

The OIC asserts that RCW 48.44.020(2) and RCW 48.46.060(3) limit standing to carriers. The former provides:

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

RCW 48.44.020(2) (emphasis added). Similarly, RCW 48.46.060(3) provides:

> Subject to the right of the health maintenance organization to demand and receive a hearing under chapters 48.04 and 34.05 RCW, the commissioner may disapprove any individual or group agreement form for any of the following grounds: . . . .

(Emphasis added).

The OIC's reasoning is fundamentally flawed because it did not rely on either RCW 48.44.020(2) or RCW 48.46.060(3) in its Disapprovals of the Filings. *See* Declaration of Dale Neer in Support of MBA Trust, BIAW Trust, NMTA Trust, and Cambia's Motion for Summary Judgment (5/6/15) ("Neer Decl.") Exs. 13-15. Rather, the OIC rejected the Filings under RCW 48.44.020(3), which provides that "the commissioner may disapprove any contract if the benefits provided therein are unreasonable in relation to the amount charged for the contract." *See* Neer Decl. Exs. 13-15. RCW 48.44.020(3) does not contain the language to which the OIC now points.

Even if the OIC's Disapprovals had relied on one of the grounds set forth in RCW 48.44.020(2) or RCW 48.46.060(3) (which they did not), the language of those provisions would not preclude the AHPs' demands for a hearing. Nothing in those provisions states that parties other than carriers no longer have appeal rights under RCW 48.04.010(1)(b). The mere acknowledgement that the OIC's disapproval of filings is "subject to the right of the health care service contractor to demand and receive a hearing" does not somehow extinguish other aggrieved parties' right to be heard. RCW 48.44.020(2); *see also* RCW 48.46.060(3). Indeed,

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RCW 48.04.010(1)(b) includes only one exception to the right to a hearing of "any person aggrieved by any act" of the Commissioner: where the proceedings involve the safeguarding of securities under RCW 48.13.475. RCW 48.04.010(b) (emphases added). Significantly, RCW 48.04.010(1)(b) does not carve out an exception to the right to a hearing where the OIC rejects filings under RCW 48.44.020(2) or RCW 48.46.060(3)—neither of which is at issue with respect to the Disapprovals, at any rate.

2. The APA Does Not Limit the AHPs' Right to a Hearing

The OIC next asserts that the three AHPs do not qualify as "any person aggrieved by any act" of the Commissioner. In so arguing, the OIC relies exclusively on case law interpreting the standing provision for judicial review of an agency decision set forth in the Administrative Procedure Act ("APA"), RCW 34.05.530. The APA and its standards are not applicable here, however, as demonstrated by the sound rejection of the APA's standing test on summary judgment by the OIC Hearings Unit Chief Presiding Officer in a recent case:

> . . . RCW 34.05.530 . . . sets forth the criteria for judicial review of an agency's decision by the Superior Court, i.e., this statute sets forth the criteria which must be met in order to appeal a final order of this agency's (or any agency's) quasi-judicial executive tribunal to the Superior Court. It does not set forth the criteria which must be met for a party aggrieved by an act of the Commissioner to contest that act before this agency's (or any agency's) quasi-judicial executive tribunal such as this one. While . . . RCW 34.05.530 might be somewhat informative because it uses the same word "aggrieved" as RCW 48.04.010, it would be in error to grant summary judgment on this case based on a statute which applies to an entirely different type of review, and based on case law interpreting that inapplicable statute.

In the Matter of Seattle Children's Hosp. & Coordinated Care Corp., Dkt. No. 13-0293 (Feb. 20, 2014) (order denying motion for summary judgment) at 3 (emphases added), *available at* http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-order-intervenors-msj.pdf (last visited May 22, 2015).

Even if the APA's standing test were applicable (which it is not), the AHPs meet both prongs of that test. First, the AHPs meet the "injury-in-fact" requirement, because the OIC's

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"action has prejudiced or is likely to prejudice" them, their Participating Employers, and their Members.[3] RCW 34.05.530(1). If Regence is required to set rates at the association level and thus impose the same rates on all Participating Employers, the rates assigned to many Participating Employers will increase substantially. Declaration of Jerry Belur in Support of MBA Trust, BIAW Trust, NMTA Trust, and Cambia's Motion for Summary Judgment ("First Belur Decl.") ¶ 13; 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 ("Second Belur Decl.") ¶ 13. Those Participating Employers with higher rates are likely to leave the AHPs and obtain health insurance elsewhere. Second Belur Decl. ¶ 13. These circumstances and market disruption will in turn impair the AHPs' ability to effectively compete for health care benefit plan business for employers falling within certain demographics. *Id.* Instead, its membership will be limited to an aging demographic that will not be sustainable in the long term. *Id.* In addition, the AHPs' per-member administrative costs will increase with reduced enrollment. *Id.* "The United States Supreme Court routinely recognizes probable economic injury resulting from

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[3] *See Am. Legion Post No. 149 v. Wash. State Dep't of Health*, 164 Wn.2d 570, 595, 192 P.2d 306 (2008):

> In addition to personal standing, a party may have standing in a representational capacity. . . . An organization "has standing to bring suit on behalf of its members when: (a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit."

(citations omitted). *See also Nat'l Elec. Contractors Ass'n v. Emp't Sec. Dep't*, 109 Wn. App. 213, 220, 34 P.3d 860 (2001) (holding that an "interest sufficient to confer standing may be shown in [a] personal or representative capacity") (internal quotation marks and citation omitted). Here, the Participating Employers and their Members are aggrieved parties in their own right, with standing to demand a hearing under RCW 48.04.010(1)(b). The AHPs' purpose is to provide high-quality, affordable health care to Participating Employers' Members—the same purpose the AHPs are advancing by protesting the OIC's Disapprovals. Finally, "neither the claim asserted nor the relief requested requires the participation of individual members," as the AHPs can effectively represent the interests of Participating Employers and Members. *Am. Legion Post No. 149*, 164 Wn.2d at 595.

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agency actions that alter competitive conditions as sufficient to satisfy the injury-in-fact requirement." *Seattle Bldg. & Constr. Trades Council v. Apprenticeship & Training Council*, 129 Wn.2d 787, 795, 920 P.2d 581 (1996) (internal quotation marks and citation omitted); *see also Snohomish Cnty. Pub. Transp. Benefit Area v. State Pub. Emp't Relations Comm'n*, 173 Wn. App. 504, 514, 294 P.3d 803 (2013) ("Economic losses, such as harm to competitive positioning in a commercial market . . . have consistently been recognized as injuries sufficient to establish standing." (internal quotation marks and citation omitted)). "[T]he fact that any economic injury . . . may not be immediate . . . is not dispositive of the standing question . . . ." *Seattle Bldg. & Constr. Trades Council*, 129 Wn.2d at 795. The prejudice caused by the OIC's Disapprovals is not speculative; it is a concrete burden directly imposed on the AHPs, their Participating Employers, and their Members as a result of the Disapprovals and the OIC's requested remedy.

Second, the AHPs meet the "zone of interest" requirement. "[A]lthough the zone of interest test serves as an additional filter limiting the group which can obtain judicial review of an agency decision,[4] the 'test is not meant to be especially demanding.'" *Id.* at 797 (quoting *Clarke v. Sec. Indus. Ass'n*, 479 U.S. 388, 399, 107 S. Ct. 750, 93 L. Ed. 2d 757 (1987)). "The test focuses on whether the Legislature intended the agency to protect the party's interests when taking the action at issue." *St. Joseph Hosp. & Health Care Ctr. v. Dep't of Health*, 125 Wn.2d 733, 739-40, 887 P.2d 891 (1995).

The only statute relied upon by the OIC in its Disapprovals, RCW 48.44.020(3), provides that "the commissioner may disapprove any contract if the benefits provided therein are unreasonable in relation to the amount charged for the contract." These provisions are clearly intended to protect the recipients of plan benefits—the very people who comprise the

[4] Note that the "zone of interest" test applies to "judicial review of an agency decision" and is not even applicable to the analysis at hand, contrary to the OIC's assertion.

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membership of the AHPs' Participating Employers—from "benefits [that] . . . are unreasonable in relation to the amount charged" by carriers.[5] RCW 48.44.020(3).

Furthermore, the Washington courts, in applying the APA, have "adopted a more liberal approach to standing when a controversy is of substantial public importance, immediately affects significant segments of the population, and has a direct bearing on commerce, finance, labor, industry, or agriculture." *Am. Legion Post No. 149*, 164 Wn.2d at 595 (internal quotation marks and citation omitted). This case presents just such a circumstance. Imposing the OIC's requested remedy will immediately affect tens of thousands of employees in the State of Washington by limiting their health care options, which will have a direct bearing on commerce and labor. *See* First Belur Decl. ¶ 13; Second Belur Decl. ¶ 13. The AHPs have a clear right to demand a hearing to seek reversal of the Disapprovals that directly prejudice the AHPs and their Participating Employers and Members without any basis in state or federal law.

3. Cambia Is the Carrier and Has Standing to Challenge the OIC's Decision

The OIC's strained standing argument is stretched even further by its assertion that Cambia somehow lacks standing. The OIC contends that Cambia is not the carrier, arguing that "Regence is the only entity that had standing to challenge the disapproval of its plans." OIC's Motion at 11. Even if Cambia were not deemed to be the carrier, the OIC's standing argument as to Cambia fails for the same reasons it fails with respect to the AHPs, as discussed above.

In reality, however, Cambia is the parent company of Regence. Not only can the OIC not cite to any legal basis for the proposition that standing is limited to the carrier, it also cannot cite to any legal basis for the position that "the carrier" does not include the carrier's parent company in this context or for the position that the carrier's parent company does not suffer harm as a result of actions directly affecting its wholly owned subsidiary. The OIC fully acknowledges

[5] To the extent the OIC attempts to rely on RCW 48.44.020(2) and RCW 48.46.060(3) (which are not applicable here), those provisions were also clearly drafted to protect recipients of benefits from issues such as "inconsistent, ambiguous or misleading clauses," "deceptive advertising," and "unreasonable restrictions on the treatment of patients." RCW 48.44.020(2); RCW 48.46.060(3).

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that Regence, Cambia's wholly owned subsidiary, has standing. *See id.* Thus, there is no question that Cambia has standing.

4. The Presiding Officer Has Discretion to Hold a Hearing

While the Presiding Officer is required to hold a hearing here, "upon written demand for a hearing made by any person aggrieved by any act . . . of the commissioner,"[6] the Presiding Officer also has broad discretion to "hold a hearing for any purpose within the scope of this code as he . . . may deem necessary." RCW 48.04.010(1). The AHPs and Cambia respectfully assert that the circumstances presented in this case—in which the health insurance benefits of tens of thousands of Washington citizens will be affected—warrant review.

B. The OIC's Position Lacks Any Legal Basis

1. The OIC Has Improperly Shifted Its Basis for the Disapprovals

In its Disapprovals, the OIC explicitly cited to a single basis for its decisions: RCW 48.44.020(3). Neer Decl. Exs. 13-15. This provision states that "the commissioner may disapprove any contract if the benefits provided therein are unreasonable in relation to the amount charged for the contract." RCW 48.44.020(3). The OIC's citation to RCW 48.44.020(3) was not inadvertent. The OIC clearly expressed the following in the Disapprovals:

> . . . This tells us that your rates, filed for various employers, are unreasonable in relation to the amount charged for the contract for one single employer,[7] Master Builders Association of King and Snohomish Counties. Therefore, your rate and form filings are disapproved and closed under the authority of RCW 48.44.020(3).

Neer Decl. Ex. 13 (emphasis added); *see also id.* at Exs. 14-15 (including identical language, with the exception of the identity of the relevant AHP).

As discussed in MBA Trust, BIAW Trust, NMTA Trust and Cambia's Motion for Summary Judgment, RCW 48.44.020(3), the sole provision on which the OIC relied in its

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[6] RCW 48.04.010(1)(b); WAC 284-02-070(b).

[7] As discussed in MBA Trust, BIAW Trust, NMTA Trust and Cambia's Motion for Summary Judgment, the OIC altered the language of RCW 48.44.020(3) in its Disapprovals, but it is clear that it intended to rely solely on that provision.

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Disapprovals, is inapplicable. That provision allows for disapproval of a contract "if the benefits provided therein are unreasonable in relation to the amount charged for the contract." RCW 48.44.020(3) (emphasis added). The OIC does not claim that the benefits provided under the Plans are unreasonable. Rather, the OIC asserts that the rates are somehow unlawful.

In a tortured attempt to justify its reliance on RCW 48.44.020(3), the OIC asserts that "it is impossible to evaluate a plan's benefits in relationship to its rates by considering only one side of the equation and without evaluating both the rates and benefits." OIC's Motion at 22-23. But the OIC's argument only serves to highlight that "benefits" and "rates" are not synonymous. While the OIC may consider rates in connection with its analysis of whether "benefits provided therein are unreasonable," the clear language of RCW 48.44.020(3) permits rejection only on the basis of one of those factors: the benefits.[8] The OIC has not raised any concerns, and there are none, regarding the reasonableness of the Plans' benefits.

The OIC implicitly acknowledges the inapplicability of its sole cited basis for the Disapprovals, as it instead relies on completely different bases under federal law in its Motion. In another contrived effort to salvage its position, the OIC suddenly points to entirely different provisions from those cited in its Disapprovals, attempting now to rely on RCW 48.44.020(2)(f), which provides:

> The commissioner may on examination . . . disapprove any individual or group contract form for any of the following grounds:

[8] The OIC also suggests that MBA Trust, BIAW Trust, NMTA Trust and Cambia have somehow not met their burden to demonstrate that the actuarial requirements of WAC 284-43-915(2) have been met. OIC's Motion at 23. WAC 284-43-915(2) provides that "[b]enefits will be found not to be unreasonable if the projected earned premium for the rate renewal period is equal to" specified actuarially sound estimates and provisions. Any purported burden to prove that the actuarial requirements were met was never triggered because the OIC's basis for its Disapprovals was not the contention that the Plans' benefits were unreasonable. Thus, WAC 284-43-915(2) is completely inapplicable (as is the statute on which the OIC expressly relied). MBA Trust, BIAW Trust, NMTA Trust and Cambia's point in raising WAC 284-43-915(2) in their Motion for Summary Judgment was to underscore the fact that RCW 48.44.020(3) is inapplicable. The actuarial requirements of WAC 284-43-915(2) highlight that RCW 48.44.020(3) applies to an analysis of the reasonableness of the benefits, not to an analysis of whether an association may assess rates at the Participating Employer level.

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

See OIC's Motion at 22. The OIC then points to WAC 284-43-125, which generally requires carriers to "comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits." *See id.* In so doing, the OIC ignores the statute cited in its Disapprovals and now offers the new argument that it actually rejected the Filings based on entirely different legal standards and based on the vague premise that the carriers are required to "comply with all Washington state and federal laws." WAC 284-43-125.

The OIC's ever-shifting position[9] is improper and highlights the arbitrary and capricious nature of its Disapprovals. Parties affected by an agency's decision should be entitled to rely on the reasons expressly articulated in the decision and to focus their challenge on those articulated reasons. At the very least, the OIC's inability to focus on any particular law is telling: its ever-shifting justification for its objections and disapprovals of the Filings betrays the fact that there is no law prohibiting an association from rating at the Participating Employer level. Throughout its entire Motion, not once does the OIC point to a law or regulation that actually precludes the setting of rates at the Participating Employer level. That is because no such law or regulation exists. In fact, state law expressly permits association health plans to rate at the employer level, based on factors that include the claims experience of an employer group. *See* RCW 48.44.024 (exempting "[e]mployers purchasing health plans provided through associations" from community rating requirements in the small group market); *Associated Indus. of the Inland Nw. v. OIC,* No. 2007-02-00592-1 (Spokane Cnty. Super. Ct. 2007) (attached as **Exhibit 1**) (holding that OIC policy requiring association health plans to rate based on the "health of the entire

[9] Notably, in its Objection Letters, the OIC cited to federal law as to concerns it raised, but it then proceeded to reject the Filings on the basis of state provisions entirely unrelated to carrier compliance with federal law. *See* Neer Decl. Exs. 5-9. Now, the OIC's arguments have again shifted back to purported concerns under federal law that are entirely unrelated to the provisions cited in the Disapprovals. *See id.* at Exs. 13-15.

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association group," rather than on the experience of employer subgroups, violated the separation of powers doctrine because it conflicted with RCW 48.44.024) (emphasis omitted).

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

As noted above, the OIC now asserts that its Disapprovals were premised on the following labored logic: (1) the Rejections were not made pursuant to RCW 48.44.020(3), the only provision actually cited in the Disapprovals; (2) the Disapprovals were instead authorized by RCW 48.44.020(2)(f) (not cited in the Disapprovals), which allows rejection on the basis of failure to conform to standards required by the Commissioner pursuant to rule or regulation; (3) WAC 284-43-125 (also not cited in the Disapprovals) generally requires carriers to comply with federal law; and (4) therefore, the Disapprovals were grounded in federal law. At the end of this winding path, however, the OIC still cannot identify a single federal law that actually prohibits rate-setting at the Participating Employer level.

The OIC's reasoning is instead based on a misapplication of federal law and on the fundamentally incorrect assertion that there has been a recent change in the law affecting the ability of association health plans to set rates at the Participating Employer level. The OIC asserts that unspecified "new federal language specifically abolished any exemption from federally required community rating or from the other ACA small group market reforms for associations or small employers purchasing through associations." OIC's Motion at 13 (emphasis added). But the OIC fails to identify this purported "new federal language." It argues instead that the AHPs must be treated as a single employer for rating purposes merely because the ACA has adopted the definition of "employer" found in Section 3(5) of the Employee Retirement Income Security Act ("ERISA"). Specifically, the ACA provides that carriers may sell "employee welfare benefit plans," as defined by ERISA, and that "employee welfare benefit plans" must be "established or maintained by an employer," which is defined in ERISA as including "a group or association of employers acting for an employer in such capacity." 29 U.S.C. §§ 1002(1) and 1002(5). Absolutely nothing in the ACA or ERISA requires that an

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association health plan set its rates at the association level. The OIC has unilaterally determined, without legal authority, that "identifying which entity is the employer" under ERISA is synonymous with "determining the level at which the plan exists" for purposes of rate-setting. OIC's Motion at 15-16. But it cannot point to any legal justification for its position. The OIC is attempting to extend a federal law concept from one context far beyond its intended boundaries and to force it into an entirely separate state law context on which the federal law is silent.

Moreover, none of the concepts on which the OIC now relies are novel. The ACA merely pulled definitions into the statute that were already present in the federal regulations.[10] The Health Insurance Portability and Accountability Act ("HIPAA") nondiscrimination provisions have been in place for a decade. Nothing has changed in the law to warrant a sudden change in the OIC's position as of January 1, 2014.

The OIC points to three sources of purported support for its position. None of them, however, are laws or regulations prohibiting rate-setting at the Participating Employer level.

First, the OIC relies on a September 1, 2011 bulletin issued by the Centers for Medicare and Medicaid Services ("CMS"). *See* OIC's Motion at 15 and Addendum 1. Notably, this bulletin was issued in 2011, underscoring that there has been no sudden change in the law as the OIC claims. *Id.* at Addendum 1. The "bona fide association" definition included in Public Health Service Act ("PHSA") § 2791(d)(3), discussed in the CMS bulletin, provides some

[10] Health care reform extended HIPAA's health status nondiscrimination requirement to health insurance issuers offering individual health insurance coverage, effective January 1, 2014. *See* Section 2705(a) of the Public Health Service Act ("PHSA"), as added by Section 1201(4) of the ACA. The effective date for the provisions is contained in Section 1255 of the ACA. The health status-related factors are found in ERISA 702(1)(1); Code Section 9802(a)(1) and PHSA 2705(a). A "catch-all" category was added by ACA §1201(4), which was "any other health status-related factor determined appropriate by the Secretary [of HHS]." PHSA § 2705(9). Notably, HHS could have—but has not—promulgated any rules regarding association health plan rating. Certain programs of health promotion or disease (referred to as "wellness programs") are an exception to the general prohibition on discrimination based on a health status-related factor. Health reform codified the 2006 HIPAA regulations' nondiscrimination requirements for wellness programs, without significant changes apart from an increase in the maximum permissible reward. The codified rules are effective for plan years beginning on or after January 1, 2014. PHSA §2705(j), as amended by ACA.

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guidance, but does not affect the analysis of whether health insurance coverage belongs in the large or small group market for regulatory purposes, including Federal Community Rating requirements. The OIC fails to mention that the very same CMS bulletin on which it relies expressly clarifies that, other than "for purposes of providing limited exceptions from its guaranteed issue and guaranteed renewability requirements," "[t]he bona fide association concept has no other significance under the PHS Act." *Id.* at 2 n.4 (emphasis added). Again, nothing in the CMS bulletin prohibits rate-setting at the Participating Employer level or points to any law or regulation that does so.

Second, the OIC cites the case of *Fossen v. Blue Cross Blue Shield of Montana, Inc.*, 744 F. Supp. 2d 1096 (D. Mont. 2010). OIC's Motion at 16-17. But *Fossen* does not provide a legal basis for the OIC's position. *Fossen*, decided by a federal district court in Montana, is not binding on this proceeding. Even if it was, it does not offer helpful guidance, as it (i) predated the ACA, (ii) was based in part on an analysis of a Montana state statute prohibiting discriminatory premiums, and (iii) involved a suit filed by the plan members against the carriers, none of which factor in this case. Nor did *Fossen* hold that rates cannot be set at the Participating Employer level with respect to an association under federal law; instead, it merely held that the association in that case could set rates on that basis. *Fossen*, 744 F. Supp. 2d 1096.

Finally, the OIC points to an email it solicited from Doug Pennington of the Center for Consumer Information and Insurance Oversight ("CCIIO") in October 2014.[11] OIC's Motion at 19. The CCIIO has absolutely no jurisdiction over the Filings at issue. Mr. Pennington's personal opinion, offered in equivocal terms such as "it would appear to be inappropriate" and "it would seem inappropriate," without any citation to any legal basis for that position, adds nothing to the legal analysis. *Id.* (emphases added).

[11] The CCIIO is the unit within CMS charged with helping implement many reforms of the ACA, and it oversees the implementation of provisions related to private health insurance. *See* The Center for Consumer Information and Insurance Oversight, http://www.cms.gov/cciio/.

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In sum, the OIC has no legal basis for its position. But even if a nonexistent law did require the AHPs to be treated as the only employer for rate-setting purposes, the OIC's position ignores two critical points: (1) the HIPAA nondiscrimination provisions prohibit only the assessment of different rates for similarly situated individuals "based on any health factor that relates to the individual or a dependent of the individual;" and (2) "a plan may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice." 26 C.F.R. §§ 54.9802-1(c)(1), (d)(1) (emphases added).

Not only does the OIC fail to identify any rating practices that are based on a health factor and that relate to any individual Member (because there are none), it also fails to address the fact that the Participating Employers are permissible "distinct groups of similarly situated individuals . . . based on a bona fide employment-based classification." 26 C.F.R. § 54.9802-1(d)(1). Instead, the OIC brushes over this point, assuming that there must be an additional "employment-based classification" beyond status as an employee of a distinct Participating Employer. But if factors such as "membership in a collective bargaining unit" or "different geographic location" are sufficient to constitute "employment-based classifications," as the OIC suggests,[12] then a Member's status as an employee of a separate Participating Employer, located at that Participating Employer's separate place of business, is an even clearer "employment-based classification."[13] Thus, employees of different Participating Employers need not be treated

[12] 26 C.F.R. § 54.9802-1(d)(1); OIC Motion at 19.

[13] The OIC contends, without any support in the record, that "two identically situated plan participants with the same job classification, collective bargaining unit, geographic location, and hours may pay widely divergent rates for the same benefit package." OIC's Motion at 19. This is demonstrably false. A collective bargaining unit is, by necessity, a unit involving employees from a single Participating Employer. Similarly, job classifications are employer-specific. Because all employees of a Participating Employer are assigned to the same Risk Category, similarly situated employees in the same collective bargaining unit and same job classifications cannot be charged the "widely divergent rates" that the OIC claims. There is no situation where the above could occur with respect to the Plans offered by the AHPs. Second Belur Decl. ¶ 12.

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identically even under the express terms of the HIPAA nondiscrimination provisions. *See id.* Again, and moreover, the OIC never cited HIPAA requirements as a basis for its Disapprovals and thus should not be permitted to introduce this unduly distracting (and unavailing) argument now.

C. The OIC's Policy Arguments Are Inaccurate and Irrelevant

The OIC's Motion is replete with policy arguments intended to garner sympathy for its position and to cloud the legal issues. *See, e.g.,* OIC's Motion at 12-13 and Declaration of Jim C. Keogh in Support of OIC Staff's Motion for Summary Judgment ("Keogh Decl."). Many of the "facts" on which its policy arguments are based are simply not accurate as applied to these three AHPs' demographics and rating practices.[14] For example, the OIC asserts that "for association health plans, enrollees over 50 make up less than 20% of their demographic," which the OIC contends "implies that employers with a significant number of employees over 50 are being priced out of the association health plan market." *Id.* at ¶ 10 and Ex. A, Chart 3. In fact, 35.1% of Members insured through the AHPs are over the age of 50, far exceeding the average of 25% for the small group market. Second Belur Decl. ¶ 5 and Ex. 1. Similarly, the OIC contends that "for association health plans, older enrollees were charged as much as 8 times what the youngest enrollees in a plan were charged." Keogh Decl. ¶ 8. The largest difference in rates for any of the three AHPs, however, is 2.9 to 1. Second Belur Decl. ¶ 8 and Ex. 2. Even more astonishingly, the OIC asserts that "particularly for women in child bearing years, association health plans charge significantly more for women than for men." Keogh Decl. ¶ 11. But the age-banded rates offered to MBA Trust, BIAW Trust and NMTA Trust Participating Employers are not gender-based. Second Belur Decl. ¶ 6. In fact, gender-based rating factors are not used at

[14] The fact issues discussed in this section need not be decided in order to grant MBA Trust, BIAW Trust, NMTA Trust, and Cambia's Motion for Summary Judgment. They are discussed here to further underscore the fatal weakness of OIC's legal position, which the agency unsuccessfully tries to prop up with its misleading policy-based arguments about association health plan rating practices. If the OIC desires to effectuate a policy change, however, it must do so within the confines of existing law. As the law currently stands, there is nothing impermissible about the AHPs' rating practices.

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all in the AHPs' rate structures. *Id.* Thus, there is no difference in the rate paid by a Participating Employer's female employee of childbearing age and a same-aged male employee. *Id.*

In addition, the OIC, through Mr. Keogh's declaration, provides an inapposite comparison of "sample plan rates" among offices of certified public accountants, carpentry contractors, and offices of optometrists. Mr. Keogh does not explain how those comparisons (and his assertion that "rates within AHPs can vary by up to 27% depending on the type of business") might apply to MBA Trust, BIAW Trust, and/or NMTA Trust. These three AHPs are each bona fide association health plans and thus none has Participating Members in disparate industries. Second Belur Decl. ¶ 10. In any event, for MBA Trust, there is only a 12.4% difference between the highest and lowest rate paid by Participating Employers in a sample set of representative sub-industries (sprinkler, plumbing, painting, mechanical, roofing and concrete companies). *Id.* at ¶10 and Ex. 3. For BIAW Trust, there is a 15.5% difference between the highest and lowest rate paid by Participating Employers in a sample set of representative sub-industries (heating and cooling, general contractor, paving, roofing, and landscaping companies). *Id.* at ¶ 10 and Ex. 4. For NMTA Trust, there is only a 6.3% difference between the highest and lowest rate paid by Participating Employers in a sample set of representative sub-industries (yacht charter, marina, boat manufacturer, fishing supplies, propeller manufacturer, and yacht club). *Id.* at ¶10 and Ex. 5.

The OIC's sweeping accusations of disparity in association health plan rating practices seem aimed at evoking sympathy for employees who are allegedly paying too much for health care premiums. Not only does the argument fall flat as a legal matter (given the OIC's inability to identify a legal basis for prohibiting association health plans from rating at the Participating Employer level), it ignores reality. Under the Trust Agreements for the AHPs, Participating Employers are required to pay a minimum of 75% of the premium costs for their employees. Second Belur Decl. ¶ 7. The vast majority of the Participating Employers choose to pay 100% of

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their employees' premium costs. *Id.* Thus, for the vast majority of Members receiving health care coverage through the AHPs, any premium cost variance that might exist is borne 100% by the Participating Employers. *Id.*

As these examples demonstrate, the Plans provided through the AHPs are not the inequitable constructions the OIC tries to depict. More importantly, the rates associated with those Plans do not, as the OIC wrongly suggests, utilize any health factors relating to any individual Member. Neer Decl. ¶¶ 8-10. No amount of policy arguments can obfuscate the simple fact that the OIC's Disapprovals have no legal foundation.

D. The OIC Cannot Walk Away from Its Own Admissions That It Lacks Authority to Review Rates for Association Health Plans

The positions the OIC takes in its Motion are also contrary to its own public statements about the scope of its authority to review association health plan rates. By its own admission, the OIC in fact has no authority to review (and hence disapprove) the AHPs' rates. As Commissioner Kreidler stated to CMS in 2010:

> We do not have authority to review large group rates, other than for disability insurers. We interpret our statutory requirements as treating association health plans as large groups. States where rates do not compare as favorably to Washington's in the individual and small group markets typically do not have rate review authority that matches or exceeds ours. As discussed below, the Commissioner needs additional authority to review rates that includes setting a required, meaningful level of aggregation for reporting issuer administrative costs by plan, and authority to consider overall issuer financial performance as affected by the proposed rate.
>
> . . . .
>
> The OIC currently reviews all rate filings in the individual and small group markets. Those markets represent only a small percentage of the total number of plans and covered lives in Washington State. Consumers in all markets have been ill-served by the limits on the Commissioner's authority to review large group and association health plan market rates in Washington.

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Exhibit 1 to MBA Trust, BIAW Trust, NMTA Trust, and Cambia's Motion for Summary Judgment at 7, 9; *see also id.*, Ex. 2 at Appx. A ("For AHPs, the OIC can require prior approval of both rates and forms only for disability carriers. For all other carriers that write AHP business, the OIC has authority to require filing of rates and forms, but can review only forms, and cannot disapprove either rates or forms.").

More recently, in May 2013, the Commissioner lamented the "lack of written guidance from federal regulators," which he claimed has "made it challenging for regulators like myself to provide definitive guidance [regarding association health plans]." Letter from Mike Kreidler, State Ins. Comm'r, to Washington Legislators (May 30, 2013) (attached as **Exhibit 2**). After summarizing the limited federal guidance his agency has received, the Commissioner proceeded to separate association health plans "into two groups." In describing the first group (the "true employer" health plans, which MBA Trust, BIAW Trust and NMTA Trust indisputably are), the Commissioner correctly noted that small group market reforms (such as community rating requirements) "do not need to apply" to these plans:

> **True "employers" under the Employee Retirement Income Security Act.** These types of plans continue to be issued as large group, so long as they comply with federal rules. We have worked with a number of Association Health Plans over the past 18 months, and there are several—including the Master Builders Association of King and Snohomish Counties—whose members have taken the appropriate steps to meet this federal test. Beyond some changes to plan design and membership, they can maintain current large group status, and issuers do not need to apply the small group market reforms to these plans.

Id. at 2 (emphasis added).

The OIC's Disapprovals and its position in this dispute are a complete about-face from these public statements. Yet no law or rule has actually changed or been adopted that would justify OIC reversing its position and effectively limiting health care options for tens of thousands of Washington citizens. As such, the OIC's Disapprovals are the epitome of arbitrary and capricious decision-making. *See, e.g., Children's Hosp. & Med. Ctr. v. Wash. State Dep't of*

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Health, 95 Wn. App. 858, 872, 975 P.2d 567 (1999) (holding that agency's decision was arbitrary and capricious when it was not based on any specialized knowledge and expertise, but on an erroneous interpretation of statutes and agency regulations as applied to facts).

E. The OIC Lacks the Authority to Impose Its Proposed Remedy

The OIC completely fails to address the argument that it lacks authority to impose its proposed remedy. As discussed in MBA Trust, BIAW Trust, NMTA Trust and Cambia's Motion for Summary Judgement, the OIC's Disapprovals of the 2014 Filings cannot support a mandate that the AHPs transition Members off of their 2015 Plans, which the OIC has not rejected.

V. CONCLUSION

For the reasons set forth above, as well as the reasons articulated in MBA Trust, BIAW Trust, NMTA Trust and Cambia's Motion for Summary Judgment, MBA Trust, BIAW Trust, NMTA Trust and Cambia respectfully request that the OIC's Motion be denied, that the Disapprovals be overturned, and that the 2014 rate and form Filings be approved by the OIC.

Dated this 26th day of May, 2015.

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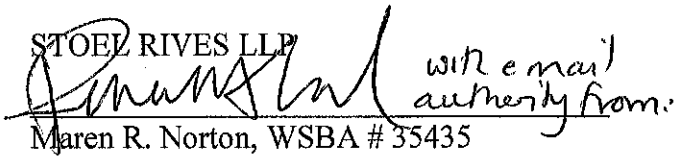

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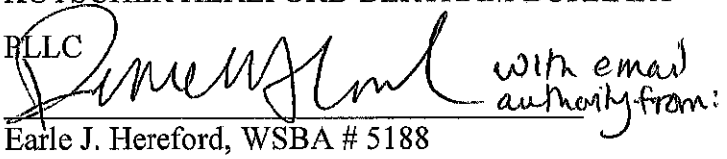

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CERTIFICATE OF SERVICE

I, Kay M. Sagawinia, certify under penalty of perjury under the laws of the State of Washington that, on May 26, 2015, I caused the foregoing document to be served on the persons listed below in the manner shown:

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

Via email and U.S. Mail

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

Via email and U.S. Mail

Dated this 26th day of May, 2015, at Seattle, Washington.

Kay M. Sagawinia

Kay M. Sagawinia, Legal Secretary
PERKINS COIE LLP

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EXHIBIT 1

SUPERIOR COURT OF WASHINGTON FOR SPOKANE COUNTY	
ASSOCIATED INDUSTRIES OF THE INLAND NORTHWEST, a Washington Non-Profit Corporation; THE ASSOCIATION OF WASHINGTON BUSINESSES, a Washington Corporation, Plaintiffs, vs. STATE OF WASHINGTON OFFICE OF THE INSURANCE COMMISSIONER; MIKE KREIDLER, Washington State Insurance Commissioner, Defendants.	NO. 2007-02-00592-1 MEMORANDUM DECISION

This matter came before the court for oral argument on June 8, 2007, on the Plaintiffs' Motion for Summary Judgment and the Defendants' Cross-Motion for Summary Judgment. Both sides are asking the court for a ruling regarding the validity of Technical Assistance Advisory T06-07 (TAA 06-07) issued by the Office of the Insurance Commissioner (OIC) on December 15, 2006.

Both sides agree that this court has jurisdiction to decide the issue either under the Uniform Declaratory Judgment Act, RCW 7.24, or the Administrative Procedure Act, RCW

34.05. Both sides also agree that summary judgment is the proper procedure to determine the validity of TAA 06-07.

Prior to oral argument the Plaintiffs' Motion to Strike a Thurston County Superior Court decision was granted as it constituted an "unpublished" decision.

FACTS

The facts are not in dispute. Plaintiffs are independent business associations which serve employer members. They make health insurance plans available to their small employer members. They are not insurance companies but the health plans they offer to their members are subject to OIC approval.

In 1995 the legislature enacted RCW 48.44.023(3) and RCW 48.44.024(2). RCW 48.44.024(2) is a statutory exception to RCW 48.44.023(3). Since that time Plaintiffs have offered insurance plans to their small employer members where the premium for individual employer members has been calculated using "experience rating". That is, the premium takes into consideration each employer's claims experience and aggregated health history. This method is an exception to the community rating pooling requirements of RCW 48.44.023(3).

On December 15, 2006, the Office of the Insurance Commissioner issued TAA 06-07. This advisory indicated it was the OIC position that "(A)ny rating based on the health information of an individual member employee was prohibited."

STATUTES/TAA 06-07

RCW 48.44.023(3):

(3) Premium rates for health benefit plans for small employers a defined in this section shall be subject to the following provisions:

> (a) The contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rated for:

(i) Geographic area;
(ii) Family size;
(iii) Age; and
(iv) Wellness activities.

. . . .

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage.

RCW 48.44.024(2):

(2) Employers purchasing health plans provided through associations . . . are not small employers and the plans are not subject to RCW 48.44.023(3).

Technical Assistance Advisory T 06-07:

The Office of Insurance Commissioner (OIC) is issuing **Technical Assistance Advisory (TAA) T – 06-07** to offer guidance on the nondiscrimination requirements that health insurance carriers must follow when rating member employers of association health plans (AHPs). The TAA applies to all AHP contracts issued or renewed on or after January 1, 2008.

Association health plans provide an important alternative for obtaining employer sponsored health insurance. Some plans, however, unlawfully discriminate against their members based on their health. Approximately 7 percent of association plans are in violation of the law by using health information t set rates for individual member employers. Rates must be based on the health of the *entire association group.* Any rating based on the health information of an individual member employer is prohibited. (emphasis in original)

ISSUES

1. Did the issuance of TA 06-07 violate APA rulemaking requirements?

2. Did the OIC violate the Washington State Constitution when it issued TA 06-06?

1. Did the issuance of TA 06-07 violate APA Rulemaking Requirements?

TA 06-07 is not a rule. In oral argument defense counsel conceded that it could not be enforced as a rule. TA 06-07 was issued under RCW 34.05.230(1). The statute permits a state agency to "advise the public of current opinions, approaches and likely courses of action" the agency may take in the future. It is advisory only. It is not subject to the rulemaking requirements of the APA.

2. Did the OIC violate the Washington State Constitution when it issued TA 06-06?

The basis for this claim by the Plaintiffs is their view that the OIC has violated the separation of powers doctrine by promulgating TA 06-07. In substance TA 06-07 treats the entire association as the group. Interestingly, both sides believe the language of RCW 48.44.023(3) and 48.44.024(2) is unambiguous and supports their diametrically opposing views.

The Plaintiffs approach the issue by emphasizing the fact that the legislature passed a specific exemption to RCW 48.44.023(3). From the Plaintiffs' perspective, TA 06-07, in effect, eviscerates the exception and now makes their plans subject to RCW 48.44.023(3). In their view this violates the separation of powers because the OIC, as an executive agency, does not have the power to enact legislation. Also, this particular legislation does not have a grant of authority from the legislature to the agency to make changes.

The Defendants argue that their approach is supported by Federal law which defines employer as "group or association of employers". CFR §144.103. How "group" is defined is key to Defendants argument. Use of individual employer's rating as the "group" is discriminatory and, arguably, a violation of Federal law. In addition, RCW 48.44.024, while providing an exemption, does not address how the association plan should be rated.

Defendants suggest that if there was no exemption the small employers would be in the small group rating pool, which is subject to community rating, instead of being pooled with their association(s). Thus under the exemption the rate calculation would be based upon the association's experience.

Both sides have asked the court to decide which interpretation of the statutes is correct. What information I have on legislative intent as well as the statutes themselves indicates that the legislature intended to exempt plaintiffs from RCW 48.44.023(3). The plaintiffs have been

operating under that understanding for over 12 years and have "experience rated" employer members. The OIC did not officially disagree with plaintiff's interpretation until the promulgation of TA 06-07 in December 2006.

This court's view is that the plaintiffs had a right to proceed on the statutory exemption. Their interpretation of that exemption remained unchallenged for over a decade. While OIC can issue technical advisories, they are not rules and are not enforceable. TA 06-07 amounts to a major policy shift from the plaintiff's perspective. Policy is made by the legislature. The legislature should make the decision. More than a decade has past since the legislation was enacted, if the legislature believes it is time for a change they will act.

The Plaintiff's Motion For Summary Judgment is Granted.

Dated: August 27, 2007

KATHLEEN M. O'CONNOR
SUPERIOR COURT JUDGE

EXHIBIT 2

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

Phone: (360) 725-7000

OFFICE OF
INSURANCE COMMISSIONER

May 30, 2013

The Honorable Randi Becker, Chair
Senate Health Care Committee
PO Box 40402
Olympia, WA 98504-0402

The Honorable Karen Keiser, Ranking Minority Member
Senate Health Care Committee
PO Box 40433
Olympia, WA 98504-0433

The Honorable Eileen Cody, Chair
House Health Care & Wellness Committee
PO Box 40600
Olympia, WA 98504-0600

The Honorable Joe Schmick, Ranking Minority Member
House Health Care & Wellness Committee
PO Box 40600
Olympia, WA 98504-0600

RE: The Future of Association Health Plans under the Affordable Care Act

Dear Legislators:

Since the passage of the federal Affordable Care Act in 2010, many questions have arisen about the future of Association Health Plans (AHPs), which comprise an unusually large part of the health insurance market in Washington state. As you know, efforts have been made to address these issues.

As I'm sure you can appreciate, the complexity of the Affordable Care Act, constant changes to federal implementation rules, and a lack of written guidance from federal regulators have made it challenging for regulators like myself to provide definitive guidance. We understand the concerns that have been expressed and appreciate your patience in awaiting answers that we, too, are awaiting.

As a general matter, the Affordable Care Act's market reforms apply based on the market in which a plan is offered (individual, small group or large group). Here in Washington state, because of state law that exempts plans purchased through associations from small group rating requirements, it was unclear which market rules applied to these plans.

Knowing well our state's unique statutory framework for AHPs that cover small employers, we sent a letter to the federal government as early as October 11, 2010 asking for direction, and did not receive a written response from the Center for Consumer Information and Insurance Oversight (CCIIO) until May 13, 2013 as to the question of "grandfathering" AHPs, i.e. allowing some to continue to function as they did prior to passage of the ACA. In between when we sent the letter and when we received the written response, CCIIO and the U.S. Department of Labor issued guidance on AHPs more generally.[1]

[1]For example, see http://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf

Based on federal guidance, we can break Association Health Plans into two groups:

1) True "employers" under the Employee Retirement Income Security Act.[2] These types of plans can continue to be issued as large group, so long as they comply with federal rules. We have worked with a number of Association Health Plans over the past 18 months, and there are several – including the Master Builders Association of King and Snohomish Counties – whose members have taken the appropriate steps to meet this federal test. Beyond some changes to plan design and membership, they can maintain current large group status, and issuers do not need to apply the small group market reforms to these plans.

2) Non-employer AHP or member-governed groups, which can be broken into two sub-categories:

   a) "Grandfathered" small employers whose coverage existed on or before March 23, 2010 and who did not change their plans in a way that would trigger loss of grandfathered status may continue their benefits under their current plan as long as they don't lose their grandfathered status and the insurance carrier maintains continuity of coverage. Federal law defines how grandfathered status is lost. Insurance carriers may need to modify the rating methodology applicable to these plans.

   b) "Non-grandfathered" employers or individuals who joined an Association Health Plan on or after March 23, 2010, or whose plan lost its grandfathered status, will need to change to ACA-compliant products at their first plan renewal date on or after January 1, 2014, and be rated as part of the issuing insurance carrier's individual and small group pools. AHPs cannot move their master contract date or enroll new members in existing products after January 1, 2014.

We are working to accommodate individual and small employer choice as much as possible under the law. We will continue to meet – as we have along the way – with carriers whom we regulate and their Association Health Plan clients to present transition information. For clarity, and to ensure a level playing field, we will also initiate rulemaking on transition guidelines for insurance carriers.

Please feel free to contact me if you have any questions, and thank you for your interest in this matter.

Sincerely,

Mike Kreidler
Insurance Commissioner

cc: Bob Crittenden, M.D., Governor's Policy Office

[2] See "What Is an 'Employer'?" discussion at http://www.dol.gov/ebsa/Publications/mewas.html.