BEFORE THE NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE

IN THE MATTER OF	)	
TRINITY HEALTHSHARE, INC.,	)	**Docket No. 20-00020-COMP-CL**
Respondent.	)	
	)	

HEARING OFFICER'S RECOMMENDED DECISON

THIS MATTER came before Hearing Officer R. Alfred Walker for a hearing on the merits on July 8, 2020, and the Hearing Officer having considered the evidence, the submissions of the parties, and the arguments of counsel, and being advised in the premises;

THE HEARING OFFICER FINDS AND CONCLUDES:

FINDINGS OF FACT

1. The New Mexico Superintendent of Insurance ("the Superintendent") initiated this docket by issuing his Order to Cease and Desist and Imposing Penalty ("Superintendent's Order") on March 26, 2020.

2. The Superintendent's Order addressed membership plans offered and provided in New Mexico by Respondent Trinity Healthshare, Inc. ("Respondent" or "Trinity"), which is a health care sharing ministry ("HCSM").

3. The Superintendent's Order concluded that: "The principal object and purpose of a Trinity membership plan is to indemnify the member against qualifying health care expenses and, thus, each such plan constitutes 'insurance' under New Mexico law as defined in the Insurance Code and in case law." Superintendent's Order, ¶ 20.

4. The Superintendent's Order also concluded that: "By selling health care sharing membership plans in New Mexico, Trinity transacted the business of insurance in this state." *Id*. ¶ 21.

5. The Superintendent's Order additionally concluded that: "By entering into agreements to provide, deliver, arrange for, pay for or reimburse the costs of certain health care services, funding permitting, Trinity qualifies as a 'health insurance carrier' as that term is defined in NMSA (1978), § 59A-16-21.2(C)(2)." Superintendent's Order, ¶ 22.

6. The Superintendent's Order further concluded that: "Because they include an agreement to reimburse costs of health care services, funding permitting, the Trinity memberships constitute 'health benefit plans' as that term is defined in NMSA (1978), § 59A-16-21.2(C)(1)." Superintendent's Order ¶ 23.

7. The Superintendent's Order also concluded that: "Because Trinity has not provided any evidence that it is subject exclusively to the jurisdiction of another agency of this state or the federal government, the Superintendent has jurisdiction over Trinity pursuant to NMSA (1978), § 59A-15-16." Superintendent's Order ¶ 25.

8. The Superintendent ordered Respondent to cease and desist from selling, or offering for sale, health care sharing plans in New Mexico until it obtains a certificate of authority from the Superintendent.

9. The Superintendent also ordered Respondent to pay a $20,000 fine for each of the 1,620 membership plans Respondent reported that it had sold in New Mexico, or in the alternative cancel the plans, refund all contributions, and inform the members their options for obtaining major medical coverage.

10. The Superintendent's Order informed Respondent that it had twenty days to request a hearing pursuant to Section 59A-16-27 NMSA 1978 (1993) to challenge the Superintendent's Order.

11. Respondent timely requested a hearing on April 15, 2020.

12. Section 59A-16-27(B) requires the Superintendent to conduct hearings on cease and desist orders in the manner set forth by Article 4 of the Insurance Code.

13. Section 59A-4-7 NMSA 1978 (1984) requires hearings before the Superintendent to follow the applicable provisions of the New Mexico Administrative Procedures Act.

14. Section 12-8-11(I) NMSA 1978 (1969) informs the parties that "rules of practice and procedure applicable to civil actions in the district courts may be utilized by the parties at any stage of any proceeding[.]"

15. This Hearing Officer scheduled an evidentiary hearing that commenced on July 8, 2020.

16. Respondent incorporated in Delaware on June 27, 2018. Tr. 81:11-13 (Guarino).

17. Respondent is a registered 501(c)(3) not-for-profit organization that operates an HCSM. Tr. 34:24-25 (Guarino); Tr. 164:10-13 (Duhamel); Bates No. 00009-00010.

18. Respondent's HCSM operates offers a variety of healthcare sharing programs that feature various participation levels, affording members different levels of sharing eligibility based on different levels of contributions the member makes. *See* Tr. 38:24-39:17 (Guarino); Tr. 56:16-24 (Guarino); Bates No. 000023.

19. On January 6, 2020, Respondent voluntarily sent a letter to the New Mexico Superintendent of Insurance. Bates No. 000069-000071; Tr. 83:4-16 (Guarino); Tr. 187:23-188:6 (Duhamel).

20. This letter stated that the number of Trinity Households in New Mexico were 1,620 and the number of Trinity Individual Lives in New Mexico were 2,443 as of December 18, 2019. Bates No. 00070.

21. On May 14, 2020, Respondent filed a Notice of Correction of Voluntary Notice. The Notice stated that the numbers provided in the January 6, 2020 letter were incorrect. The correct numbers were 134 Trinity Households in New Mexico and 257 Trinity Individual Lives in New Mexico as of December 18, 2019. Tr. 84:15-85:11 (Guarino); Bates No. 000214-000215.

22. As of December 18, 2019, the correct number of Trinity Households in New Mexico was 134 Trinity Households in New Mexico and 257 Trinity Individual Lives. Tr. 84:15-85:11 (Guarino); Bates No. 000214-000215.

23. Respondent sold healthcare sharing programs in New Mexico without a certificate of authority to sell insurance. Tr. 88:15-20 (Guarino).

24. Trinity maintains membership guides that describe the features of each of Trinity's health care sharing programs. Tr. at 136:17-22 (Guarino).

25. These guides are publicly accessible to prospective members in New Mexico and elsewhere on Trinity's website; one does not have to be a member to access the guides. Tr. 166:2-6 (Duhamel).

26. Respondent's 2019 membership guides were available to the public on Respondent's website on November 4, 2019. Tr. 21:24-22:18 (Guarino).

27. There were similar membership guides on Respondent's website prior to November 4, 2019. Tr. 23:8-24:13 (Guarino).

28. The Superintendent's Order attached Trinity's Complete Care Guide; however, the membership guides for all of Respondent's plans are available on Respondent's website. Tr. 24:24-25:1 (Guarino); Tr. 136:21-22 (Guarino); Tr. 151:25-152:11 (Guarino).

29. Trinity's membership guide for the Care Complete program includes the statement, "THIS IS NOT AN INSURANCE PRODUCT," on the front cover of the member guide. The

statement is printed in capital letters, centered on the page. Bates No. 000012. The statement is re-printed in large, capital letters on every page of the membership guide. Bates No. 000012-000052.

30. Respondent's member guides state that Respondent "does not assume any risk for medical expenses and makes no promise to pay." Bates No. 000037. Similar statements appear throughout Respondent's member guides.

31. The home page of Respondent's website contains at least two disclaimers stating that Respondent's programs are not insurance. Bates No. 000073; Bates No. 000074.

32. Respondent's website includes a section that describes Respondent's position that Respondent's programs are different from insurance. Bates No. 001185.

33. Respondent's member plans are TrinityCare Everyday and TrinityCare Complete. Within each of these plans there are three different tiers, Value, Plus and Premium. Bates No. 000512, Tr. 153:8-154:8 (Guarino).

34. To join one of Respondent's member plans, a prospective member must fill out an application or membership enrollment form that includes a medical history prior to acceptance. Tr. 61:13-63:11 (Guarino).

35. Once accepted for enrollment, members must send monthly payments or "contributions" to Respondent to maintain their membership. Tr. 60:8-51:12 (Guarino); Tr. 65:10-67:4 (Guarino).

36. Membership contributions range from $346.94 to $2,322.34 monthly (as of November 1, 2019) and vary based on a member's age, number of members in a plan, and choice of out-of-pocket expenses. Bates No. 000527, Tr. 38:12-41:2 (Guarino); Tr. 47:19-48:1 (Guarino).

37. If a member changes their mind and wishes to cancel their plan, they can receive a full refund of their contribution if the cancellation is within 10 days. If a member's contribution is

not received by the 1st or 15th of the month, depending on the effective date, an administrative fee can be assessed. If the contribution is not received within 45 days their membership will become inactive as of the last day of the month in which the monthly contribution was received. Bates No. 000040-000041.

38. Members may cancel their participation in Respondent's sharing programs at any time. Tr. at 71:18-72:18 (Guarino); Tr. 175:8-13 (Duhamel).

39. Trinity's Management and Administrative Agreement ("2018 Agreement") with Aliera became effective on August 23, 2018. Bates No. 000053-000068; Tr. 81:7-10 (Guarino).

40. The 2018 Agreement was in effect until December 31, 2019. Tr. 81:14-25 (Guarino).

41. The 2018 Agreement sets forth how Respondent distributed membership payments through January 1, 2020. Bates No. 000057, 000066-000068; Tr. 81:7-82:22 (Guarino); 88:21-91:17 (Guarino).

42. Under the 2018 Agreement, Respondent receives 1.5 percent of the member contribution. Tr. 151:11-21 (Guarino). This is money not available for health care cost sharing. Tr. 89:12-90:15 (Guarino).

43. Respondent has no other sources from which it receives funding. Tr. 151:22-24 (Guarino).

44. Member-to-member sharing for the health care sharing programs is facilitated through ShareBox technology. Tr. at 127:2-9 (Guarino).

45. The ShareBox is an application that applies a matching algorithm, whereby sharing requests for eligible medical expenses that members submit are matched with other members' contributions to Respondent's programs. Tr. at 127:2-9 (Guarino).

46. The money that is used to pay for members' medical expenses after a sharing request is made comes from members' contributions. Tr. at 125:3-6 (Guarino).

47. Respondent maintains a ShareBox account into which a member's contributions are deposited to await being matched with eligible medical expenses that other members submit. Tr. at 127:10-12 (Guarino).

48. The ShareBox account is the account out of which members' medical expenses are shared. Tr. 127:14-16 (Guarino).

49. Less than half of the money collected from member monthly payments goes to the ShareBox Member Reserve, from which the member's medical bills are paid. Bates No. 00066-00068; Tr. 90:6-91:9 (Guarino).

50. If a sharing request is for an eligible service and there are sufficient members' contributions to meet that expense, funds are transmitted from the ShareBox account to the medical provider. Tr. 34:19-21 (Guarino).

51. Members consent to having their contributions shared in this manner. Tr. 129:15-20 (Guarino).

52. Members each sign a disclaimer expressly acknowledging that Respondent does not promise to pay any portion of the members' medical expenses. Tr. 60:22-25 (Guarino).

53. Each member is given access to a ShareBox portal, an application that allows members to view how the member's contributions have been shared and, if the member has medical expenses that are eligible for sharing, how other members are contributing to meet that expense. Tr. 131:21-25 (Guarino); Bates No. 000680-000695.

54. The ShareBox portal notifies members of sharing requests that have been submitted and allows individual members to opt out of sharing their contributions in response to any specific sharing request. Tr. 132:1-9 (Guarino).

55. Respondent maintains for each program guidelines concerning the eligibility of certain designated medical expenses for sharing to ensure financial viability and program functionality. Tr. 54:6-9 (Guarino); Tr. 141:22-25 (Guarino).

56. If a member has an alternative form of insurance, sharing is only available for expenses that the member's insurance does not cover. Tr. 74:15-25 (Guarino).

57. Respondent uses a member's age to determine cost of membership. Tr. 47:19-48:1 (Guarino).

58. Once a member enrolls, they are provided a member I.D. card from Respondent that has Respondent's information and a 9-digit I.D. number for the member. Tr. 29:22-30:13 (Guarino).

59. Respondent's members can avail themselves of FirstCall Telemedicine for no charge. Bates No. 000019-000020; Tr. 36:23-25 (Guarino).

60. Respondent provides members with Rx Valet, a prescription benefits plan. Tr. 29:5-10 (Guarino).

61. Respondent has a network of health care providers for its members. Bates No. 000019; Tr. 28:12-29:4 (Guarino).

62. Respondent directly pays health care providers for services rendered to members. Tr. 34:19-21 (Guarino); 35:12-36:18 (Guarino); 129:15-17 (Guarino).

63. Respondent has negotiated an arranged discount with the health care providers in Respondent's health care provider network. Bates No. 000019; Tr. 28:23-29:4 (Guarino).

64. Members choose which medical providers they see and make their own appointments. Tr. 135:22-136:3 (Guarino).

65. Respondent's members all have a specified amount of money that the member must pay out of pocket each year before Respondent will pay a claim. Bates No. 000019; Tr. 44:16-47:18 (Guarino); 50:8-17 (Guarino).

66. The specified out-of-pocket payment amount varies from plan to plan and ranges from $1,000 to $10,000. Bates No. 000512 and 000527; Tr. 45:2-5 (Guarino).

67. Members are responsible for paying a percentage of any incurred medical expense, referred to as the Member Shared Responsibility Amount ("MSRA"), before that expense may be submitted to other members for sharing. Tr. 32:5-33:2 (Guarino); Tr. 44:16-23 (Guarino).

68. Respondent's members also have access to preventative care for no up-front cost with a 70% Trinity, 30% member payout, which is consistent for the majority of medical services. Bates No. 000527.

69. Respondent's members have access to primary care, pediatrics and ob/gyn service for a consult fee of $20, prior to meeting their out of pocket deductible or MSRA. Bates No. 000527.

70. Specialty care and urgent care carry a $75 consult fee and emergency room services have a $150 consult fee, prior to meeting a member's out of pocket deductible or MSRA. Bates No. 000527.

71. Respondent does not maintain reserve funds to pay a member's medical expenses if member contributions were insufficient to meet sharing requests. Tr. 134:23-135:1 (Guarino).

72. Respondent does not have reinsurance. Tr. 135:2-3 (Guarino).

73. Respondent does not use actuaries for forecasting. Tr. 133:8-9 (Guarino).

74. Respondent engages in underwriting by basing its risk decisions on a member's age and health history, along with the level of contribution a member makes in choosing a plan. Tr. 47:19-48:1 (Guarino); Tr. 61:13-63:11 (Guarino); Tr. 38:24-39:17 (Guarino); Tr. 56:19-24 (Guarino); Bates No. 000023. *See State, Dep't of Commerce, Community & Econ. Dev., Div. of Ins. v. Progressive Cas. Ins. Co.*, 165 P.3d 624, 628 (Alaska 2007) ("underwriting" is the process by which an insurer decides whether, and at what price, the insurer will accept a given risk).

75. If the amount of eligible expenses that members have submitted for sharing exceeds the amount of money members have contributed to the programs, Respondent may: (i) initiate a pro-rata share of eligible medical expenses "whereby the members share a percentage of eligible medical bills within that month and hold back the balance of those eligible medical expenses to be shared the following month," Bates No. 000040; or (ii) increase – temporarily or permanently – the suggested share amount to satisfy the eligible medical expenses. Bates No. 000040; Tr. 68:6-18 (Guarino).

76. Respondent does not guarantee that either of these steps will be taken in the event members' eligible expenses exceed contributions. Tr. 208:3-8 (Duhamel).

77. Any Finding of Fact proposed by Respondent or by OSI not accepted above, in whole or in part, is rejected as not supported by substantial evidence.

CONCLUSIONS OF LAW

1. The New Mexico Superintendent of Insurance has jurisdiction over Respondent and the subject matter of this proceeding.

Rationale

Respondent disputes the jurisdiction of the Superintendent over Respondent and the subject matter of this proceeding. Trinity Healthshare, Inc.'s Closing Argument at 18 n.13. The Insurance Code states that

> any person who provides coverage in this state for health benefits … shall be presumed to be subject to the provisions of the Insurance Code and the jurisdiction of the superintendent unless the person provides evidence satisfactory to the superintendent that he is subject exclusively to the jurisdiction of another agency of this state or the federal government.

NMSA 1978, § 59A-15-16 (1993). Respondent asserts that the question of jurisdiction "is not the question before the Hearing Officer." Trinity Healthshare, Inc.'s Closing Argument at 18 n.13. However, the question of jurisdiction is always before the decision-maker.

The decision-maker must determine in the first instance whether he or she has jurisdiction. *See In re Salazar*, 2013-NMSC-007, ¶ 15, 299 P.3d 409 ("One of the primary responsibilities of a judge in adjudicating any matter is determining whether the judge has jurisdiction over the matter"); *Grace v. Oil Conservation Comm'n of N.M.*, 1975-NMSC-001, ¶ 12, 87 N.M. 205, 531 P.2d 939 ("A lack of jurisdiction means an entire lack of power to hear or determine the case and the absence of authority over the subject matter or the parties"). "The test of the jurisdiction of a court is whether or not it had ***power to enter upon the inquiry***; not whether its conclusion in the course of it was right or wrong." *State v. Patten*, 1937-NMSC-034, ¶ 13, 41 N.M. 395, 69 P.2d 931 (emphasis in original). "[L]ack of jurisdiction at any stage of the proceedings is a controlling consideration which must be resolved before going further." *Glaser v. LeBus*, 2012-NMSC-028, ¶

25, 274 P.3d 114. There is no reason to treat the jurisdiction of an agency in an adjudicatory proceeding any differently than the jurisdiction of a court.

In fact, it is a tenet of administrative law that the agency has the primary authority to determine its jurisdiction.

> The need to protect the primary authority of an agency to determine its own jurisdiction is obviously greatest when the precise issue brought before a court is in the process of litigation through procedures originating in the agency. While the agency's decision is not the last word, it must assuredly be the first.

Fed. Power Comm'n v. La. Power & Light Co., 406 U.S. 621, 647 (1972) (internal quotation marks and alteration marks omitted). The Superintendent must determine that he has jurisdiction before proceeding further.

Respondent recognizes that the question of jurisdiction in this matter is inextricably intertwined with the merits of this matter. "Assuming without conceding the presumption that OSI has jurisdiction over Trinity because Trinity 'provides coverage . . . for health benefits' (i.e., that jurisdiction exists), OSI must still exercise that jurisdiction consistent with applicable law." Trinity Healthshare, Inc.'s Closing Argument at 18 n.13. If Respondent provides coverage for health benefits, and is not subject to the jurisdiction of another state agency or the federal government, then the Superintendent has jurisdiction over Respondent. Respondent has not demonstrated that it is subject to the jurisdiction of another state agency or the federal government pursuant to Section 59A-15-17 NMSA 1978 (1991). As will be demonstrated below, Respondent provides coverage for health benefits and is subject to the New Mexico Insurance Code. Therefore, the Superintendent has jurisdiction over Respondent and the subject matter of this proceeding.

2. There is no Constitutional impediment to the Superintendent's exercise of jurisdiction or exercise of his enforcement powers in this proceeding.

Rationale

"Trinity contends the [Superintendent's] Order is also invalid as an unconstitutional infringement on the religious freedom of Trinity and the members of the health care sharing programs Trinity offers." Trinity Healthshare, Inc.'s Closing Argument at 2 n.2. Respondent asserts that constitutional issues are beyond OSI's adjudicatory authority, and therefore Respondent reserves the right to present its constitutional arguments in a subsequent judicial appeal. *Id*. Although a facial constitutional challenge to a statute may be beyond the authority of the Superintendent to decide, the Superintendent may have primary authority to address an as-applied constitutional challenge (which this appears to be). The Hearing Officer has not found any New Mexico authority on the subject, but federal courts have held with respect to federal agencies created by Congress: "Administrative agencies, although they may consider constitutional claims, lack the authority to deal with them dispositively; the final say on constitutional matters rests with the courts." *Singh v. Reno*, 182 F.3d 504, 510 (7th Cir. 1999); *cf. Jones Bros., Inc. v. Secretary of Labor*, 898 F.3d 669, 663-64 (6th Cir. 2018) ("This administrative agency, like all administrative agencies, has no authority to entertain a facial constitutional challenge to the validity of a law. … [O]nly the Judiciary enjoys the power to invalidate statutes inconsistent with the Constitution[,]" citing *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177–78 (1803)). Certainly, whether Respondent has a facial or an as-applied constitutional challenge, Respondent has not waived any constitutional challenge it may have.

Nevertheless, the Hearing Officer has not questioned the nature or sincerity of the religious beliefs of Respondent or its members. *See* Ronald D. Rotunda & John E. Nowak, Treatise on

Constitutional Law—Substance & Procedure § 21.6(c) ("It is difficult to see how the Supreme Court could define religion in a manner that would not involve the governmental punishing beliefs or granting a denominational preference"). However, the United States Supreme Court has "never held that an individual's religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the State is free to regulate." *Employment Div., Dept. of Human Resources v. Smith*, 494 U.S. 872, 878-9 (1990); *see also Elane Photography, LLC v. Willock*, 2013-NMSC-040, ¶ 60, 309 P.3d 53 ("the right of free exercise does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)", quoting *Smith*, at 879), *cert. denied*, 572 U.S. 1046 (2014); Rotunda & Nowak, §21.6(c) ("The difficulty of defining religion or testing sincerity may be a reason why the Supreme Court has not created free exercise clause exemptions from laws of general applicability"). The Hearing Office accepts as indisputable that the beliefs of Respondent and its members are religious and sincere, but it is also indisputable that the State is free to regulate insurance and health care benefits under the laws of general applicability found in the Insurance Code.

Respondent argues that the Superintendent's proposed enforcement action is inequitable and discriminatory, because the Superintendent has not initiated enforcement actions against other HCSMs operating in New Mexico. Trinity Healthshare, Inc.'s Closing Argument at 21-22. This appears to be an Equal Protection argument, but Respondent does not assert that this argument is reserved to the courts to decide. "The constitutional right to equal protection concerns whether the legislature may afford a legal right to some individuals while denying it to others who are similarly situated." *Cummings v. X-Ray Assocs. of N.M., P.C.*, 1996-NMSC-035, ¶ 22, 121 N.M. 821, 918 P.2d 1321. To support an equal protection claim, the proponent of the claim must show that the

legislation draws classifications that discriminate against a group of persons to which he or she belongs. *State v. Munoz*, 2008-NMCA-090, ¶ 30, 144 N.M. 350, 187 P.3d 696, *cert. quashed*, 2009-NMCERT-009. Respondent has not argued that HCSMs are discriminated against as a group; rather, Respondent argues that it has been singled out among HCSMs for enforcement and thus discriminated against individually.

This is an argument that this proceeding is selective enforcement of the Insurance Code that results in disparate treatment of Respondent. But Respondent's argument must be supported by more than the fact that the Superintendent has not filed similar enforcement actions against other HCSMs. *See* Trinity Healthshare, Inc.'s Proposed Findings of Fact & Conclusions of Law, Proposed Findings of Relevant Fact Nos. 63-67 (proposing facts showing that the Superintendent has not investigated and has not sought to enforce the Insurance Code against other HCSMs operating in New Mexico). "One cannot merely presume a discriminatory purpose; there must be a showing of clear and intentional discrimination. Under this standard, a plaintiff must prove more than mere nonenforcement against other violators." *Campos de Suenos, Ltd. v. County of Bernalillo*, 2001-NMCA-043, ¶ 34, 130 N.M. 563, 28 P3d 1104 (quoting *Barber's Super Mkts., Inc. v. City of Grants*, 1969-NMSC-115, ¶ 19, 80 N.M. 533, 458 P.2d 785), *cert. denied*, 130 N.M. 484, 27 P.3d 476 (2001); *see also State ex rel. Bingaman v. Valley Sav. & Loan Ass'n*, 1981-NMSC-108, ¶ 4 n.2, 97 N.M. 8, 636 P.2d 279 ("Nonuniform enforcement of a statute is not a denial of equal protection"); *Clayton v. Farmington City Council*, 1995-NMCA-075, ¶ 28, 120 N.M. 448, 902 P.2d 1051 ("Nonuniform enforcement of a statute is not necessarily a denial of equal protection, arbitrary, otherwise illegal, or even reprehensible"), *cert. denied*, 120 N.M. 184, 899 P.3d 1138 (1995). Respondent has not provided evidence of clear and intentional

discrimination, and a discriminatory purpose cannot be presumed only from mere nonenforcement against other violators.

3. This proceeding is not subject to dismissal for asserted flaws in the Superintendent's Order or the process leading to the Superintendent's Order.

Rationale

Respondent argues that the process leading to the Superintendent's Order, which is the order initiating this proceeding, was flawed and that the Superintendent's Order is not supported. Trinity Healthshare, Inc.'s Closing Argument at 6-8. "Regardless of the substantive conclusion OSI reached, for the Order to be valid, administrative law requires that OSI provide a reasoned, rational explanation for the Order's issuance that is supported by substantial evidence." *Id*. at 6, citing *Paule v. Santa Fe Cty. Bd. of Cty. Comm'rs*, 2005-NMSC-021, 138 N.M. 82, 117 P.3d 240, and *Akel v. N.M. Human Servs. Dep't*, 1987-NMCA-154, 106 N.M. 741, 749 P.2d 1120. But, as explained in this Hearing Officer's Order Denying Respondent's Motion for Summary Judgment ¶¶ 30-34, the cases relied on by Respondent discuss judicial review of final agency orders. The Superintendent's Order is not a final agency action.

The Superintendent's Order was a cease and desist order issued pursuant to Section 59A-16-27 NMSA 1978 (1993). *See* Superintendent's Order, ¶ 27. Respondent had the choice to follow the order or request a hearing before the Superintendent on the order. § 59A-16-27(A). Respondent chose to request a hearing before the Superintendent. That means the Superintendent's Order could not be the final agency action subject to judicial review.

The Superintendent's Order did not need to meet the requirements for judicial review of administrative decisions. Respondent relies on *Paule*, ¶ 26, which states in part:

> In administrative appeals, we review the administrative decision under the same standard of review used by the district court while also determining whether the

> district court erred in its review. Administrative decisions are reviewed under an administrative standard of review. Under this standard of review, reviewing courts are limited to determining whether the administrative agency acted fraudulently, arbitrarily or capriciously; whether the agency's decision is supported by substantial evidence; or whether the agency acted in accordance with the law.

(Citations omitted.) This is an unremarkable and classic statement of ***judicial*** review of a ***final*** agency decision.

The Superintendent's Order is not a ***final*** agency decision. "'Final decision' is defined in Section 39-3-1.1(H)(2) [NMSA 1978 (1999)] as 'an agency ruling that as a practical matter resolves all issues arising from a dispute within the jurisdiction of the agency, once all administrative remedies available within the agency have been exhausted.'" *Paule*, ¶ 9. Respondent's administrative remedy was the hearing it requested and that commenced on July 8, 2020. This Recommended Decision will lead the Superintendent to enter a Final Order, which may or may not be different from the Superintendent's Order initiating this docket. Entry of the Final Order will be the trigger for judicial review of this administrative action, if such is desired. The Superintendent's Order is not subject to judicial review.

Similarly, *Akel*, 1987-NMCA-154, ¶ 11, discusses the necessity that a hearing officer's "decision adequately reflect the basis for his determination and the reasoning used in arriving at such determination" to allow for adequate judicial review. Again, there is only judicial review after a final order, not after the initial document starting the administrative process. The Superintendent's Final Order, and that much of this Recommended Decision the Superintendent chooses to adopt, will be the final agency action to which judicial review will apply.

Because the Superintendent's Order was not a final decision, but a notice to Respondent of the Superintendent's proposed action, the Superintendent's Order was adequate to inform Respondent of the nature of the proceedings. The Superintendent's Order gave Respondent notice

of the Superintendent's proposed action and also gave Respondent an opportunity to be heard on the proposed action. The Superintendent's Order gave Respondent due process in this proceeding.

> Procedural due process requires notice and an opportunity to be heard prior to a deprivation of a protected liberty or property interest. The specific requirements of procedural due process depend on the facts of each case, and could encompass any number of the following components: (1) notice of the basis for the government action; (2) a neutral decision maker; (3) the opportunity to orally present a case against the state; (4) the opportunity to present evidence and witnesses against the state; (5) the opportunity to cross-examine witnesses; (6) the right to have an attorney present at the hearing; and (7) a decision based on the evidence presented at the hearing accompanied by an explanation of the decision.

Mills v. N.M. State Bd. of Psychologist Examiners, 1997-NMSC-028, ¶ 14, 123 N.M. 421, 941 P.2d 502 (citation omitted). Respondent has received all process that is due.

The Superintendent's Order gave Respondent notice of the basis of the Superintendent's proposed action. Contrary to Respondent's argument, OSI was not required to provide more than sufficient cause to believe Respondent was violating the Insurance Code. *See* Trinity Healthshare, Inc.'s Closing Argument at 6 ("OSI's analysis of Trinity's operations was sparse and incomplete. As referenced, Exhibits A through E attached to the Order represent the full extent of the material that OSI considered before issuing the Order"). Whether the evidence attached to the Superintendent's Order would be sufficient to support a final order, all it needed to do was give notice to Respondent that its conduct offering HCSMs in New Mexico potentially violates provisions of the Insurance Code. *See In re Dixon*, 2019-NMSC-006, ¶¶ 21-22, 435 P.3d 80 (disciplinary board's specification of charges gave notice to attorney that his conduct in certain lawsuits was at issue, and his counsel was able to mount a vigorous defense). The Superintendent's Order gave Respondent sufficient notice of the basis of the Superintendent's actions.

And Respondent has received an adequate opportunity to be heard. The proceedings have taken place in front of a neutral decision maker, and Respondent's attorneys have mounted a

vigorous, well-presented, and well-argued case, orally and by the presentation of evidence and witnesses, along with the cross-examination of OSI's witnesses. This Recommended Decision is the decision based on the evidence presented at the hearing accompanied by an explanation of the decision. The Superintendent's Order was the "charging document," and it is subsumed into the final decision.

4. Respondent "provides coverage in this state for health benefits" and is "subject to the provisions of the Insurance Code[.]"

Rationale

OSI relies on Section 59A-15-16 NMSA 1978 for the Superintendent's jurisdiction over Respondent. That provision is part of the Health Care Benefits Jurisdiction Act, Sections 59A-15-14 through -19 NMSA 1978 (1991, as amended), and it states:

> Notwithstanding any other provision of law and except as provided in the Health Care Benefits Jurisdiction Act, any person who provides coverage in this state for health benefits, including coverage for medical, surgical, hospital, osteopathic, acupuncture and oriental medicine, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental or optometric expenses, whether such coverage is by direct payment, reimbursement or otherwise, shall be presumed to be subject to the provisions of the Insurance Code and the jurisdiction of the superintendent unless the person provides evidence satisfactory to the superintendent that he is subject exclusively to the jurisdiction of another agency of this state or the federal government.

NMSA 1978, § 59A-15-16. Thus, this provision applies to "any person" who "provides coverage" for "health benefits," including but not limited to the listed benefits, regardless whether that coverage is by direct payment, reimbursement, "or otherwise[.]" This provision applies to Respondent.

"In the statutes and rules of New Mexico … 'person' means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture or any

legal or commercial entity[.]" NMSA 1978, § 12-2A-3(E) (1993). Respondent is incorporated in Delaware as a non-profit entity. Respondent is a person.

Respondent "provides coverage in this state for health benefits[.]" "Coverage" is not defined in the Health Care Benefits Jurisdiction Act.

> Unless a word or phrase is defined in the statute or rule being construed, its meaning is determined by its context, the rules of grammar and common usage. A word or phrase that has acquired a technical or particular meaning in a particular context has that meaning if it is used in that context.

NMSA 1978, § 12-2A-2 (1997). "Coverage" means "[i]nclusion of a risk under an insurance policy; the risks within the scope of an insurance policy[.]" Black's Law Dictionary "coverage (1)" (11th ed. 2019). The question whether Respondent's HCSMs are "insurance" policies is discussed below. But Respondent's plans include the risks of various health care services, many (if not all) of which are listed in Section 59A-15-16.

Interpreting Section 59A-15-16 to include Respondent's HCSMs furthers Legislative intent. "The purpose of the Health Care Benefits Jurisdiction Act is to assure the superintendent's jurisdiction over providers of health care benefits in this state[.]" NMSA 1978, § 59A-15-15 (1991). When engaged in statutory construction, the "guiding principle is to determine and give effect to legislative intent." *Baker v. Hedstrom*, 2013-NMSC-043, ¶ 11, 309 P.3d 1047, quoting *El Paso Elec. Co. v. N.M. Pub. Reg. Comm'n*, 2010-NMSC-048, ¶ 7, 149 N.M. 174, 246 P.3d 443. "We will not construe a statute to defeat its intended purpose." *Baker*, ¶ 21 (internal quotation marks and alteration marks omitted). The intent of the Health Care Benefits Jurisdiction Act is to exercise jurisdiction over "providers" of health care benefits. Respondent is a provider of health care benefits in this state through its HCSMs.

"Health benefits" is defined by reference to a list of included (but not exclusive) health care services in Section 59A-15-16. Thus, "health benefits" is defined by its context. Respondent's HCSMs include "coverage" for health benefits.

Respondent's HCSMs pay for health benefits "by direct payment, reimbursement or otherwise[.]" Respondent argues that Respondent does not "indemnify" for health benefits, but the scope of "coverage" in Section 59A-15-16 is far broader than traditional indemnification. The statute is not limited to traditional indemnification, whether called direct payment or reimbursement, or other traditional payment methods. The Legislature's use of the phrase "or otherwise" indicates an intent to include any possible method of paying for health benefits; it certainly includes the methods used by HCSMs.

Thus, Respondent is "subject to the provisions of the Insurance Code and the jurisdiction of the superintendent[.]" As noted above, the jurisdiction of the Superintendent is established. But Respondent is also subject to the substantive provisions of the Insurance Code.

5. Respondent offers a "health benefits plan" in New Mexico.

Rationale

Respondent's HCSMs provide coverage for health benefits. This makes the HCSMs health benefits plans. "'[H]ealth benefits plan' means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services[.]" NMSA 1978, § 59A-16-21.2(C)(1) (2019). (Discussion of the definition of "health insurance carrier" is below.) Respondent argues that OSI has not proved that any resident of New Mexico has entered into a contract with Respondent for an HCSM offered by Respondent. Yet, Respondent has stated that 134 Trinity Households and 257 Trinity Individual Lives are covered by Respondent's HCSMs in New Mexico. Further, Respondent has not argued

that these HCSMs are not offered in New Mexico. The HCSMs are agreements offered by Respondent in New Mexico to provide, deliver, arrange for, or reimburse any of the costs of health care services contemplated by the HCSMs. Respondent offers health benefits plans in New Mexico.

6. **Respondent is a "health insurance carrier[.]"**

Rationale

Because Respondent offers health benefits plans, Respondent is a health insurance carrier.

> "[H]ealth insurance carrier" means an entity subject to the insurance laws and regulations of this state, including a health insurance company, a health maintenance organization, a hospital and health services corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers or administers health benefits plans or managed health care plans in this state.

NMSA 1978, § 59A-16-21.2(C)(2). Respondent has stated that 134 Trinity Households and 257 Trinity Individual Lives are covered by Respondent's HCSMs in New Mexico. Respondent is "an entity subject to the insurance laws and regulation of this state," because it provides coverage in this state for health benefits. NMSA 1978, § 59A-15-16. Respondent is an "entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers or administers health benefits plans … in this state." Respondent is a health insurance carrier that offers health benefits plans in New Mexico.

7. **Respondent is in violation of Section 59A-16-21.2(A) NMSA 1978.**

Rationale

Respondent's sale or issuance of HCSMs in New Mexico violates Section 59A-16-21.2(A), which states: "No person or entity shall sell or issue, or cause to be sold or issued, a health benefits

plan that is unlicensed or unapproved for sale or delivery in the state." Respondent has stated that 134 Trinity Households and 257 Trinity Individual Lives are covered by Respondent's HCSMs in New Mexico. The HCSMs are not licensed or approved for sale or delivery in New Mexico.

8. Respondent's health care sharing ministry programs are "insurance" subject to regulation under the Insurance Code.

Rationale

Respondent argues that the issue to be decided in this case is "whether the programs that Trinity offers through Trinity's health care sharing ministry ('HCSM') constitute 'insurance' as that term is defined under the New Mexico Insurance Code[.]" Trinity Healthshare, Inc.'s Closing Argument at 2. As noted above, Respondent "provides coverage in this state for health benefits" and is "subject to the provisions of the Insurance Code[.]" Because of that, Respondent is in violation of Section 59A-16-21.2(A) NMSA 1978. This is true even if Respondent's HCSMs are not "insurance" subject to regulation under the Insurance Code. However, Respondent's HCSMs are insurance.

A popular American aphorism apparently began with the Hoosier Poet, James Whitcomb Riley, who said, "When I see a bird that walks like a duck and swims like a duck and quacks like a duck, I call that bird a duck." Michael Heim, Exploring Indiana Highways 68 (2007). "'Insurance' is a contract whereby one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils, or to pay or grant a specified amount or determinable benefit in connection with ascertainable risk contingencies, or to act as surety." NMSA 1978, 59A-1-5 (1984). "Insurance is a contract whereby for consideration one party agrees to indemnify or guarantee another party against specified risks." *Cordova v. Wolfel*, 1995-NMSC-061, ¶ 8, 120 N.M. 557, 903 P.2d 1390. Respondent's HCSMs pay, indemnify, or guarantee Respondent's

members as to loss from certain specified contingencies, perils, or risks. Therefore, the HCSM agreements are insurance.

Respondent relies heavily on the argument that the "principal object and purpose" of the contract must be indemnity before the contract can be described as one for insurance. Trinity Healthshare, Inc.'s Closing Argument at 8-15, relying on *Guest v. Allstate Inc. Co.*, 2010-NMSC-047, 149 N.M. 74, 244 P.3d 342. Respondent argues that the HSCM agreements do not provide indemnity and conspicuously state on every page of the agreement that the agreement is not insurance. However, *Guest* requires this Hearing Officer to adopt a functional approach in applying the Insurance Code definition of insurance without regard to the labels used in the agreements. "But the current definition, adopted by the Legislature as part of the Insurance Code in 1984, articulates a functional approach, looking to the substance of the contract rather than to its label." 2010-NMSC-047, ¶ 62. The function and the substance of the agreements are insurance.

Guest used a functional approach to hold that a promise to indemnify was a contract of insurance; *Guest* did not hold that an agreement is an insurance contract ***if and only if*** it is a contract of indemnity. The statutory language defines insurance as an agreement to "pay ***or*** indemnify" another if a certain event occurs. Insurance is not limited to an agreement to "indemnify"; insurance is also an agreement to "pay." These words must mean different things, because it is a maxim of statutory construction that "the [L]egislature is presumed not to have used any surplus words in a statute; each word is to be given meaning." *Baker,* 2013-NMSC-043, ¶ 24 (internal quotation marks omitted; alteration in original). Respondent's agreements are agreements to pay another as to loss from certain specified contingencies or perils. The fact that the contingency is specified as both a health care cost and the existence of money available for the payment does not remove the promise to pay from the definition of insurance. And slapping a label

on a waterfowl that says "THIS IS NOT A DUCK" will not save the poor bird during duck hunting season.

Respondent's promise is also a promise to indemnify. In *Guest*, Ms. Guest was an attorney who represented Allstate in an arbitration where Allstate's insureds sought to recover under an uninsured motorist policy. 2010-NMSC-047, ¶¶ 3-4. After they were successful in the arbitration, the insureds then sued Allstate and Allstate's adjuster for bad faith; they also sued Ms. Guest for statutory and tort claims for her actions in the arbitration. *Id*., ¶ 5. Following repeated demands by Ms. Guest, Allstate promised to defend and indemnify Ms. Guest in the litigation. *Id*., ¶ 11. The dissent in *Guest* described this as a "gratuitous promise." *Id*., ¶ 74 (Chavez, J., joined by Serna, J., dissenting). This promise to defend and indemnify was not based on any insurance policy with Allstate as the insurer; rather, this promise arose solely out of the attorney-client relationship between Ms. Guest and Allstate.

Nevertheless, "for this contract to be one of insurance, the definition simply requires that Allstate agreed to 'indemnify [Guest] as to loss from certain specified contingencies or perils.'" *Id*., ¶ 62 (alteration in original). Respondent argues that the HCSM agreements do not promise to "indemnify" Respondent's members. But "looking to the substance of the contract rather than to its label," *id*., the agreements promise some form of payment or reimbursement for health care costs. "The typical meaning of 'indemnify' is akin to 'reimburse' rather than 'reimburse for losses incurred by third parties.'" *Battelle Mem. Inst. v. Nowsco Pipeline Servs., Inc.*, 56 F.Supp.2d 944, 951 (S.D. Ohio 1999). "'Indemnification' is merely a tool for allocating costs between contracting parties." *Id*. at 952. The HCSM agreements are a tool for allocating costs of health care between a member and Respondent. This is a form of indemnification which falls within the promise made in the HCSM agreements.

Respondent points out that "a promise to indemnify is not enough[,]" *Guest*, 2010-NMSC-047, ¶ 64, to create a contract of insurance. But the *Guest* Court made this statement in the context of distinguishing the promise before it from an incidental promise in a contract where the primary purpose is something other than indemnity. "Experience teaches that this kind of indemnity clause is common in the commercial setting and is often a boiler-plate feature of a contract of adhesion." *Id*. This is why the *Guest* Court looked to the "principal object and purpose" of the promise for "an appropriate limiting principle to what would otherwise be an overly inclusive definition of insurance." *Id*., ¶ 65. "The test directs a court to consider not whether risk is involved or assumed, but whether that or something else to which it is related in the particular plan is its ***principal object and purpose***." (internal quotation marks and ellipses omitted; emphasis by Court). Respondent argues that the principal object and purpose of its HCSM agreements is "provid[ing] members a service in the form of negotiating fee arrangements with health care providers and facilitating payment to those providers." Trinity Healthshare, Inc.'s Closing Argument at 12. Even this description, however, meets the definition of "indemnification" as "merely a tool for allocating costs between contracting parties." *Battelle Mem. Inst.*, 56 F.Supp.2d at 952. Looking to the substance of Respondent's agreements rather than to their label, the principle object and purpose of Respondent's agreements is to indemnify members for some or all of the health care costs that are the subject of the agreements.

Each of Respondent's HCSM agreements is a contract whereby Respondent undertakes to pay or indemnify a member as to loss from certain specified contingencies or perils. This payment or indemnification is the principal object and purpose of each agreement, and each agreement meets the definition of "insurance" in Section 59A-1-5. Respondent's health care sharing ministry programs are "insurance" subject to regulation under the Insurance Code.

9. Respondent acts as an insurer in New Mexico and therefore is required to have a certificate of authority from the Superintendent.

Rationale

Because Respondent's agreements are "insurance," Respondent is an "insurer" for purposes of the Insurance Code. "'Insurer' includes every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance." NMSA 1978, § 59A-1-8(A) (1984).

> No person shall act as an insurer, and no insurer shall transact insurance in this state by direct solicitation or solicitation through the mails or otherwise, unless so authorized by a subsisting certificate of authority issued by the superintendent, except as to such transactions as are expressly otherwise provided for in the Insurance Code.

NMSA 1978, § 59A-5-10(A) (1984). Respondent is required to have a certificate of authority from the Superintendent to sell insurance; that is, Respondent must have a certificate of authority in order to enter into its HCSM agreements in New Mexico.

10. Respondent is in violation of the Insurance Code by selling health benefits plans or insurance in New Mexico without a certificate of authority.

Rationale

Respondent does not have a certificate of authority to sell insurance in New Mexico, and Respondent is therefore not an authorized insurer. "An 'authorized insurer' is an insurer holding a valid and subsisting certificate of authority, issued by the superintendent, to transact insurance in this state." NMSA 1978, § 59A-1-8(B). Respondent is selling health benefits plans in New Mexico in violation of Section 59A-16-21.2(A), and Respondent is selling insurance in New Mexico in violation of Section 59A-5-10(A).

11. The Superintendent has the authority to require Respondent to cease and desist from offering to sell, or selling, health care sharing plans in New Mexico, unless and until Trinity obtains a certificate of authority to operate as a health insurer in this state, and its plans are approved by the Superintendent for sale in this state.

Rationale

Respondent has violated Section 59A-16-21.2(A) by selling unapproved health benefits plans in New Mexico, and the Superintendent has the authority to order Respondent to cease and desist from offering to sell, or selling, it's HCSMs in New Mexico. "If the superintendent has cause to believe that any unfair method of competition or act or practice defined or prohibited in Chapter 59A, Article 16 NMSA 1978 is being engaged in by any person, he shall order such person to cease and desist therefrom." NMSA 1978, § 59A-16-27(A). Because Respondent may only sell those plans as an authorized health insurance carrier subject to the laws of this state, Section 59A-16-21.2(C)(2), Respondent must obtain a certificate of authority to sell those plans. NMSA 1978, § 59A-1-8(A); § 59A-5-10(A). The Superintendent may order Respondent to cease and desist until Respondent complies with the requirements of the Insurance Code.

12. The Superintendent has the authority to levy a fine on Respondent in the amount of $2,680,000 or allow Respondent, in lieu of the fine, to cancel all 134 of the membership plans it sold in New Mexico, refund all contributions received by the members of those plans, and inform each plan member of all possible options for obtaining major medical coverage.

Rationale

The Superintendent may impose a fine on Respondent as an unauthorized insurer for each violation of the Insurance Code. "Any unauthorized insurer which transacts in this state any insurance business in violation of the Insurance Code shall be subject to fine of not to exceed

twenty thousand dollars ($20,000) for each such violation." NMSA 1978, § 59A-15-10 (1984). Each of the 134 membership plans issued by Respondent in New Mexico is a violation of the Insurance Code, so the Superintendent is authorized to levy a fine not to exceed twenty thousand dollars ($20,000) for each violation, for a total fine of $2,680,000.00.

OSI has not identified a statute that allows the Superintendent to give Respondent the option to take alternative actions in lieu of a statutory fine. However, the Superintendent's authority to do so is implied from his general powers. "A monetary penalty imposed may be additional to any applicable suspension, revocation or denial of a license or certificate of authority." NMSA 1978, § 59A-1-18(C) (1989). "The superintendent shall … have the powers and authority expressly conferred by or reasonably implied from the provisions of the Insurance Code[.]" NMSA 1978, § 59A-2-8(D) (2013). "The superintendent shall … have the power to make, enter into and enforce all contracts, agreements and other instruments necessary, convenient or desirable in the exercise of the superintendent's powers and functions and for the purposes of the Insurance Code[.]" § 59A-2-8(G). "The superintendent shall … comply with the provisions of the Administrative Procedures Act [('APA').]" § 59A-2-8(J). Under the APA, "where relief or procedure is not otherwise provided for, rules of practice and procedure applicable to civil actions in the district courts may be utilized by the parties at any stage of any proceeding[.]" NMSA 1978, § 12-8-11(I) (1969). Thus, the APA allows the Superintendent to fashion relief that would be available in the district courts.

A district court has equitable powers under the rules of practice and procedure applicable to civil actions in the district courts. "New Mexico courts do not distinguish between actions brought at law or suits brought in equity. … Under our court rules, there is 'one form of action to be known as "civil action",' in which all claims may be joined and all remedies are available."

Sims v. Sims, 1996-NMSC-078, ¶ 27, 122 N.M. 618, 930 P.2d 153, quoting Rule 1-002 NMRA. The Superintendent can impose the fine required by law but may also fashion equitable relief by the terms of the APA.

13. Any Conclusion of Law proposed by Respondent or OSI not accepted above, in whole or in part, is hereby rejected.

14. Trinity Healthshare, Inc.'s Motion to Exclude Expert Report of Paige Duhamel is hereby denied. The Hearing Officer has given no weight to any expert testimony offered by Respondent or OSI.

15. A copy of this Recommended Decision should be served to the persons listed on the attached certificate of service, by email unless otherwise noted.

THE HEARING OFFICER THEREFORE RECOMMENDS that the Superintendent enter a Final Order:

A. Adopting this Recommended Decision as his own;

B. Ordering Respondent to cease and desist from offering HCSMs in New Mexico;

C. Imposing a fine on Respondent in the amount of $2,680,000 or allowing Respondent, in lieu of the fine, to cancel all 134 of the membership plans it sold in New Mexico, refund all contributions received by the members of those plans, and inform each plan member of all possible options for obtaining major medical coverage; and

D. Giving Respondent ten (10) days from entry of the Final Order to choose the option in lieu of fine, because open enrollment in the health care marketplace ends December 15, 2020.

Recommended this 17th day of November, 2020.

R. Alfred Walker
Hearing Officer

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing *Hearing Officer's Recommended Decision* was sent via electronic mail to the following individuals, as indicated below, this 17th day of November, 2020.

Bryan Brock, General Counsel
Office of Superintendent of Insurance
P.O. Box 1689, Santa Fe, NM 87504-1689
bryan.brock@state.nm.us

Mark S. Barron, Counsel for Respondent
Baker & Hostetler LLP
1801 California Street, Suite 4400
Denver, Colorado 80202-2662
mbarron@bakerlaw.com
mbaisley@bakerlaw.com
dbauer@bakerlaw.com
jbaxter@bakerlaw.com
jmenk@bakerlaw.com
Attorneys for Trinity Healthshare, Inc

Rebecca Branch, Staff Counsel
Office of Superintendent of Insurance
P.O. Box 1689, Santa Fe, NM 87504-1689
rebecca.branch@state.nm.us

R. Alfred Walker, Hearing Officer
Office of Superintendent of Insurance
P.O. Box 1689, Santa Fe, NM 87504-1689
alfred.walker@state.nm.us

Melissa Y. Gutierrez

MELISSA Y. GUTIERREZ, Law Clerk
Office of General Counsel
Office of Superintendent of Insurance