The Honorable Robert S. Lasnik

**UNITED STATES DISTRICT COURT**
**WESTERN DISTRICT OF WASHINGTON**
**AT SEATTLE**

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| BUSINESS HEALTH TRUST, in its fiduciary capacity for an association or member-governed group plans; and THE ASSOCIATION OR MEMBER GROUP-GOVERNED PLANS,<br><br>Plaintiffs,<br><br>v.<br><br>MIKE KREIDLER, in his capacity as WASHINGTON STATE INSURANCE COMMISSIONER,<br><br>Defendant. | NO. 2:14-CV-01918<br><br>DECLARATION OF JIM C. KEOGH IN SUPPORT OF THE WASHINGTON STATE INSURANCE COMMISSIONER'S OPPOSITION TO PLAINTIFFS' 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 25, 2013.



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2. Attached as Exhibit A is a copy of the Concise Explanatory Statement for the OIC's Market Transition Rules.

SIGNED this 1st day of June, 2015 at Tumwater, Washington.

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



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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.

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| 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.

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."
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> 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:**

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| **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 |

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| insurance coverage takes the position that it is a grandfathered health plan."<br>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.<br><br>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:**

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| **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).<br><br>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.<br><br>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.<br><br>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 |

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| 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 |

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| | date. |

**Comments regarding WAC 284-170-955**

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| **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:<br>(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. |

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| 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.~~<br><br>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 |

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| 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**

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| **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."<br><br>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 |

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| 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]<br>[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.<br>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 T06-07 (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:<br>(i) Health status<br>(ii) Medical condition, including both physical and mental illnesses<br>(iii) Claims experience<br>(iv) Receipt of health care<br>(v) Medical history<br>(vi) Genetic information<br>(vii) Evidence of insurability, including conditions arising out of acts of domestic violence<br>(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. |

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| **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.<br><br>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. |

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| 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.<br>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:<br>"An issuer must not use data or information relating to health status from a specific employer to establish rates for that group purchaser."<br>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. |

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| Suggested revision:<br><br>(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.~~<br>(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.<br><br>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.<br><br>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.<br><br>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 |

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| | 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.