The Honorable Robert S. Lasnik

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

BUSINESS HEALTH TRUST, in its fiduciary capacity for an association or member-governed group plans; and THE ASSOCIATION OR MEMBER GROUP-GOVERNED PLANS,

Plaintiffs,

v.

MIKE KREIDLER, in his capacity as WASHINGTON STATE INSURANCE COMMISSIONER,

Defendant.

NO. 2:14-CV-01918

DEFENDANT WASHINGTON STATE INSURANCE COMMISSIONER'S RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I. INTRODUCTION

The Patient Protection and Affordable Care Act (Affordable Care Act) limits the sale of large group health plans to those entities that satisfy the definition of "employer" incorporated into the Affordable Care Act from the Employee Retirement Income Security Act (ERISA). In Washington State, the Insurance Commissioner is tasked with ensuring that plans sold by authorized carriers, like Premera Blue Cross (Premera), comply with the law. After reviewing nearly identical, cursory, and conclusory statements submitted by Premera in each of 13 different health plan filings, the Commissioner determined that he had not received sufficient information to approve these plans. The Commissioner could not agree with Premera's determination that Premera's health plans were issued to the 13 associations that satisfy the

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definition of "employer" found in state law and the Affordable Care Act. Despite repeated requests to Premera for specific, objective proof related to the formation, membership, control, and activities of the 13 associations, no such information was forthcoming. In the absensce of concrete, factual responses to the Commissioner's questions, The Commissioner concluded that it appeared that the Seattle Metropolitan Chamber of Commerce (the Chamber), ***not*** the members of the 13 associations, who are not even parties to this suit. Therefore, the Commissioner, on February 17, 2015, disapproved the health plan filings submitted by Premera.

Plaintiffs, which include the Chamber's third party insurance administrator, Business Health Trust (BHT), but the 13 associations, now rely on the same cursory and conclusory statements already rejected by the Insurance Commissioner, to claim that they have demonstrated that each of the 13 associations is in fact, an "employer". However, reviewing the unsubstantiated statements submitted first to the Insurance Commissioner, and now to this court, along side the filings submitted to the Commissioner through the System for Electronic Rate and Form Filing (SERFF), it is more reasonable to conclude that the 13 associations were created at the end of 2013, solely for the purposes of securing health plans that do not otherwise comply with the Affordable Care Act in 2014. Further, the materials submitted to the Insurance Commissioner create a material question of fact as to whether the Chamber or the 13 associations have actually conducted any of the "lobbying, networking, educational, and other support activities" claimed in their conclusory statements to this court, and to the Commissioner.

Plaintiffs attempt to ignore the glaring questions of fact created by Premera's filings, by simply reiterating the same conclusory statements. These unsupported allegations, however, do not provide this court with the objective evidence necessary to determine that each of the 13 associations is in fact an employer. Because of the objective evidence available to the

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Commissioner and the Court indicate that the 13 associations are not "employers", Plaintiffs have failed to demonstrate that they are entitled to summary judgment.

Further, ERISA does not provide Plaintiffs with standing, or this Court with jurisdiction, to challenge the Commissioner's regulatory decisions. For these reasons, Plaintiffs' suit should be dismissed.

II. FACTS

A. State Regulation Of Insurance Plans

The regulation of insurance is reserved to the states. 15 U.S.C. § 1012 ("The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business."). In Washington State, that responsibility is delegated to the Insurance Commissioner. Wash. Rev. Code 48.02.060. His authority includes the authority to review and disapprove rate and form filings submitted by health plan issuers, such as Premera. Wash. Rev. Code 48.44.020[1]; Wash. Admin. Code 284-43-920. The Commissioner also has authority to disapprove rate and form filings that do not satisfy the requirements of the Insurance Code (Title 48 Wash. Rev. Code), or applicable federal laws, such as the Patient Protection and Affordable Care Act (Affordable Care Act). Wash. Rev. Code 48.44.020(2); Wash. Admin. Code 284-43-125.

The Affordable Care Act reserved to state insurance regulators their already existing authority to review health plan rate and form filings. The Affordable Care Act also vested state insurance regulators with the responsibility of ensuring that health plans satisfy the requirements of the act. 42 U.S.C.A. § 300gg-22 ("each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part with respect to such issuers.");

[1] Wash. Rev. Code 48.44.020 is specific to health care service contractors. Other sections of the Washington State Insurance Code vest the Commissioner with the same authority to review health plans filings submitted by other types of authorized health plan issuers. However, because the filings in this case were submitted by Premera Blue Cross, a health care service contractor, this brief will primarily cite only to the provisions applicable to health care service contractors.

45 Code Fed. Reg. § 150.201 ("Except as provided in subpart C of this part, each State enforces PHS Act requirements with respect to health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State.") Nothing in the Affordable Care Act abrogated the Commissioner's concurrent jurisdiction with the U.S. Department of Labor to regulate multiple employer welfare arrangements (MEWAs) (formerly refered to as Multiple Employer Trusts, or "METs") including those that claim to be ERISA-covered employee welfare benefit plans, such as that provided by the Plaintiff to the associations at issue in this case. *See* Employee Benefits Security Administration, U.S. Department of Labor *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation*, 5 (2013) ("As a result of the 1983 MEWA amendments to ERISA . . . States are now free to regulate MEWAs whether or not the MEWA may also be an ERISA-covered employee welfare benefit plan.").

B. Association Health Plans

Since 1996, Washington State law has required that small group plans be community rated and provided an exemption from the community rating requirement for employers purchasing through associations. Wash. Rev. Code 48.44.024(2) and (3). However, the Affordable Care Act, created federal community rating, effective January 1, 2014. 42 U.S.C.A. § 300gg (a)(1)(A). This pre-empted our state community rating scheme, and abolished our specific exemption. Under the Affordable Care Act, health plans and markets are specifically defined. 42 U.S.C.A. § 300gg-91. The fact that an employer choses to purchase through an association is irrelevant for purposes of the federal market definitions. 42 U.S.C.A. § 300gg-91, see also 45 CFR 154.102 (2014), Rate Increase Disclosure and Review: Definitions of "Individual Market" and "Small Group Market", 76 Fed. Reg. 54969, 54977 (September 6, 2011).

This was a significant shift for associations in Washington arranging large group insurance for participating small-group employers. Now, the term "group health plan" means

"an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(1)]) to the extent that the plan provides medical care. . . " In order to constitute an employee welfare benefit plan under ERISA, the plan must be "established or maintained by an employer or by an employee organization." 29 U.S.C.A. § 1002 (1). The term "employer" is further defined to mean "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." 29 USCS § 1002 (5). The Affordable Care Act further divides the group market into large and small groups. The large group market is defined as the market under which individuals obtain health insurance coverage through a plan maintained by a large employer. 42 USCS §300gg-91 (e)(3). A large employer is one with at least 101 employees. 42 U.S.C.A §300gg-91 (e)(2).

As a result, after the effective date of the federal community rating law (42 U.S.C.A §300gg), if an association does not qualify as a large "employer", then the health plans that an issuer may only sell to the employer's members of that association are dictated by the size of that particular employer. Dkt. #16-1, ¶2; *see* 45 CFR 154.102 (2014) ("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."); Rate Increase Disclosure and Review: Definitions of "Individual Market" and "Small Group Market", 76 Fed. Reg. 54969, 54971 (September 6, 2011). Therefore, if an association does not constitute a large employer, then the only plans a health plan issuer can sell to the small employer members of the association are small employer plans that contain all of the protections guaranteed by the Affordable Care Act.

Although these definitions would not directly impact health plan issuers in Washington State until 2014, at least as early as 2012, following the adoption of the final rules by HHS, the Commissioner and his staff began working with issuers and associations in the State of

Washington to help them understand the changing landscape of the large group market in light of the Affordable Care Act's more limited definition of employer. Dkt. #16-2 ¶3. That outreach included presentations detailing the federal requirements for associations under the Affordable Care Act. Because the Affordable Care Act incorporates the definition of employer from ERISA, the guidance issued by the U.S. Department of Labor addressing what constitutes an "employer" has been heavily relied on by the Commissioner. Dkt. #16-1 ¶3.

The Commissioner also provided guidance to associations on two threshold requirements for demonstrating "employer" status under the Affordable Care Act: 1) employer member control of health care; and 2) industry alignment necessary to support a sufficient nexus of interests. Dkt. #16-2 ¶4.

The Commissioner's staff also worked with health plan issuers to provide clear rules and filing instructions. Dkt. #16-2 ¶4. In 2013, the Commissioner adopted rules addressing issuance of large group health plans to associations:

> (1) An issuer must not offer or issue a plan to individuals or small groups through an association or member-governed group as a large group plan unless the association or member-governed group to whom the plan is issued constitutes an employer under 29 U.S.C. § 1002(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et. seq.), as amended, and the number of eligible employees is more than fifty.
> (2) An issuer must make a good faith effort to ensure that any association or member-governed group to whom it issues a large group plan meets the requirements of subsection (1) of this section prior to submitting its form and rate filings to the commissioner, and prior to issuing such coverage. An issuer must maintain the documentation supporting the determination and provide it to the commissioner upon request. An issuer may reasonably rely upon an opinion from the U.S. Department of Labor as reasonable proof that the requirements of 29 U.S.C. 1002(5) are met by the association or member-governed group.

Wash. Admin. Code 284-170-958(1-2). In adopting these rules, the Commissioner indicated that, "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." Declaration of Jim Keogh in Support of the Washington State Insurance Commissioner's Opposition to Plaintiff's Motion for Summary Judgment (Keogh

Decl.), Exhibit A, Market Transition Rules, Concise Explanatory Statement: R. 2013-13, 5 (December 11, 2013). The Commissioner's filing instructions to all issuers informed them that the documentation they relied on in making good faith determination that a group is an employer under Wash. Admin. Code 284-170-958(2) should be filed with the issuer's rate and form filing. Dkt. # 16-2 ¶5; Dkt. #23-1, Exhibit B, Washington State SERFF Health and Disability Rate Filing General Instructions (SERFF Filing Instructions) 6-17. These filing instructions note that the documentation submitted in the Supporting Documentation tab as "Evidence as an Employer" must include "at a minimum" either a DOL opinion or an attorney opinion. Dkt. #23-1 (SERFF Filing Instructions) 13, sec. III.I.5.

The Commissioner's rules were directed at health plan issuers, not employers who will purchase plans from the insurance carriers he regulates. Nor do his rules attempt to impose any obligation on the programs or trusts established by groups of employers for the purpose of purchasing insurance. Rather, the Commissioner's rules and filing instructions are directed exclusively at Washington health insurance carriers, and the insurance products they are required by state law to file with the insurance commissioner, for his review.

C. The Commissioner and the Seattle Chamber of Commerce

The Commissioner and his staff had numerous conversations with the Chamber beginning in 2012. Dkt. #16-1 ¶5; Dkt. 31-1, Exhibit C, Letter dated October 28, 2014, from Commissioner Kreidler to Maud Daudon, President and CEO of the Seattle Metropolitan Chamber of Commerce (Commissioner's Letter) 21. Of particular concern to the Commissioner's staff was a DOL advisory opinion issued in 2008, finding that the Bend Chamber of Commerce did not satisfy the definition of "employer" under ERISA, because the primary nexus of the members (to develop private businesses in a particular geographic area) would encompass any employer in that area. U.S. Department of Labor Advisory Opinion 2008-07A. Based on this DOL decision, the Chamber described to the Commissioner's staff its intention to file multiple plans for multiple trusts, aligned by industry. Dkt. #16-1 ¶6.

DOL, gave the distinct impression that this multiple trust structure would not likely satisfy the definition of "employer". Dkt. #29-3, Exhibit A, 6-9. After conversations with the Chamber, and DOL, the Commissioner's staff expressed their concerns that the multiple trust arrangement the Chamber was pursuing would not satisfy the requirements of ERISA. Dkt. #29-3 ¶6. It was not until Premera filed its 13 association health plans, that the Commissioner became aware that the Chamber had persisted in their multiple trust arrangement, despite DOL's lack of approval. Dkt. 29-3, ¶12.

D. The Commissioner's Review Of Premera's Association Rate And Form Filing

On February 12, 2014, Premera uploaded into the System for Electronic Rate and Form Filing (SERFF), 13 large group health plan filings, and indicated that each plan would be sold to one of the 13 groups identified[2] as an "association" in the Complaint. Dkt. #29-2 ¶6. Because health plans sold to large groups are negotiated, issuers generally do not have to file their rates before they begin to sell their product. Dkt. #29-2 ¶7. However, the Commissioner still has the authority to review large group health plan filings, and to reject or "disapprove" such filings in the event they do not comply with the law. Dkt. #29-2 ¶8; RCW 48.44.020(2). All issuers must submit their health plans for review in SERFF. Dkt. #29-2 ¶9. All questions and concerns concerning the rate and form filing submitted by an issuer are communicated to the issuers as "objections" in SERFF. Dkt. #29-2 ¶9. All responses to those objections must be made through the SERFF System. Dkt. #29-2 ¶9. The SERFF review process includes threshold questions (such as the appropriate market for the health plan that has been submitted), a compliance review of the forms that have been filed, and a technical actuarial review of the rating methodology submitted by the issuer. Dkt. #29-2 ¶10.

When the Commissioner began his review of Premera's 13 health plan filings, he identified several serious concerns to Premera. First, the Commissioner noted that the documents submitted by Premera were often substantially similar, sometimes identically

[2] Although the 13 associations are identified in the Complaint, they are not listed as Plaintiffs. Dkt. #1 2.

worded, and generally signed by the Chamber President and CEO, Maud Daudon. Nollette Declaration in Support of the Washington State Insurance Commissioner's Opposition to Plaintiff's Motion for Summary Judgment (Nollette Decl.), Exhibit A 56, 110-37; Exhibit B 55, 108-137; Exhibit C 55, 108-139; Exhibit D 55, 109-136; Exhibit E 55, 109-138; Exhibit F 55, 109-137; Exhibit G 55,109-137; Exhibit H 57, 99-127;Exhibit I 55, 108-136, Exhibit J 55, 109-137; Exhibit K 55, 109-138; Exhibit L 55, 107-136, Exhibit M 54, 107-137. Second, while the trust documents facially demonstrated control of the trusts by the members of the sponsoring associations, the documentation lacked sufficient factual detail. Nollette Decl., Exhibit A 110, 136; Exhibit B 108, 136; Exhibit C 108; 138; Exhibit D 109, 135; Exhibit E 109, 137; Exhibit F 109, 136; Exhibit G 109, 136; Exhibit H 99, 126; Exhibit I 108, 135; Exhibit J 109, 36; Exhibit K 109, 137; Exhibit L 107, 135; Exhibit M 107, 136. To address these shortcomings, in April 2014, the Commissioner's staff requested that Premera provide:

> additional detail including how association members were/are solicited; who is entitled to participate and who actually participates in the association; the process by which it was formed (including whether it is a sub-trust of a larger association, the history of the larger association, and the history of the sub-trust itself); what, if any, were the pre-existing relationships of its members (including a description of what other sub-trusts exist within the larger association, and a description of activities delegated to the sub-trust or retained to the association); and what industry relationship exists between employer members apart from participating in the same or similar industry.

Nollette Decl., Exhibit A 56; Exhibit B 55; Exhibit C 55; Exhibit D 55; Exhibit E 55; Exhibit F 55; Exhibit G 55; Exhibit H 57; Exhibit I 55; Exhibit J 55; Exhibit K 55; Exhibit L 55; Exhibit M 54.

Unfortunately, the responses submitted by Premera again contained conclusory statements that largely ignored the specific requests the Commissioner made. Dkt. # 29-2 ¶13, Nollette Decl., Exhibit A 138-140; Exhibit B 138-140; Exhibit C 138-140; Exhibit D 137-139; Exhibit E 138-140; Exhibit F 139-141; Exhibit G 138-140; Exhibit H 128-130; Exhibit I 137-139; Exhibit J 138-140; Exhibit K 139-140; Exhibit L 137-139; Exhibit M 138-140. The pamphlets and documents submitted for each health plan filing in no way indicate how the

respective associations were involved in the events. Nollette Decl., Exhibit A 141-158; Exhibit B 141-167; Exhibit C 141-192; Exhibit D 140-168; Exhibit E 141-157; Exhibit F 142-164; Exhibit G 141-154; Exhibit H 131-148; Exhibit I 140-148; Exhibit J 141-149; Exhibit K 141-182; Exhibit L 140-178; Exhibit M 141-164. By and large, the only entity related to BHT and identified in the materials submitted, was the Chamber. *Id*. In September 2014, the Commissioner's staff again requested the following information from Premera:

> How members are/were solicited, now and prior to January 2014;
> Who actually participated/s, now and prior to January 2014;
> The membership and activities of the Washington Trade Conference, as compared with the membership and activities of the Group, demonstrating the origins of the Group.
> Documentation of the described meetings and trainings (now and prior to January 2014) including but not limited to attendance lists, minutes, curriculum, agenda, trainers and sponsors;
> Detailed explanation and supporting documentation of the organized activities to support the mission of the Group, including
> economic activities, business promotion, networking and business development, public affairs and business advocacy.
> The process by which the Group was formed, including the principal advisors and drafters of the documents;
> The pre-existing relationships between the employer members, Maud Daudon, Business Health Trust, and Wells Fargo Ins. Services;
> Identification of Group members who participate/d in the control, direction and selection of the offered health plans, including names,
> meeting dates and agendas, and specific activities.

Dkt. # 29-2 ¶12, Nollette Decl., Exhibit A 53; Exhibit B 52; Exhibit C 52; Exhibit D 52; Exhibit E 52; Exhibit F 52; Exhibit G 52; Exhibit H 52; Exhibit I 52; Exhibit J 52; Exhibit K 52; Exhibit L 52; Exhibit M 52. Unfortunately, Premera provided conclusory statements rather than specific documentation. Dkt. # 29-2 ¶13. For each of the 13 health plans submitted by Premera, there are roughly 150 to 200 pages of documents chronicling the Commissioner's repeated requests for information, and the incomplete responses he received. Dkt. # 29-2 ¶13.

Plaintiffs filed this suit on December 17, 2014. On that same date, plaintiffs requested an administrative hearing before the Commissioner, concerning the very filings at issue in this matter. Dkt. #16-1 ¶10. Plaintiffs' initial administrative hearing demand was dismissed on

February 17, 2015, for lack of jurisdiction, due to Plaintiffs' failure to allege a "threatened act" by the Commissioner. Because neither Plaintiffs' motions for a Temporary Restraining Order or Preliminary Injunction were granted in this matter, on February 17, 2015, the Commissioner disapproved the 13 health plan filings on two grounds: 1) the documentation Premera submitted to date fails to demonstrate that the 13 associations are true associations as required under the Affordable Care Act; and 2) Premera has failed to explain the rating factors used by Premera in charging different premiums to different employer members of the alleged associations. Dkt. # 29-2 ¶17. At this time, no one remains enrolled in the 2014 plans.

III. STANDARD OF REVIEW

Summary Judgment is limited to those instances where "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." FRCP 56. The moving party bears the burden of showing the absence of a genuine issue as to any material fact. *Adickes v. S. H. Kress & Co.*, 398 U.S. 144, 157, 90 S. Ct. 1598, 1608, 26 L. Ed. 2d 142 (1970). For purposes of summary judgment, the material submitted by the Plaintiff must be viewed in the light most favorable to the opposing party. *Id.* Further, where the moving party has the burden of showing the absence of a genuine issue as to any material fact, "unexplained gaps" or a failure to address known vulnerabilities concerning material facts in the moving party's case, precludes summary judgment. *Adickes*, 398 U.S. at 157.

IV. ARGUMENT

Here, as a matter of law, Plaintiffs lack standing, and this court lacks jurisdiction, to challenge the Commissioner's regulatory review of Premera's health plan filings under ERISA. Therefore, Plaintiff's ERISA Complaint (Dkt. #1) should be dismissed.

In addition, despite the Commissioner's repeated requests for concrete factual details in the health plan filings that prompted this suit, Plaintiffs' motion, like its previous motions, and like Premera's submissions to the Commissioner, relies on conclusory statements, that lack

sufficient factual detail to demonstrate that each of the 13 associations satisfy the fact specific test for what constitutes an employer. In addition, the materials provided to the Commissioner, and submitted to this Court, when taken in the light most favorable to the Commissioner, present a genuine issue of material fact, defeating summary judgment.

A. ERISA Does Not Give Plaintiff's Standing To Challenge The Commissioner's Regulatory Review Of A Health Plan Issuer's Health Plan Filing.

The sole cause of action cited by Plaintiffs in their complaint is ERISA, particularly 29 U.S.C.A. § 1132(a)(1) and (3). Unfortunately, neither of these provisions provide Plaintiffs standing to challenge of the Commissioner's decision. ERISA provides, in pertinent part:

> A civil action may be brought--
> (1) by a participant or beneficiary--
> (A) for the relief provided for in subsection (c) of this section, or
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
> . . .
> (3) by a participant, beneficiary, or fiduciary (A) to *enjoin* any *act or practice* which *violates any provision of this subchapter* or the *terms of the plan*, or (B) to obtain other appropriate *equitable* relief (i) to *redress such violations* or (ii) to *enforce any provisions of this subchapter* or the terms of the plan;

29 U.S.C.A. § 1132(a) (emphasis added). There are no "participants or beneficiaries" named as plaintiffs in this matter. Rather the Plaintiffs consist of BHT and "The Association or Member Group-Governed Plans or 'Health Benefit Trusts'." ERISA Complaint, Dkt. #1, at 2 ¶2. Plaintiffs have previously attempted to argue that the Trustees of BHT can bring suit as participants in one of the 13 BHT trusts. Dkt. #22 5, nt. 1. However, neither the trustees, nor any other plan participant, has been named as a party to this suit. Dkt. #1 at 2. The Complaint contends that under 29 U.S.C.A. § 1132(d)(1), "such plans have standing to sue." *Id.* However, 29 U.S.C.A. § 1132(a)(1) does not provide jurisdiction over claims brought by the plans.

BHT asserts that it is a fiduciary, and that under 29 U.S.C.A. § 1132, it thus has standing to sue. However, the courts have narrowly read the jurisdiction granted under 29 U.S.C.A. § 1132(a)(3). In the Ninth Circuit, the court has noted:

> A declaratory judgment may be said to "enforce" ERISA or the terms of an ERISA plan where it seeks to establish the primacy of an ERISA obligation over some independent, potentially conflicting federal or state law duty. Thus in *Franchise Tax Board*, the Court stated that section 502(a)(3)(B) authorized "a declaratory judgment action in federal court to determine whether the plan's trustees may comply with a state levy on funds held in trust." 463 U.S. at 27, 103 S.Ct. at 2855; see also *United Food & Commercial Workers Trust v. Pacyga*, 801 F.2d 1157 (9th Cir.1986) (jurisdiction assumed without discussion; declaration sought by fiduciary that state anti-subrogation law did not apply to ERISA insurance plan specifically calling for subrogation in some circumstances). A declaratory judgment might also be sought to "enforce" an ERISA term by establishing that the party against whom it is brought is charged with carrying out an ERISA duty which that party is allegedly disregarding. See, e.g., *Pacyga*, 801 F.2d at 1159 (beneficiary allegedly had obligation under plan that she sought to avoid). The instant case fits neither of these categories.

Transamerica Occidental Life Ins. Co. v. DiGregorio, 811 F.2d 1249, 1252 (9th Cir. 1987). In *Transamerica*, the court held that where the fiduciary was seeking to clarify its own rights and obligations, not uphold the obligations imposed by ERISA, or address violations of duties imposed on others by ERISA, the case simply did not fall under 29 U.S.C.A. § 1132(a). Similarly, the Eleventh Circuit has held:

> Congress did not intend ERISA fiduciaries to use declaratory judgment actions to determine the benefit rights of participants/beneficiaries. Section 1132 is essentially a standing provision: it sets forth those parties who may bring civil actions under ERISA and specifies the types of actions each of those parties may pursue. These standing provisions must be construed narrowly; civil actions under ERISA are limited only to those parties and actions Congress specifically enumerated in section 1132.

Gulf Life Ins. Co. v. Arnold, 809 F.2d 1520, 1524 (11th Cir. 1987).

Assuming, for the sake of argument, that the Plaintiffs are "fiduciaries" to each of the 13 association plans, under ERISA, 29 U.S.C.A. § 1132(a)(3) does not grant this Court jurisdiction over Plaintiffs' claims. Plaintiffs have not identified any provision of ERISA, or specific term of the 13 health plans that the Commissioner has violated. Simply seeking

clarification regarding whether this plan falls under ERISA or not, is not an action to "enjoin any act or practice which violates any provision of this subchapter or the terms of the plan."

B. ERISA Does Not Grant This Court Jurisdiction Over The Washington State Insurance Commissioner's Regulatory Review Of A Health Plan Issuer's Health Plan Filing.

In addition, 29 U.S.C.A. § 1132(a)(3)(B)(ii) only gives courts the authority to issue injunctive relief *after* a determination has been made that the "plan" is provided by an ERISA employer. *Int'l Ass'n of Entrepreneurs of Am. v. Angoff*, 58 F.3d 1266, 1270 (8th Cir. 1995). Until a court determines that the Plaintiff Associations are in fact employers under ERISA, they cannot sue for declaratory judgment under 29 U.S.C.A. § 1132. While there may be other grounds for Plaintiffs to sue for declaratory relief, none have been cited in their complaint, or any of the three motions Plaintiffs have filed in this matter to date.

Although Plaintiffs have previously cited cases where other parties sought declaratory judgment against an Insurance Commissioner (Dkt. #22 5-6), in each of those cases, the dispute was whether the plan issued by the alleged employer was in fact insurance. Here, there is no question that the health plans issued by Premera, a Washington authorized health care service contractor, to the 13 associations, are in fact, insurance products. Therefore, cases previously cited by Plaintiffs are inapposite. Because 29 U.S.C.A. § 1132 is not a proper vehicle for declaratory judgment until after employer status is determined, it cannot be the vehicle Plaintiffs use to obtain a declaration from the court that they are employers. Therefore, Plaintiff's claims under 29 U.S.C.A. § 1132(a) should be dismissed.

In contrast, under Washington State law, Plaintiffs have an exclusive administrative remedy to challenge an agency's order or other agency action in the Washington State Administrative Procedures Act, Wash. Rev. Code 34.05 (WAPA). The WAPA provides that "This chapter establishes the exclusive means of judicial review of agency action. . .". Wash. Rev. Code 34.05.510. It further provides that entities seeking judicial revew of agency action must first exhaust their administrative remedies. Wash. Rev. Code 34.05.534. Plaintiffs

currently have a new administrative hearing demand pending before the Hearings Unit of the Washington State Insurance Commissioner's Office[3]. Absent jurisdiction under 29 U.S.C.A. § 1132(a), Plaintiffs have offered no basis to allow them to circumvent state law administrative exhaustion requirements.

C. Plaintiffs' Have Failed To Demonstrate That They Meet The Definition Of Employer.

Most importantly, Plaintiffs have failed to demonstrate that they in fact are employers under the definition found in the Affordable Care Act, incorporated from ERISA. Although the Commissioner's review of Premera's health plan filing is governed by the Affordable Care Act, because that act incorporated the definition of "employer" from ERISA, guidance about what constitutes an "employer" from the U.S. Department of Labor (DOL) is particularly helpful. While Plaintiffs correctly cite the general elements that the courts, states, and DOL consider when determining if an association is a true employer, it is important to note that satisfaction of just one element does not establish employer status. Rather, "a determination whether there is a bona fide employer group or association for this ERISA purpose must be made on the basis of all the facts and circumstances involved." Department of Labor Advisory Opinion 2008-07A. The question of whether an entity is an "employer" is inherently fact specific. Further, particularly in summary judgment, where all fact, and reasonable inferences must be viewed in the light most favorable to the non-moving party, Plaintiffs should not be permitted to rely on unsupported declarations and allegations.

The Department of Labor has issued guidance to assist state regulators grappling with the question of who is an "employer", and the regulation of Multiple Employer Welfare Agreements (MEWAs). It provides:

> In order for a group or association to constitute an "employer" within the meaning of Section 3(5), there must be a bona fide group or association of employers acting in the interest of its employer-members to provide benefits for

[3] A copy of BHT's hearing demand can be found online at http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/a-b/.

> their employees. In this regard, the Department has expressed the view that where several unrelated employers merely execute identically worded trust agreements or similar documents as a means to fund or provide benefits, in the absence of any genuine organizational relationship between the employers, no employer group or association exists for purposes of Section 3(5). Similarly, where membership in a group or association is open to anyone engaged in a particular trade or profession regardless of their status as employers (i.e., the group or association members include persons who are not employers) or where control of the group or association is not vested solely in employer members, the group or association is not a bona fide group or association of employers for purposes of Section 3(5).

Employee Benefits Security Administration, U.S. Department of Labor *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation* (MEWA Guide), 5 (2013). The following factors are considered determining whether a bona fide group or association of employers exists:

- how members are solicited;
- who is entitled to participate and who actually participates in the association;
- the process by which the association was formed;
- the purposes for which it was formed;
- what, if any, were the pre-existing relationships of its members;
- the powers, rights and privileges of employer-members;
- who actually controls and directs the activities and operations of the benefit program; and
- whether the employer-members of the group or association that participate in the benefit program directly or indirectly, exercise control over that program, both in form and in substance

Id.

Here, there are genuine disputes of material fact, and "unexplained gaps" that prevent summary judgment on the issue of whether Plaintiffs can demonstrate that the 13 associations are "employers" based on DOL's general factors.

1. Solicitation, Formation, and Purpose

The purpose of looking at how members are solicited is to limit entrepreneurial enterprises from masquerading as ERISA plans. As the Courts have recognized:

> . . . certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in profiting from the provision of administrative services are establishing insurance companies

> and related enterprises. The entrepreneur will then argue that [its] enterprise is an ERISA benefit plan which is protected, under ERISA's preemption provision, from state regulation.... [W]e are of the opinion that these programs are not 'employee benefit plans'.... [T]hese plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction.... They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan.

MDPhysicians & Associates, Inc. v. State Bd. of Ins., 957 F.2d 178, 184 (5th Cir. 1992), citing House Report No. 94-1785 (1976). The issue identified in *MDPhysicians* is not whether an insurance carrier is soliciting. Rather, the concern is ensuring that entrepreneurial enterprises aren't masquerading as employers in order to profit off the sale of insurance. Plaintiffs assertion that Premera is not soliciting membership does not end the inquiry.

On two different occasions, the Commissioner specifically requested additional information concerning how members are solicited into membership with the 13 associations. Nollette Decl., Exhibit A 53, 56; Exhibit B 52, 55; Exhibit C 52, 55; Exhibit D 52, 55; Exhibit E 52, 55; Exhibit F 52, 55; Exhibit G 52, 55; Exhibit H 52, 57; Exhibit I 52, 55; Exhibit J 52, 55; Exhibit K 52, 55; Exhibit L 52, 55; Exhibit M 52, 54. Plaintiffs now respond that the bylaws for the 13 associations indicate that that membership in the associations is voluntary, and limited to only employers in their respective industries. Dkt #37, 19. This wholly fails to answer the question of how these health plans or these associations are marketed to new and prospective members, and therefore, how members are solicited. The real burden that Plaintiffs have, and have not met, is to demonstrate that the BHT trusts are not "established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others." *MDPhysicians*, 957 F.2d at 184.

The evidence contained in the records demonstrates, the bylaws of each of the 13 associations were drafted to be effective January 1, 2014, the same day that each trust became effective. Nollette Decl., Exhibit A 116, 135; Exhibit B 114, 135; Exhibit C114, 135; Exhibit D 115, 134; Exhibit E 15, 136; Exhibit F 115, 136; Exhibit G 115. 135; Exhibit H 105, 124; Exhibit I 114, 134; Exhibit J 115. 135; Exhibit K 115, 136; Exhibit L 113, 134; Exhibit M 113,

134. This is the same day BHT, the trust created by the Chamber, was forced to stop selling health plans to Chamber members. Dkt. # 21, 2 ¶3. The bylaws, trust documents, attorney opinions, fiduciary certifications, and descriptions submitted to the Commissioner were nearly identical for all 13 associations. Exhibit A 56, 110-37; Exhibit B 55, 108-137; Exhibit C 55, 108-139; Exhibit D 55, 109-136; Exhibit E 55, 109-138; Exhibit F 55, 109-137; Exhibit G 55,109-137; Exhibit H 57, 99-127;Exhibit I 55, 108-136, Exhibit J 55, 109-137; Exhibit K 55, 109-138; Exhibit L 55, 107-136, Exhibit M 54, 107-137. In fact, the fiduciary signing the 13 certifications, Maud Daudon, is also the President and CEO of the Chamber. The only membership applications submitted by Premera were applications to become members of the trust, not members of the associations. Nollette Decl., Exhibit A 128-131; Exhibit B 126-129; Exhibit C 126-129; Exhibit D 127-130; Exhibit E 127-130; Exhibit F 127-130; Exhibit G 127-130; Exhibit H 117-120; Exhibit I 136-129; Exhibit J 127-130; Exhibit K 128-131; Exhibit L 136-129; Exhibit M 136-129. It is the Chamber that has requested meetings with the Commissioner, and with whom the Commissioner has corresponded expressing concerns about the Chamber's plans to create subtrusts. Dkt. #16-1 ¶ 5-6; Commissioner's Letter, Dkt. # 31-1 21. The "supporting documentation" submitted in response to the Commissioner's objections identifies the Chamber, not the individual associations, as the sponsor, organizer, or marketer for the various events allegedly sponsored by the Associations. Nollette Decl., Exhibit A 141-158; Exhibit B 141-167; Exhibit C 141-192; Exhibit D 140-168; Exhibit E 141-157; Exhibit F 142-164; Exhibit G 141-154; Exhibit H 131-148; Exhibit I 140-148; Exhibit J 141-149; Exhibit K 141-182; Exhibit L 140-178; Exhibit M 141-164. In addition, it is the trusts, not the associations, that are named plaintiffs to this suit. And it is the trusts, not the associations, whose business will allegedly be damaged by the Commissioner's disapproval of Premera's filings. Dkt. #11 2 ¶7.

In looking at "the process by which the association was formed" and "the purposes for which it was formed and what, if any, were the pre-existing relationships of its members,"

these factors tend to inform each other. The objective facts appear to be: the timing of the creation of the associations and trusts, the striking similarity of the materials submitted; BHT's previous roles in offering health plans to the members of all 13 associations; and the Chamber's apparently significant involvement in any and all activities conducted by members of the associations prior to 2014. The evidence indicates that the Chamber and BHT, not the associations or their members, were the ones primarily responsible for the formation of the associations.

Looking at the facts as a whole, particularly the timing of the formation of both the 13 associations and the corresponding trusts, it appears that associations and trusts were formed by BHT and the Chamber for the purpose of providing health care benefits. Further, the trusts created by those associations, appear to be entrepreneurial mechanisms, like BHT itself that allow the Chamber and BHT (not the relevant associations) to continue to market large group insurance products to Members of the Chamber of Commerce. Taking the evidence and reasonable inferences in the light most favorable to the non-moving party, Plaintiffs cannot claim summary judgment on this factor.

2. Participation

This issue looks at "who is entitled to participate and who actually participates in the association." MEWA Guide 5. Here, the Commissioner agrees that facially, the bylaws and trust agreements limit participation in each association and trust to members of certain industry groups. However, this only addresses the first part of the inquiry of who is entitled to participate. The second piece, of who actually participates, was never answered, despite multiple requests. This additional gap prevents summary judgment on this factor.

Moreover, while DOL has determined in certain circumstances that industry alignment demonstrates a true employer association, DOL requires both industry alignment, and a "genuine organization relationship". DOL Advisory Op. 96-25A. Unrelated employers simply signing identically worded documents does not create such a relationship. *Id.* In finding that a

health plan sold to employers in the home health care industry was not an employee benefit plan, DOL noted:

> Although the employers who adopt the HCPBP Plan may have some commonality of interest, based on being in the same industry, there does not appear to be any genuine organizational relationship between them or any history of organized cooperation. Each employer's membership in the Council begins and ends with the period of its adoption of the HCPBP Plan. Further, although you indicate that some or all of these employers are members of NAHC, you have specified that NAHC has no involvement in the establishment or maintenance of the HCPBP Plan and therefore cannot be considered to be sponsoring the HCPBP Plan.

Id. Here, despite Plaintiffs' insistence, the documentation provided demonstrates no organization interest within the membership of each of the 13 associations, absent membership and coordination with the Chamber of Commerce. *See* Nollette Decl., Exhibit A 141-158; Exhibit B 141-167; Exhibit C 141-192; Exhibit D 140-168; Exhibit E 141-157; Exhibit F 142-164; Exhibit G 141-154; Exhibit H 131-148; Exhibit I 140-148; Exhibit J 141-149; Exhibit K 141-182; Exhibit L 140-178; Exhibit M 141-164. However, because the Chamber's membership is so broad, membership in the Chamber would be insufficiently limited to constitute a commonality of interests. *See* DOL Advisory Op. 2008-07A.

3. Control, in Form and Substance

Control of the benefit plan by the employers purchasing through the plan is essential to ensuring that the special relationship between employee and employer is what governing the provision of health services.

> This special relationship protects the employee, who can rely on the "person acting directly as an employer" or the person "acting indirectly in the interests of" that employer to represent the employee's interests relating to the provision of benefits.

MDPhysicians, 957 F.2d at 186. DOL has repeatedly noted in its advisory opinions, that "control" of an employee benefit plan must be both in form and substance, but that the issue of "whether employer-members of a particular group or association exercise control in substance

over a benefit program is an inherently factual issue on which the Department generally will not rule." MEWA Guide 5.

The Commissioner has noted that the submitted documentation facially establishes employer control over the respective trusts. However, the Commissioner, again, requested specific factual information concerning this control, including "identification of members who participated in the control, direction, and selection of the offered health plans, including names, meeting dates, and agendas." This specific factual detail was never provided.

The evidence detailed above actually demonstrates that the formation of the 13 associations was directed by the Chamber and BHT, not the members of the respective associations. It appears that although on paper the associations govern the trusts that secure health coverage, in substance BHT and the Chamber directed the negotiation, selection and administration of health plans.

Taken as a whole, the absence of specific factual proof from Plaintiffs creates an issue of material fact concerning whether the 13 associations constitute employers. More importantly, it is impossible to conclude, in light of the Commissioner's repeated requests for specific information that was never provided, that the Commissioner erred in determining that Premera failed to provide sufficient information for the Commissioner to determine that each of the 13 associations satisfy the definition of "employer" found in the Affordable Care Act. For these reasons, Plaintiffs motion for summary judgment should be denied.

D. The Oregon Insurance Commissioner's Decision To Ignore DOL Guidance Is Neither Binding, Nor Persuasive.

Plaintiffs urge this Court to ignore, or at the very least, minimize its consideration of the 2008 DOL opinion concerning the Bend Chamber of Commerce (DOL Advisory Opinion 2008-07A), because the Oregon Insurance Commissioner has approved the Bend Chamber of Commerce Plans. Dkt. #37 23. However, Plaintiffs provide no indication the DOL has approved or agreed with the Oregon Commissioner's decision. Further, according to the

material submitted by Plaintiffs, the plan approved in Oregon, the "Bend Chamber of Commerce Employee Benefit Plan and Trust for Real Estate Employers" was not issued to a separate association of employers, but to the Bend Chamber of Commerce. If the Bend Chamber of Commerce truly reorganized its structure in a manner similar to Plaintiffs, then Plaintiff's argument actually supports the Commissioner's conclusion that it is the Chamber, not the 13 associations, that formed, solicited, created, managed, and controlled the health plans Premera sold to the 13 associations.

E. Plaintiffs Unsupported, Incoherent Claim That The Commissioner's Decision Was Somehow Arbitrary Or Capricious Is Not A Basis For Summary Judgment

Without explanation, authority, or evidentiary support, Plaintiffs allege that the Commissioner's decision is arbitrary and capricious, apparently because he has determined that one of DOL's advisory opinions applies to Plaintiffs. Dkt. #37 4. They give no support for why the Commissioner's application of a DOL advisory opinion is "arbitrary and capricious" but their own citation to DOL advisory opinions is permissible. In addition, Plaintiffs mention two approvals issued by the Commissioner, apparently as support for their positions that the Commissioner is somehow applying additional requirements on the 13 associations at issue here. While the Commissioner did approve association plans for the Washington Education Association (WEA), and the Microsoft Alumni Network Benefits Trust, Plaintiffs have submitted no evidence that these plans are in anyway similar. In fact, the WEA plans were created by employee groups, and are subject to a completely different legal analysis than applies to the employer groups in this matter. Plaintiffs offer no support for their bald allegation that the Microsoft Alumni Network Benefits Trust lacks industry alignment. The mere fact that the Commissioner has approved numerous association health plans, does not make his disapproval of Premera's filings arbitrary, capricious, or incorrect.

V. CONCLUSION

Plaintiffs lack standing, and this court lacks jurisdiction, under the single legal theory Plaintiffs have presented. Moreover, plaintiffs have failed to demonstrate that there is no material genuine issue of material fact. Plaintiffs have not demonstrated that they are entitled to summary judgment declaring them to be "employers" for the purposes of the Affordable Care Act.

DATED this 1st day of June, 2015.

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CERTIFICATE OF SERVICE

I hereby certify that on this 1st day of June, 2015, I electronically filed the *Defendant Washington State Insurance Commissioner's Response In Opposition to Plaintiffs' Motion for Summary Judgment* on behalf of Defendant Mike Kreidler, Insurance Commissioner of the State of Washington with the Clerk of the Court using the CM/ECF System, which will send notification of such filing to the following:

Richard J. Birmingham, Attorney for Plaintiffs
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DATED this 1st day of June, 2015, at Olympia, Washington.

s/ Darla Aumiller
DARLA AUMILLER
Legal Assistant