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Hearings Unit, DIC  
Patricia D. Peterson  
Chief Hearing Officer

BEFORE THE STATE OF WASHINGTON  
OFFICE OF THE INSURANCE COMMISSIONER

*In the Matter of:*

**COORDINATED CARE CORPORATION,**

An Authorized Health Maintenance  
Organization.

**Docket No. 13-0232**

**COORDINATED CARE  
CORPORATION'S  
PREHEARING BRIEF**

**Table of Contents**

I. INTRODUCTION ..... 2

II. OIC'S NETWORK FINDINGS ARE NOT SUPPORTED BY LAW ..... 5

    A. Timing of Network Review ..... 6

    B. Coordinated Care Had Adequate Massage Therapists ..... 8

    C. Coordinated Care's Plan Provided Full Access to Pediatric Services and Level 1 Burn  
    Unit Services ..... 9

        1. Network Adequacy Standards ..... 9

        2. Coordinated Care's Network is Fully Adequate ..... 10

        3. Single Case Agreements Are Lawful and Commonly Used ..... 13

III. OIC'S OBJECTIONS TO THE FORM FILING ARE WITHOUT MERIT ..... 15

    D. None of the Language is Misleading, Confusing, or Ambiguous ..... 15

        1. Eligible Service ..... 16

        2. "Bronze Product, Specialty Drug Benefit" ..... 16

        3. Pharmacy Benefit – Mail Order Drugs ..... 18

    E. None of the Provisions Identified by the OIC are "Too Restrictive." ..... 19

        1. Objection No. 6: "Adding an Adopted Child" ..... 19

        2. Objection No. 7: "For Dependent Members" ..... 21

        3. Objection No. 8: "Family Planning Services" ..... 23

        4. Objection No. 9: "Home Health Care Services Benefits" ..... 24

        5. Objection No. 10: "Premiums" ..... 27

IV. OIC'S RATE FILING OBJECTIONS ARE NOT LEGALLY REQUIRED OR WERE  
MERE OVERSIGHTS BY THE OIC. .... 28

    F. Objection 1 (Documentation of Counties in a Rate Schedule) Is Not Based on Any Legal  
    Requirement ..... 29

1 G. Objection 2 (Support for Contribution to Surplus) Is Meritless – All Required Items  
Were Included in the Rate Filing..... 30

2 H. Objections 3 and 4 (Missing Exhibits) Are Unfounded..... 33

3 V. THE OIC’S BINDER FILING OBJECTIONS WERE EASILY REMEDIED..... 35

4 VI. THE OIC HAS THE DISCRETION TO PERMIT CORRECTION OF MINOR ERRORS  
AFTER FILING..... 35

4 VII. CONCLUSION..... 39

5

**I. INTRODUCTION**

6

7 Coordinated Care’s core business goal (in Washington, and nationally) was to lead the  
8 competition in offering an affordable product to uninsured/underinsured patients, including those  
9 who “churn” off and on Medicaid as their income changes. Nearly 800,000 Washingtonians are  
10 covered by Medicaid managed care health plans now, and thousands of them “churn off”  
11 Medicaid each month (due to changes in income), and will be eligible to obtain health coverage  
12 on the Exchange in 2014. Coordinated Care’s products (gold/silver/bronze) are designed in a  
13 manner to avoid significant adverse selection, but still take Coordinated Care’s share of high  
14 acuity patients (through co-pay/coinsurance/deductible design). Coordinated Care applied as a  
15 Qualified Health Plan (“QHP”) largely with the intent to provide high quality, affordable,  
16 continuity of care for these vulnerable, low income individuals and families.

17

18 Since the outset, the OIC indicated that it would rather deal with only commercial  
19 carriers for this year’s Exchange and with Medicaid carriers next year. Interestingly, the OIC  
20 has accomplished its goal – it did not approve any of the Medicaid carriers’ plans for this year’s  
21 Exchange. The OIC informed Medicaid carriers early on that they should rent a network if they  
22 wished to succeed. Heeding the OIC’s advice, Coordinated Care rented MultiPlan’s network at  
23 the outset and is still renting that network today. However, a rented network came at a higher  
24 cost to the consumers. This was contrary to Coordinated Care’s objectives in providing a low-  
25 cost option, but was presented by the OIC as the only option for participation in the 2014  
26 Exchange. Consistent with the Health Benefit Exchange’s mission statement, Coordinated Care  
decided to look for innovative solutions to provide consumer choice in collaboration with the

1 healthcare community. It did so by deciding to set up its own network in addition to the  
2 MultiPlan network, which would eventually replace the MultiPlan network. Coordinated Care  
3 never withdrew its agreement with MultiPlan from its OIC filings. By creating its own network,  
4 Coordinated Care was able to provide a plan at a substantially lower price than any of the other  
5 commercial carriers in the Exchange. Nothing in the statutes or regulations prevented  
6 Coordinated Care from doing so.

7 Coordinated Care built its network around federally-qualified health centers (FQHCs)  
8 and Rural Health Clinics (RHCs) that have a high quality/low utilization reputation, based on its  
9 results to-date in Medicaid. In addition to primary care physicians, Coordinated Care ensured  
10 that appropriate specialists, hospital services, and ancillary services were available in every  
11 county that it applied for using network adequacy standards common to the Washington  
12 Medicaid program, Medicare, and commercial networks. Pursuant to WAC 284-43-200(2), this  
13 may be used to demonstrate network sufficiency for the Exchange.

14 The OIC was cooperative with Coordinated Care when it believed Coordinated Care  
15 would use a rented network. However, that attitude changed when Coordinated Care decided to  
16 build its own network. The OIC rejected submissions for overly technical reasons. It did not  
17 conduct a full analysis of Coordinated Care's submission until July 2013, despite the fact that it  
18 had a complete product to review beginning with Coordinated Care's June 2013 filing. This  
19 approach differed from OIC's treatment of the commercial carriers. For instance, the OIC issued  
20 numerous objection letters to other commercial carriers, such as Group Health, in May, June, and  
21 July and gave them numerous opportunities to correct errors in order to assist them in submitting  
22 an acceptable plan for approval. Yet, the OIC sent only one set of objections to Coordinated  
23 Care in July. Many of the objections were vague or unclear. Coordinated Care was instructed  
24 not to contact Jennifer Krietler to ask any questions. Therefore, Coordinated Care invested  
25 significant resources seeking to understand the objections, carefully review the relevant statutes  
26

1 and regulations, and do what it believed was necessary to address those objections. Despite this,  
2 on July 31, 2013, the OIC issued a letter disapproving Coordinated Care's entire submission.

3 Throughout the process, the OIC gave conflicting instructions. For example, after  
4 receiving the OIC's concerns about the adequacy of pediatric hospitals in Coordinated Care's  
5 network in July, Coordinated Care expressly asked if it was required to include Children's  
6 Hospital as a participating provider. The OIC expressly stated that it was not required. Despite  
7 this, the OIC later disapproved Coordinated Care's submission based in part on the fact that it  
8 had not contracted with Children's Hospital.

9 Many of the OIC's objections were also made-up requirements that were not mandated  
10 by any law or included in any prior instruction to the filers. For instance, there is no requirement  
11 that the carriers include a list of the counties offered in their plan on the Rate Schedule. While  
12 Coordinated Care is happy to accommodate these types of requests as a courtesy, the OIC may  
13 not base its disapproval on these arbitrary, non-legal grounds.

14 Moreover, the OIC makes a number of misleading statements in its brief. For instance, it  
15 states that Coordinated Care's submissions appeared to miss "entire categories of providers . . .  
16 such as Ear, Nose, and Throat specialists, pediatric hospitals, proctologists, and pulmonologists."  
17 See OIC Brief, 8. These were all included in Coordinated Care's submission (in its Form A).  
18 They were simply coded differently. The codes used by Coordinated Care were expressly  
19 allowed by the OIC as alternate codes. Moreover, the term "proctologist" has not been used for  
20 years. These doctors are now called Gastroenterologists or Colorectal Surgeons and were  
21 properly identified as such in Coordinated Care's materials. The OIC's decision to disapprove  
22 Coordinated Care's plan has reduced competition, a key tenet of the Washington Health Benefits  
23 Exchange ("HBE"). In some counties this has resulted in only one carrier providing a plan,  
24 essentially eliminating the concept of consumer choice and comparative shopping for plans.  
25 According to the Washington State Health Care Authority, the benefit of having Medicaid health  
26 plans on the Washington HBE was to give those caught up in churn "a chance to stay with a

1 familiar provider network and plan.” The lack of Medicaid plans in the Washington Exchange  
2 adversely impacts affordability of the products on the Exchange, will be overly burdensome on  
3 Washington’s low income citizens, and will lead to lack of adequate coverage for them.

4 The fact of the matter is that none of the OIC’s objections were valid. Even the OIC does  
5 not appear to believe in the strength of those objections; it had to add new bases and  
6 justifications for these objections in its Hearing Brief. None of these new bases should be  
7 considered, and regardless they too are without merit. Coordinated Care’s network was adequate  
8 under the standards provided under Washington law. The OIC’s objections to Coordinated  
9 Care’s form and rate filings were not based on any legal requirement or were otherwise  
10 unfounded. The OIC’s objections to Coordinated Care’s binder filing were overly technical and  
11 could have been easily corrected had the OIC timely informed Coordinated Care of these  
12 concerns. The OIC has the discretion to allow a carrier to correct errors after a filing and to  
13 request more time for its review. That would have made sense here where the OIC’s own  
14 technical “compression” problems (discussed further below) precluded it from fully reviewing  
15 Coordinated Care’s network until after July 25. Given that the OIC’s findings were in error,  
16 Coordinated Care seeks regulatory certification from the OIC to be presented to the Washington  
17 State Health Benefits Exchange as a qualified health plan for 2014.

## 18 II. OIC’S NETWORK FINDINGS ARE NOT SUPPORTED BY LAW

19 The OIC asserted a number of objections in the July 31, 2013 disapproval letter  
20 (“Disapproval Letter”), pertaining to alleged network adequacy issues. However, in the OIC’s  
21 Hearing Brief, the OIC has admitted that all of the network adequacy issues have been addressed  
22 except for two. The OIC claims that the following kinds of network adequacy problems were  
23 not resolved by July 31: (1) lack of massage therapists, and (2) lack of certain specialty  
24 hospitals. That is simply untrue. Coordinated Care’s plan has sufficient massage therapists and  
25 specialty hospitals to assure that all health plan services will be accessible to covered persons  
26 without unreasonable delay.

COORDINATED CARE CORPORATION’S PREHEARING BRIEF - 5

1     **A.     Timing of Network Review**

2             The OIC states that Coordinated Care prevented them from conducting a full review of its  
3 network and filings because of various alleged problems and that it did not have a full plan to  
4 review until July 1, 2013. First, this is incorrect. Coordinated Care did not “file as a disability  
5 carrier” in April. The issue is not as simple as the OIC implies. There is no category under  
6 which a filing is done. The OIC simply believed the contract submitted in April read more like a  
7 disability carrier contract than an HMO contract and summarily disapproved the contract on that  
8 basis. With the second filing on May 2, 2013, again the issue was not that Coordinated Care  
9 picked the wrong box (i.e. a “disability carrier” box); the OIC still believed that something in the  
10 contract sounded more like disability insurance language. There was no question that  
11 Coordinated Care’s plan was filed as an HMO policy. Indeed, in the May SERFF filing, the  
12 “Project Name” for Coordinated Care’s filing was “Individual HMO.”

13             Coordinated Care attempted to address the OIC’s concerns as well as remove any  
14 bracketed language before resubmitting its form filing on May 25, 2013. The OIC argues that  
15 the entire May 31 form filing had to be rejected because the submission still contained some  
16 brackets. The May 31 filing only contained *one set* of brackets in the Schedule of Benefits. No  
17 brackets were included in the contract that was filed. The brackets had no impact on the  
18 contract, the rate filing, or the binder submission. There was nothing that precluded the OIC  
19 from examining the rest of the submission. Yet, the OIC unreasonably used the single set of  
20 brackets as excuse to disapprove all of Coordinated Care’s filings. Moreover, the OIC took 25  
21 days to realize that there were brackets before disapproving the entire filing. On July 1, 2013,  
22 Coordinated Care resubmitted each filing in its identical form as its May 31 submission,  
23 excluding the brackets.

24             Second, it clearly would not have mattered if Coordinated Care had submitted a perfect  
25 submission in April. The OIC admits that it “announced in early 2012 that it would conduct its  
26 review of new networks for use in Exchange plans using each network’s June 10, 2013 Form A”

1 and in fact did not review Coordinated Care's network until after June 10. *See* OIC Hearing  
2 Brief, 8.

3 Coordinated Care submitted its network Form A documents every month beginning in  
4 April 2013. Coordinated Care did not receive any feedback from the OIC on any Form A  
5 submission except the June 10 submission. Had the OIC examined them earlier, it would have  
6 discovered the "compression problems" that were occurring with its own system.<sup>1</sup> The OIC first  
7 informed Coordinated Care of this compression problem on or around July 11, 2013. According  
8 to the OIC, a glitch in its system would compress the data provided in a Form A filing, changing  
9 some of the fields on the provider list. This modified the data that was provided in a way that  
10 made it false and incomplete. As a result of this glitch, the OIC was not able to properly review  
11 Coordinated Care's network. This was through no fault of Coordinated Care. The time crunch  
12 was of the OIC's own making; it was the OIC's independent decision to wait to review  
13 Coordinated Care's Form A submission until less than a month before the deadline. Contrary to  
14 the OIC's assertions, Coordinated Care properly submitted a revised Form A on July 25, 2013  
15 using the alternative mechanism provided by the OIC (i.e., emailing it to OIC staff), an  
16 alternative mechanism that Coordinated Care was not made aware of until the OIC informed it  
17 of the compression problem in mid-July 2013. It was not Coordinated Care's responsibility to  
18 ferret out technical problems in the OIC computer system and guess at a potential solution.  
19 Rather, once made aware of the OIC's problem and asked to provide materials in an alternative  
20 matter, it was Coordinated Care's responsibility to provide that alternative information, which it  
21 did.

22  
23  
24 <sup>1</sup> The OIC only deferred review of "new" networks, therefore it must have reviewed the  
25 Form A submissions of the established commercial carriers and other Medicaid carriers who  
26 used rented networks in advance of reviewing Coordinated Care's June Form A. Indeed, the  
OIC approved some carrier's networks prior to June. It is unclear why these compression issues  
were not discovered upon the OIC's earlier review of these carriers' Form A submissions.

1 **B. Coordinated Care Had Adequate Massage Therapists.**

2 The OIC claims that Coordinated Care had no contracted massage therapists in its  
3 network as of July 31, 2013. This is flat out wrong. By July 31, Coordinated Care had an OIC-  
4 approved contract to rent the Healthways network, which includes massage therapists,  
5 chiropractors, acupuncturists, and naturopaths. The Healthways network is completely adequate  
6 and is used by a number of commercial carriers, including Group Health. Indeed, the OIC  
7 admitted to this in a meeting on July 16.

8 Coordinated Care submitted its Healthways contract form to the OIC for approval on July  
9 9, 2013. Under RCW 48.46.243(3)(b), any contract form that is not affirmatively disapproved  
10 within 15 days of filing shall be deemed approved. The OIC may only extend that approval  
11 period for an additional 15 days if it gives notice before the expiration of the initial 15-day  
12 notice. RCW 48.46.243(3)(b). The OIC did not disapprove or give notice of its intent to extend  
13 the approval period by July 9, 2013, as required by the statute. Therefore, the Healthways  
14 contract was deemed approved by July 30, 2013. The OIC's attempt to disapprove the contract  
15 on August 8, 2013, was too late. By that point, the OIC's approval had already been deemed  
16 approved by operation of law. Moreover, even if the August 8th disapproval was proper (which  
17 it was not), as of July 30, 2013, the contract had deemed and, therefore all the massage  
18 therapists, chiropractors, acupuncturists, and natural paths that were included therein were part of  
19 the Coordinated Care network.

20 The OIC claims that the Healthways contract that was submitted on July 9, 2013 did not  
21 include massage therapists and that Coordinated Care was therefore required to either submit a  
22 revised contract or file a stand-alone amendment to the existing contract to correct the problem.  
23 The OIC misunderstands. *The Healthways contract always included massage therapists.* The  
24 only place massage therapists was omitted from was the accompanying sheet that was attached to  
25 the contract in the SERFF filing (called the Coordinated Care Group Summary). Coordinated  
26

1 Care asked to amend the filing solely to correct the summary sheet. The OIC's instructions did  
2 not address the issue. No amendment to the contract was required.

3 Because Coordinated Care had an adequate number of massage therapists in its network  
4 as of July 31, 2013, the OIC improperly disapproved its submission on this basis.

5 **C. Coordinated Care's Plan Provided Full Access to Pediatric Services and Level 1**  
6 **Burn Unit Services.**

7 The OIC claims that Coordinated Care's network is inadequate because it lacks two kinds  
8 of specialty hospitals in its network: (1) a pediatric hospital and (2) a level 1 burn unit. *See* OIC  
9 Hearing Brief, 11. This is incorrect. Coordinated Care's network includes sufficient facilities to  
10 ensure that all health plan services, including all pediatric and level 1 burn services, are  
11 accessible to consumers without unreasonable delay.

12 **1. Network Adequacy Standards.**

13 The standards for network adequacy are articulated in WAC 284-43-200. WAC 284-43-  
14 200(1) requires that carriers have a network "sufficient in numbers and types of providers and  
15 facilities to assure that all health plan services to covered persons will be accessible without  
16 unreasonable delay." A health carrier is not required to meet this requirement prior to receiving  
17 approval by the OIC. Rather, the regulations require carriers to meet this requirement "by the  
18 end of the first year of initial operation of the network and at all times thereafter." WAC 284-43-  
19 200(1) (emphasis added). WAC 284-43-200(4) also requires health carriers to ensure reasonable  
20 proximity of network providers and facilities to the business or personal residence of covered  
21 persons, taking into consideration the relative availability of health care providers or facilities in  
22 the service area under consideration and the standards established by state agency health care  
23 purchasers (such as the Medicaid program in which Coordinated Care currently participates).

24 Under WAC 284-43-200(2), sufficiency and adequacy of choice may be established by  
25 the carrier with reference to any reasonable criteria, including provider-covered person ratios by  
26 specialty, primary care provider-covered person ratios, geographic accessibility, waiting times

1 for appointments with participating providers, hours of operation, and the volume of  
2 technological and specialty services available to serve the needs of covered persons requiring  
3 technologically advanced or specialty care. WAC 284-43-200(2) expressly states that evidence  
4 of compliance with the network adequacy standards that are substantially similar to standards  
5 established by state agency purchasers (e.g., Medicaid) may also be used to demonstrate  
6 sufficiency. Therefore, the fact that Coordinated Care's network is substantially similar to the  
7 standards established by Medicaid demonstrates its network sufficiency. Coordinated Care  
8 demonstrated this in its Network Access Plan. There, it showed the OIC that its network met all  
9 of the Medicaid standards for network sufficiency in addition to a number of the reasonable  
10 criteria listed above. *See* Network Access Plan.

11 The network adequacy standards do not require that all services be provided by contracted  
12 providers. WAC 284-43-200(3) expressly allows carriers to utilize out-of-network providers for  
13 any purpose as long as the consumer is not put in a worse position. WAC 284-43-200(3). In  
14 other words, the law allows for single case agreements.

15 **2. Coordinated Care's Network is Fully Adequate.**

16 Under the express regulations, Coordinated Care's network is fully adequate. Coordinated  
17 Care's plan gives consumers access to all pediatric and Level I burn services without  
18 unreasonable delay through participating providers or single case agreements.

19 First, Coordinated Care has an adequate network for providing pediatric services,  
20 including hospital services. Included in Coordinated Care's network are four children's specialty  
21 service providers and hospitals. Providence and Swedish merged in early 2012, enhancing their  
22 existing, and substantial hospital programs around pediatric specialty care. Providence is an  
23 example of a system that provides extensive, in depth, specialty pediatric care at multiple sites  
24 statewide. Coordinated Care's network also includes Providence Sacred Heart Children's  
25 Hospital in Spokane. Sacred Heart provides pediatric services to those in Eastern Washington.  
26

1 Sacred Heart provides 99% of the services provided by Children's Hospital. Coordinated Care  
 2 recently also contracted with Shriners Hospital for Children in Spokane, which provides  
 3 additional services for the Eastern Washington region. Below are examples of the types of  
 4 services that each of these participating hospitals provide to children.

5 Providence Sacred Heart 6 Children's Hospital in 7 Spokane	Pediatrics at Swedish 8 Medical Center in 9 Seattle	Providence Regional 10 Medical Center in Everett	Shriners Hospital for 11 Children in Spokane
12 Oncology/Hematology	Gastroenterology	Pediatric Cancer Care	Orthopedics
13 Neonatal Intensive Care	Neonatal Intensive Care (Level III)	Neonatal Intensive Care (Level III)	Otolaryngology
14 Pediatric Intensive Care Unit 15 Pediatric Level I Trauma 16 Center	Orthopedic and Sport 17 Medicine	Pediatric Intensive Care 18 Unit	Psychiatry and Psychiatry
19 Neurology	General Surgery	Joint Special Care Unit (JSCU)	Rehabilitation
20 Cardiac Care Center	Intensive Care		Congenital Heart Disease
21 Neurosurgery	Neurology		Nutrition
22 Transplant Services	Endocrinology		Therapy
23 Adolescent Medicine	Nephrology		Burn Care
24 Developmental Medicine	Urologic Surgery		Spinal Cord Injury
25 Endocrinology	Ear, Nose and Throat		Imaging
26 Genetics	Epilepsy		Research
Nephrology	Infectious Disease		
Palliative Care	Nutrition		
Psychiatry	Therapy Services		
Pulmonary	Palliative Care		
Research			
Urology			

19 As with any network, there may be very rare, unique types of care that are not provided by the  
 20 facilities in Coordinated Care's network. In those cases, that service would be covered through  
 21 use of single case agreements, which are discussed below. Coordinated Care offered a full  
 22 provider network that is designed to provide coverage for Coordinated Care's Exchange  
 23 offerings.

24 The OIC's real complaint here appears to be that Coordinated Care did not include in its  
 25 network a contract with Children's Hospital ("Children's"). There is no statute or regulation that  
 26

1 requires Coordinated Care to contract with Children's. The hospitals that Coordinated Care has  
2 contracted with are able to provide nearly all of the covered pediatric services provided by  
3 Children's, at lower rates. Indeed, in July 2013, the OIC expressly told Coordinated Care that it  
4 did not need to contract with Children's to have an adequate network. Coordinated Care could  
5 have contracted with Children's, but chose not to because Children's will only accept full  
6 commercial rates, which would unnecessarily drive up the overall cost of the product to  
7 consumers.

8 Coordinated Care's goal was to create a low-cost option  
9 that meets legal requirements and consumer needs. It was able to do that with the  
10 Providence/Swedish facilities.

11 The OIC further argues that Coordinated Care's network is somehow insufficient because  
12 it does not include pediatric hospitals in its network that are located in cities other than Seattle,  
13 Everett, and Spokane. WAC 284-43-200(4) provides that health carriers "establish and maintain  
14 adequate arrangements to ensure reasonable proximity of network providers and facilities to the  
15 business or personal residence of covered persons" and to "make reasonable efforts to include  
16 providers and facilities in networks in a manner that limits the amount of travel required to  
17 obtain covered benefits." However, in determining whether a carrier has complied with this  
18 provision, the OIC must "give due consideration to the relative availability of health care  
19 providers or facilities in the service area under consideration and to the standards established by  
20 state agency health care purchasers." *Id.* "Relative availability includes the willingness of  
21 providers or facilities in the service area to contract with the carrier under reasonable terms and  
22 conditions." *Id.* The OIC is clearly not giving the requisite consideration here. There are only a  
23 limited number of pediatric hospitals in Washington state. Some counties in Washington,  
24 including some counties which Coordinated Care offers services, do not have a pediatric  
25 hospital within close proximity. Indeed, even if Coordinated Care added Children's, that would  
26 merely add another facility in King County, which is already served by a pediatric hospital in

1 Coordinated Care's network, and would not provide access in other counties. If the OIC truly  
2 required carriers to include pediatric hospitals in its network for every county, no carrier would  
3 be able to qualify to serve some of the counties in Washington. Surely that was not the intent of  
4 the Affordable Care Act.

5 **3. Single Case Agreements Are Lawful and Commonly Used.**

6 The second criticism of Coordinated Care's network advanced by the OIC is access to  
7 level 1 burn care. Coordinated Care explained in person and at length in its Network Access  
8 Plan that such care would be accessible through single case agreements. Single case agreements  
9 are standard practice in the industry, do not give rise to any consumer risk (whether in terms of  
10 access to care or potential "balance billing"), and are a seamless process to provide necessary  
11 care.

12 OIC argues that single case agreements are not allowed unless the OIC approves them  
13 because they are "alternative arrangements." OIC's belief is based on a fundamental  
14 misunderstanding of Coordinated Care's plan and misinterpretation of the regulation. The laws  
15 contemplate that carriers may not have all the necessary providers (or a sufficient number of  
16 them) in proximity to all consumers and expressly allows for such situations so long as the  
17 consumer is not put in a worse position. Therefore, where there is no participating provider for a  
18 specific covered service, the statute requires health carriers to ensure that the consumer obtains  
19 the covered service from a provider/facility within reasonable proximity at no greater cost to the  
20 consumer than if he received treatment from a participating provider. That is what a single case  
21 agreement does.

22 WAC 284-43-200(3) states:

23 (3) In any case where the health carrier has an absence of or an  
24 insufficient number or type of participating providers or facilities  
25 to provide a particular covered health care service, the *carrier*  
26 *shall ensure through referral by the primary care provider or*  
*otherwise that the covered person obtains the covered service*  
*from a provider or facility within reasonable proximity of the*

1 *covered person at no greater cost to the covered person than if*  
2 *the service were obtained from network providers and facilities,*  
3 *or shall make other arrangements acceptable to the commissioner.*

4 Under the plain language of this regulation, an "other arrangement" is necessary only if  
5 (1) the services will not be provided or (2) the consumer is charged more for the out-of-network  
6 services. Because neither of these conditions exist, no approval from the OIC is required. Use  
7 of single case agreements is in accord with WAC 284-43-200.

8 Moreover, WAC 284-43-200(3) is not limited to "extraordinarily uncommon",  
9 "atypical", "very rare" or "unforeseen" medical situations as the OIC suggests. Indeed, there are  
10 no restrictions on the use of out-of-network providers so long as the requirements under WAC  
11 284-43-200(3) are met.

12 Using the incorrect example provided by the OIC on page 13 of its Hearing Brief, this is  
13 how a single case agreement would work: If an enrollee suffers a catastrophic burn that can only  
14 be treated by Harborview, the patient will immediately be sent to Harborview and treated. No  
15 prior approval is required for emergency situations such as this. Coordinated Care is then  
16 invoiced for the services. The consumers have the same coverage, deductibles, co-pays, co-  
17 insurance, and out of pocket maximums as they would if they obtained the service from a  
18 network provider. The consumer would not be required to wait for Coordinated Care to  
19 negotiate a contract with Harborview prior to receiving medical services. This was all clearly  
20 explained in Coordinated Care's Network Access Plan. Single case agreements were described  
21 as follows:

22 Approval of out-of-network services is confirmed through the  
23 execution of Single Case Agreements and prior authorization. All  
24 hospital systems within the service areas have processes in place to  
25 manage single case agreements. Regardless of a provider's  
26 network participation status, we never require prior authorization  
for emergency services.

For example, *pediatric members* needing sub-specialized Level IV  
NICU services only available at an out-of-network provider *will*  
*receive covered benefits from the out-of-network provider at the*  
*same benefit level as if the benefit were obtained from an in-*

1            *network provider* (with appropriate deductibles, co-pays, co-  
2 insurance, out-of-pocket maximums, etc.) Likewise, for example,  
3 patients needing Level 1 Trauma or burn services only available at  
4 a non-participating provider will receive covered benefits from the  
5 out-of-network provider at the same benefit level as if the benefit  
6 were obtained from an in-network provider (with the same  
7 appropriate deductibles, co-pays, co-insurance, out-of-pocket  
8 maximums, etc.)

9            Contrary to the OIC's assertions, there is no balanced billing in single case agreements. To the  
10 contrary, the consumer receives the needed care without question.

11            In short, the OIC's objections to the adequacy of Coordinated Care's network are wholly  
12 unfounded and not a legitimate basis for disapproving Coordinated Care's submission.

### 13            **III. OIC'S OBJECTIONS TO THE FORM FILING ARE WITHOUT MERIT**

14            In its disapproval letter, the OIC articulated eight objections to Coordinated Care's rate  
15 filing on the basis that they were either (a) misleading or confusing or (b) too restrictive and  
16 noncompliant with the laws. Coordinated Care fully addressed the objections that were  
17 articulated prior to the July 31 Disapproval Letter to the extent the objection was clearly  
18 articulated. The problem is that the OIC's objections, and its alleged bases for those objections,  
19 are constantly changing. Indeed, not only did the OIC articulate new objections on July 31, it  
20 changed the basis for those very objections again in its Hearing Brief. It did so despite informing  
21 Coordinated Care's counsel that the appeal would be limited to the objections that were made in  
22 the July Disapproval Letter. The OIC's new objections should not be considered at all. And the  
23 Hearing Officer should reject all of the OIC's baseless objections.

#### 24            **D. None of the Language is Misleading, Confusing, or Ambiguous.**

25            The OIC argues that the provisions for "Eligible Service," "Bronze Product, Specialty  
26 Drug Benefit," and "Pharmacy Benefit" are confusing, misleading, or ambiguous. These  
objections are without merit.

1           **1.     Eligible Service**

2           The OIC states that the definition of eligible service is confusing and misleading because  
3 it does not clearly notify the enrollee that in addition to in-network cost-share requirements, the  
4 enrollee will be subject to “balance billing” by the provider or facility. The definition is not  
5 misleading at all because the consumer will in fact not be subject to balance billing. This  
6 objection is again premised solely on the OIC’s misunderstanding of Coordinated Care’s  
7 product.

8           The OIC believes that single case agreements result in balance billing to the consumer.  
9 See OIC’s Hearing Brief, 13. As explained in detail above, this does not happen. Consumers  
10 who use out-of-network providers for covered services “will receive covered benefits from the  
11 out-of-network provider *at the same benefit level as if the benefit were obtained from an in-*  
12 *network provider* (with appropriate deductibles, co-pays, co-insurance, out-of-pocket  
13 maximums, etc.)” Network Access Plan, 4 (emphasis added). They will not be subject to  
14 balance billing. This practice complies with WAC 284-43-200(3). Coordinated Care’s  
15 definition of eligible service therefore accurately reflects how the plan operates. See 7/25/13  
16 Product Submission, 10-11 (definition of Eligible Service). It is the OIC’s proposal to include  
17 balance billing in the definition of eligible service that would cause this definition to be  
18 misleading and inaccurate.

19           **2.     “Bronze Product, Specialty Drug Benefit”**

20           In its Objection No. 10, the OIC states that:

21                   The Bronze Product, Specialty Drug benefit includes a \$350.00  
22                   maximum “eligible coinsurance charge” before the service is paid  
23                   at 100%. This dollar amount is a deductible and must be set forth  
24                   in the policy, rate, and binder as such. The benefit as stated in the  
25                   policy is misleading per RCW 48.46.060(3)(a).  
26

1 The provision at issue here is one that places a cap on the total amount a consumer would  
2 be obligated to pay as part of his coinsurance<sup>2</sup> for a specific type of drug. In other words, the  
3 consumer will never pay more than \$350 for the specific type of drug, regardless of the  
4 coinsurance percentage. For example, if the coinsurance percentage for bronze product and  
5 specialty drugs was 80% covered by Coordinated Care and 20% covered by the consumer, the  
6 consumer would nonetheless never pay more than \$350.00 for that 20% portion. In other words,  
7 if a drug cost \$2,000, without the cap, the consumer would pay \$400 (20% of \$2,000), but with  
8 the coinsurance maximum, the consumer would only have to pay \$350. Coordinated Care would  
9 pay the rest. This cap was added solely for the benefit of the consumer.

10 The OIC mistakenly characterizes this coinsurance maximum as a deductible, which it is  
11 not. A deductible is the amount the member must pay during a calendar/plan year before any  
12 benefits are provided or payable by Coordinated Care. *See* 7/25/13 Product Submission, 10.<sup>3</sup>  
13 The \$350 does not represent an amount the consumer must pay before any benefits are provided.  
14 Nor is it an additional amount that is charged to the consumer. The consumer would be  
15 obligated to pay a certain percentage of the bronze product and specialty drugs under the policy  
16 regardless of this provision; the maximum just places a cap on that amount. The maximum  
17 eligible coinsurance charge has no impact on the deductible; coinsurance is paid in addition to  
18 the deductible. *Id.* at 28. Therefore, Coordinated Care had no obligation to make any revisions  
19 to the policy, rate, and binder.

20 Moreover, there is nothing misleading about this provision. It expressly states that \$350  
21 is the maximum amount of an "eligible coinsurance charge." Nowhere does it state that it

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22 <sup>2</sup> Coinsurance is the amount of covered expenses that are payable by the member, in  
23 addition to the deductible. *See* 7/25/13 Product Submission, pp. 9 and 27.

24 <sup>3</sup> Deductible and coinsurance are not defined in the statutes or regulations. Instead, they  
25 are rolled into "cost sharing," which is defined in RCW 48.43.005(16) and WAC 284-43-130(8)  
26 as: "Enrollee point-of-service cost-sharing means amounts paid to health carriers directly  
providing services, health care providers, or health care facilities by enrollees and may include  
copayments, coinsurance, or deductibles." Since the OIC never objected to the definitions of  
"coinsurance" or "deductible" used by Coordinated Care in its product submission, the  
definitions are presumed to be proper.

1 applies to or impacts the deductible. The OIC's unreasonable interpretation of a plainly worded  
2 benefit is not a reasonable basis for disapproval.

3 Indeed, it is unclear how a cap on the consumer's portion of coinsurance can in any way  
4 be "discriminatory against enrollees who have health conditions that require these drugs. . ." See  
5 OIC's Hearing Brief, 17. The benefit is offered to all enrollees and actually helps them obtain  
6 drugs that may otherwise be too expensive. Coordinated Care could have removed this provision  
7 entirely and required all consumers to pay the full amount of the coinsurance percentage  
8 regardless of the cost. Surely, it is not the OIC's intention to remove a benefit that would help  
9 consumers get more reasonable access to drugs.

### 10 3. Pharmacy Benefit – Mail Order Drugs

11 In its Objection No. 11, the OIC claims that the Pharmacy benefit is confusing and  
12 ambiguous because it states that the consumer's co-pay for Mail Order Drugs will be three times  
13 the retail cost sharing requirement. It claims that Coordinated Care must specifically define the  
14 cost share obligation to the member in the policy. In its brief, the OIC states that the use of a  
15 multiplier is noncompliant because (1) it is not possible to determine what the insurer means by  
16 this and (2) the amount must be either a dollar amount or a percentage of the total cost. OIC  
17 Hearing Brief, 17. The OIC does not cite a single statute or regulation that requires a carrier to  
18 define the benefit a certain way or that precludes a carrier from using a multiplier to describe the  
19 consumer's co-pay. *Id.* Nor does such a statute exist. Because Coordinated Care did not fail to  
20 comply with any statute or regulation, this cannot be used as a basis for disapproval.

21 Moreover, the description is the most accurate way to define the cost share requirement.  
22 Coordinated Care has three tiers of drugs: generic, brand, and specialty. While Coordinated  
23 Care charges a set co-pay on the generic and brand drugs (e.g., \$20), consumers pay a co-  
24 insurance on the specialty drugs based on a percentage of specific drug's value (e.g., 10%).  
25 Therefore, Coordinated Care cannot provide set amounts that will be charged for specialty drugs  
26

1 because it would depend on the value of the drug. In light of this, the most accurate way to  
2 explain the cost-share obligation for mail order drugs was to use a multiplier. There is nothing  
3 confusing or ambiguous about it. The consumer need only multiply the co-pay or co-insurance  
4 amount by three to calculate the mail order cost.

5 **E. None of the Provisions Identified by the OIC are “Too Restrictive.”**

6 The OIC articulates five objections to the Form Filing on the basis that the provisions are  
7 too restrictive, or noncompliant with the laws. These are all baseless for the reasons described  
8 below.

9 **1. Objection No. 6: “Adding an Adopted Child”**

10 In its Disapproval Letter, the OIC stated that the “Adding An Adopted Child” provision  
11 is too restrictive in conflict with RCW 48.01.180 and RCW 48.46.490. It provided two express  
12 reasons for this belief:

13 First, it is unclear why Coordinated Care has added additional  
14 language defining conditions of “placement”. Second, it is unclear  
15 what the “written notice” is a parent must provide regarding the  
16 intent to adopt the child. The enrollee is only required to apply for  
17 coverage for the new dependent.

18 Neither of these are a proper or reasonable basis for disapproving the plan. First, nothing  
19 in RCW 48.01.180 and RCW 48.46.490 (or any other law) precludes Coordinated Care from  
20 defining “placement” in its product submission. This definition was added for the benefit of the  
21 consumer. Second, RCW 48.46.490, which allows carriers to require notification and payment  
22 of additional premiums as a prerequisite to coverage for adopted children, does not require  
23 Coordinated Care to describe the type of notice that is required to show intent. It simply requires  
24 a notification. There are multiple other provisions in the product submission that requires  
25 written notice without explaining what that notice is required to say; the OIC did not require an  
26 explanation of any of those.

1 Now, for the first time, in its Hearing Brief, the OIC proffers an additional basis for its  
2 objection. Different than that what was stated in the July 31 objection, the OIC now claims that  
3 Coordinated Care's policy violates the statute because it "would require a family seeking to add  
4 an adopted child to its plan to meet conditions that a family seeking to add a biological child  
5 need not." OIC Hearing Brief, 15. Specifically, the OIC states that Coordinated Care's  
6 requirement of a letter of intent to adopt the child or a court order from an adoptive parent  
7 violates those laws. This should not be considered because it is a new objection, but it is also  
8 incorrect.

9 While RCW 48.01.180 and RCW 48.46.490 require the policies to provide coverage for  
10 dependent adopted children under the same conditions as natural, dependent children, RCW  
11 48.46.490(2) expressly allows carriers to require additional payments for such coverage and to  
12 provide notification of placement. It provides:

13 If payment of an additional premium is required to provide  
14 coverage for a child, the agreement may require that notification of  
15 placement of a child for adoption and payment of the required  
16 premium must be furnished to the health maintenance  
organization. The notification period shall be no less than sixty  
days from the date of placement.

17 Consistent with this, Coordinated Care requires the consumer to pay an additional premium for  
18 coverage of adopted children and to provide notification within 60 days. In its product  
19 submission, Coordinated Care included the following language in the Adding an Adopted Child  
20 provision:

21 Additional premium will be required to continue coverage beyond  
22 the 60th day following placement of the child. The required  
23 premium will be calculated from the date of placement for  
24 adoption. Coverage of the child will terminate on the 60th day  
25 following placement, unless we have received both: (A) written  
26 notice of your or your spouse's intent to adopt the child; and (B)  
any additional premium required for the addition of the child  
within 90 days of the date of placement.

As used in this contract, "placement" means

- i. The date that you or your spouse assume legal obligation for total or partial support of the child for the purpose of adoption whether or not the adoption has become final; or
- ii. The date of qualified court order to provide coverage.

See 7/25/13 Product Submission, 21-22. This is consistent with RCW 48.46.490(2). The statute expressly permits a carrier to require prior notice before coverage is provided. RCW 48.46.490(2). While it does not specify that the notice need be in written form, requiring notice in writing is not prohibited nor is it more restrictive than is required under the statute. Moreover, Coordinated Care's requirements are actually less restrictive than those expressed in RCW 48.46.490(2). While the statute requires notice of final placement, Coordinated Care will accept notification of a consumer's mere intent to adopt a child.

Contrary to the OIC's argument, nothing in the provision requires the consumer to obtain a court order. No reasonable person would read the definition of "placement" to require that. Even the definition of placement provides that the date of placement could be *either* the date of a qualified court order *or* the date the consumer or his spouse assumes legal obligation for the support of the child (consistent with RCW 48.01.180(1)). Coordinated Care included the date of the order as a possible date of placement because adoption placements are made via court order. This is not inconsistent with any statute.

Had the OIC articulated its objection in the July 17 objection letter (rather than in its Hearing Brief three weeks after the final disposition), Coordinated Care certainly could revised this language fairly quickly to respond to the OIC's concerns. Neither modification is required by statute or regulation, but Coordinated Care was willing to revise its submission as required by the OIC because it is committed to participating in the Exchange.

## 2. Objection No. 7: "For Dependent Members"

The OIC objected to the "For Dependent Members" provision as "too restrictive and contains language that may conflict with RCW 48.46.320." 7/31/12 Disapproval Letter.

1 Specifically, the OIC said “A carrier may not require a dependent child be ‘... continuous total  
2 incapacity ...’ to qualify for coverage.” *Id.* This objection is also baseless.

3 RCW 48.46.320 prohibits a carrier from terminating coverage of a dependent child who  
4 reaches the limiting age “while the child is and continues to be both: (1) Incapable of self-  
5 sustaining employment by reason of developmental disability or physical handicap; and (2)  
6 chiefly dependent upon the subscriber for support and maintenance. . . .” Consistent with this,  
7 Coordinated Care’s product submission states:

8 **For Dependent Members**

9 A dependent member will continue to be a member until the end of  
10 the premium period in which he or she ceases to be your dependent  
member due to divorce or if a child ceases to be an eligible child.

11 \* \* \*

12 A member will not cease to be a dependent eligible child solely  
13 beyond the 26th birthday if the eligible child is:

- 14 1. Not capable of self-sustaining employment due to  
developmental disability or physical handicap that began  
15 before the age limit was reached; and  
16 2. Mainly dependent on you for support and maintenance.

17 7/25/13 Product Submission, 23.

18 The only place “continuous total incapacity” is mentioned is in the following sentence,  
19 which immediately follows the provision above: “Enrollment for such a dependent may be  
20 continued for the duration of the continuous total incapacity, provided enrollment does not  
21 terminate for any other reason.” *Id.* This in no way restricts or limits the coverage to the  
22 dependent eligible child, nor is it inconsistent with the statute. Under RCW 48.46.320, a carrier  
23 is only required to provide coverage of a dependent eligible child who ages out “while the child  
24 *is and continues to be incapable of*’ self-sustaining employment due to physical or  
25 developmental disability. (emphasis added) Said another way, the policy may be terminated  
26 once (and as soon as) the dependent becomes capable of self-sustaining employment. Therefore,

1 it is correct to say the coverage for such dependents shall only continue for the duration of the  
2 continuous total incapacity.

3 **3. Objection No. 8: "Family Planning Services"**

4 In its July 31 Disapproval Letter, the OIC objected to the "Family Planning Services"  
5 provision on the basis that it "is too restrictive per RCW 48.46.060(3)(a) and (d) and A.C.A."  
6 The basis for this objection was that, "[a] carrier may not place restrictions on access to any FDA  
7 approved contraceptive drugs or devices." See 7/31/13 Disapproval Letter. The OIC does not  
8 provide any authority that defines what needs to be included in this type of provision.

9 The Family Planning Services provision includes over eight broad categories of items.  
10 The OIC's objections appear to pertain solely to prescription drug contraceptives, which states in  
11 relevant part:

12 Family Planning Services are covered on a voluntary basis.  
13 Covered services for Family Planning include:

14 \* \* \*

15 8. Prescription drug contraceptives.

16 Please Note: The following requirements must be met for  
17 prescription birth control to be covered at 100%: (1) they must  
18 appear on our drug formulary, and be generic; and (2) brand name  
19 drugs will be covered at 100% only if a generic version is not  
20 available.

21 7/25/13 Product Submission, 35.

22 This provision does not place restrictions on access to any FDA approved contraceptive  
23 drugs or devices. Under a plain reading of this provision, all "prescription drug contraceptives"  
24 are covered under the plan, without exception. The note at the bottom also does not limit the  
25 types of services. To the contrary, it explains to the consumer how she can have prescription  
26 birth control bills covered at 100%, rather than the cost-sharing percentage normally required for  
these types of drugs.

1 In its Hearing Brief, the OIC articulates a brand new objection. It states for the first time  
2 the plan is too restrictive because “the plan structure [does not] include a mechanism for waiving  
3 the otherwise applicable cost-sharing for the branded or non-preferred brand version” in  
4 situations where a consumer requests drugs that are determined by her provider to be medically  
5 inappropriate.<sup>4</sup> It is not entirely clear what this objection is about. But it appears to hinge  
6 entirely on the false premise that Coordinated Care has placed limitations on access to brand  
7 name or generic drugs. To be clear, Coordinated Care’s plan does not place any restrictions on  
8 any FDA-approved contraceptive drugs or devices. The Family Planning Services provision  
9 covers *all* prescription contraceptive drugs. Therefore, the OIC’s new objections appear to be  
10 baseless as well.

11 Moreover, the OIC also fails to provide any legal support for its position that the plan  
12 structure must include a mechanism for waiving cost-sharing for branded or non-preferred brand  
13 drugs. Coordinated Care is not able to find any.

14 **4. Objection No. 9: “Home Health Care Services Benefits”**

15 The Home Health Care Service Benefits provision provides:

16 **Home Health Care Service Benefits**

17 Covered services for home health care includes medically  
18 necessary care provided at the member’s home and are limited to  
19 the following charges:

- 20 1. Home health aide services.
- 21 2. Professional fees of a licensed respiratory, physical,  
22 occupational, or speech therapist required for home  
23 health care.
- 24 3. I.V. medication and pain medication.
- 25 4. Dialysis, and for the processing and administration of  
26 blood or blood components.
- 27 5. Medically Necessary supplies.
- 28 6. Rental of the durable medical equipment set forth below:
  - 29 a. I.V. stand and I.V. tubing.
  - 30 b. Infusion pump or cassette.
  - 31 c. Portable commode.

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32 <sup>4</sup> The OIC also fails to provide any legal support for their position that the plan structure  
33 must include a mechanism for waiving cost-sharing for branded or non-preferred brand drugs.  
34 Coordinated Care is not able to find any.

- d. Patient lift.
- e. Bili-lights.
- f. Suction machine and suction catheters.

At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase. If the equipment is purchased, the member may be required to return the equipment to us when it is no longer in use.

See 7/25/13 Product Submission, 36.

The OIC claims that the "Home Health Care Service Benefits" provision is too restrictive in conflict with WAC 284-43-878(1) because it contains limitations on services and supplies that may be required to provide medically necessary care in a home setting. See Disapproval Letter, Objection No. 9. This is incorrect.

WAC 284-43-878(1) expressly pertains to "ambulatory patient services", not home health care services. Coordinated Care's product submission includes a section on ambulatory services entitled, "Ambulatory Patient Services", which includes each of the services expressly required under WAC 284-43-878(1). It provides:

**Ambulatory Patient Services**

Covered service expenses for ambulatory patient services will include medically necessary services delivered in settings other than a hospital or rehabilitation or extended care facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury. Such services include:

1. Home and outpatient dialysis services;
2. Hospice and home health care, including skilled nursing care as an alternative to hospitalization.
3. Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;
4. Urgent care center visits, including provider services, facility costs and supplies;
5. Ambulatory surgery center services, including anesthesiology services, professional surgical services, and surgical supplies and facility costs;
6. Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and



1 See 7/25/13 Product Submission, 35-36 (emphasis added). There is nothing in WAC 284-43-  
2 878(6) or any other law that requires Coordinated Care to include this language in the Home  
3 Health Care Service Benefits section. Because the consumer has full coverage for all durable  
4 medical equipment under the Habilitation, Rehabilitation Facility And Extended Care Facility  
5 Benefit, the OIC's objection is improper and may not be used as a basis for disapproving  
6 Coordinated Care's product submission.

7 **5. Objection No. 10: "Premiums"**

8 In its Disapproval Letter, the OIC claims that the Premiums section as "still too  
9 restrictive in conflict with RCW 48.43.005(31)." See Disapproval Letter, Objection No. 12. No  
10 additional detail was provided. Premiums are addressed on pages 27 and 28 of Coordinated  
11 Care's product submission. Nothing in that provision conflicted with or was more restrictive  
12 than RCW 48.43.005(31).

13 In the OIC's Hearing Brief, the OIC argues for the first time that the Premiums section  
14 violates RCW 48.43.005(31) and RCW 48.46.064(1)(a). See OIC Hearing Brief, 18. It  
15 articulates two reasons for this. First, it argues that the inclusion of the phrase "[f]rom time to  
16 time, we will change the rate table used for this contract form" is not a true statement because  
17 rates may only be changed yearly. Second, the OIC argues that the inclusion of the phrase "[t]he  
18 contract, and age of members, type and level of benefits, and place of residence on the premium  
19 due date are some of the factors used in determining your premium rates" is incomplete because  
20 it does not expressly list the five reasons included in RCW 48.46.064(1)(a)(i-v). This objection  
21 should not be considered at all because it was not raised as a reason for the OIC's disapproval on  
22 July 31, 2013. However, even if the judge considers it, this objection is entirely baseless.

23 First, neither of these provisions are more restrictive than or in conflict with RCW  
24 48.43.005(31) and RCW 48.46.064(1)(a). Nothing precludes a carrier from informing the  
25 consumer that it may revise the rates from time to time. The phrase "from time to time" does not  
26

1 conflict with “yearly.” By stating that rates may be changed from time to time is not itself a  
2 violation of any statute or regulation; the violation would only occur if Coordinated Care  
3 changed the rate sooner than was permitted.

4 Moreover, there is no law that requires Coordinated Care to include in its product  
5 submission every factor that may be considered to change the rates. The OIC does not even  
6 point to any authority that requires a carrier to describe any factors at all to the consumer. The  
7 statement expressly states that it is listing only “some of the factors.” The statement is not more  
8 restrictive or in conflict with RCW 48.46.064(1)(a)(i-v).

9 Neither of these are “unreasonable restrictions on the treatment of patients.” RCW  
10 48.46.060. And, because the OIC did not object to this language on the basis that it was  
11 confusing or misleading, that cannot be used as a basis for disapproving the submission based on  
12 these provisions. The OIC admitted that it “has no authority to tell carriers what to put in their  
13 contracts.” OIC Hearing Brief, 14. Yet, this is precisely what it is attempting to do, and without  
14 a legitimate legal basis.

15 The OIC reviewed the language in the Premium provision in depth prior to issuing its  
16 July 22 objections. It had ample opportunity to identify and state these objections as well, but  
17 did not do so. Had they done so, Coordinated Care could have revised this language fairly  
18 quickly to appease the OIC’s concerns, despite the fact that the language included was fully  
19 compliant with the statutes.

20 **IV. OIC’S RATE FILING OBJECTIONS ARE NOT LEGALLY REQUIRED OR**  
21 **WERE MERE OVERSIGHTS BY THE OIC.**

22 In its disapproval letter, the OIC articulated four objections to Coordinated Care’s rate  
23 filing:

- 24 1. You did not add the counties you offer these plans in onto the rate schedule or a separate  
25 document on the Rate/Rule Schedule tab.
- 26 2. You did not provide methodology, justification, and calculations used to determine the  
contribution to surplus, contingency charges, or risk charges included in the proposed

1 base rates. Furthermore, your definition of “profit” and “contribution to surplus” is  
2 inconsistent with WAC 284-43-910(13).

- 3 3. You did not submit the calculations and justification of the area factors. You mentioned  
4 that Exhibit 3 describes the expected reimbursement level as a percentage of Medicare  
5 and rating factors by rating area. However, there is no Exhibit 3 attached to the rate  
6 filing.  
7 4. You did not provide the supporting documentation and calculations for the figures used  
8 to calculate the Index Rate to Base Rate in Appendix E. You mentioned that Exhibits 4A  
9 and 4B include detailed calculations for SG&A and Licensing, Taxes and Fees.  
10 However, there are no Exhibits 4A and 4B attached to the rate filing.

11 These objections are baseless. The first is not a requirement under the statutes or regulations and  
12 cannot be used as a basis for rejecting Coordinated Care’s submission. The other objections are  
13 based on OIC’s own oversights – Coordinated Care provided each of the items the OIC claims  
14 was not submitted.

15 In its Hearing Brief, the OIC claims for the first time that the rate filing could not be fully  
16 reviewed until the network and form issues were resolved. This was *never* raised in the prior  
17 objections. Nor was it stated as a reason for disapproval in its July 31 disapproval disposition. If  
18 this was an issue, the OIC had an obligation to formally raise this earlier. Therefore, this new  
19 argument cannot be used as a basis for disapproving Coordinated Care’s rate filing or entire  
20 submission

21 **F. Objection 1 (Documentation of Counties in a Rate Schedule) Is Not Based on Any  
22 Legal Requirement.**

23 There is nothing in the statute, regulations, or instructions provided to the filers that  
24 expressly required Coordinated Care to include the counties offered in its plans onto a “Rate  
25 Schedule” or in a Rate/Rule Schedule tab. Notably the OIC failed to cite to any legal authority  
26 in its objection.

This appears to be an attempt to use an overly technical basis to reject Coordinated  
Care’s filing. Coordinated Care had already clearly identified the counties that were offered in  
its plan in its product submission, which stated:

1           **Service area** means a geographical area, made up of counties,  
2           where we have been authorized by the State of Washington to sell  
3           and market our health plans. *Those counties are : Adams,*  
4           *Benton, Chelan, Douglas, Franklin, Grant, Grays Harbor, King,*  
5           *Skagit, Snohomish, Spokane, Thurston, Walla Walla, and*  
6           *Yakima*, This is where the majority of our Participating Providers  
7           are located where you will receive all of your health care services  
8           and supplies. You can receive precise service area boundaries  
9           from our website or our Member Services department.

10          See Revised Product Submission, submitted 7/25/13 (emphasis added). The offered counties  
11          were also included in Coordinated Care's Form A submissions, with the most updated list  
12          included in the off-cycle Form A submitted on July 25, 2013, and as part of its binder  
13          submission. See WashingtonServiceArcav3.xls (which was submitted via SERFF on 7/25/13).  
14          Prior to the disapproval letter, there should have been no question regarding which counties were  
15          included in Coordinated Care's plan.

16          The OIC had since May 1, 2013 to identify this alleged deficiency, but raised it for the  
17          first time on July 31. Had the OIC given Coordinated Care a chance to fix this concern, it would  
18          have been easily remedied. Because this objection is not based on any requirement under any  
19          law and was not raised in a reasonably timely manner, it cannot be used as a reasonable  
20          justification to disapprove Coordinated Care's submission.

21          **G.     Objection 2 (Support for Contribution to Surplus) Is Meritless – All Required Items**  
22          **Were Included in the Rate Filing.**

23          The OIC's allegation that Coordinated Care failed to provide methodology, justification,  
24          and calculations used to determine the contribution to surplus, contingency charges, or risk  
25          charges included in the proposed base rates is incorrect. This information was included in  
26          Coordinated Care's Actuarial Memorandum (the "Memorandum"), which was prepared by its  
27          consulting actuary, Jason Nowakowski,<sup>5</sup> and submitted on or around July 25, 2013. The  
28          justification, and calculations used to determine the contribution to surplus, contingency charges,

29          <sup>5</sup> Jason Nowakowski, a Principal and Consulting Actuary at Milliman, Inc., assisted Coordinated  
30          Care in developing premium rates, pricing the products, and preparing the rate filing. He is a  
31          Fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

1 or risk charges were expressly laid out in the "Profit and Contribution to Surplus" section of the  
2 Memorandum. There, it stated:

3 **Profit and Contribution to Surplus:**

4 The proposed rates reflect 5.0% as a risk margin for profit and  
5 contribution to surplus. This includes 3% profit, and 2%  
6 contribution to surplus. The risk margin load was applied to all  
7 plans.

8 WAC 284-43-930 requires an actuarially sound provision for  
9 contribution to surplus. Capital requirements are based on the risk  
10 exposure to various lines of business and Coordinated Care will  
11 need to accumulate a contribution to surplus from a portion of the  
12 proposed premium rates to develop a self-supporting line of  
13 business.

14 Coordinated Care will target accumulating an 8 to 1 premium to  
15 surplus ratio on its Individual market business over approximately  
16 six years. To achieve this goal, a contribution to surplus  
17 assumption equivalent to 2% of premium has been used in the rate  
18 development. In our opinion, this is a reasonable assumption and  
19 consistent with contribution to surplus assumptions we have seen  
20 in the market.

21 Please see the table below for an illustration of the surplus  
22 accumulation process. Targeting a ratio of \$1 in capital for each \$8  
23 in premium, and assuming an accumulation of 2% of premium per  
24 year, the required timeframe to accumulate the targeted capital  
25 surplus level is calculated as:

26 
$$\text{Timeframe} = (\$1 \text{ capital} / \$8 \text{ premium}) / 2\% \text{ of premium per year}$$
$$= 6.25 \text{ years}$$

See Memorandum, 15.

As noted there, the methodology to calculate the contribution to surplus was to use a 3% profit assumption<sup>6</sup> and a contribution to surplus assumption of 2% of the premium. The 2% was established using a methodology that was recommended by the OIC itself to another carrier and is an actuarially sound assumption. Using that methodology, Coordinated Care set a target to accumulate an 8 to 1 premium to surplus ratio over approximately a six-year period. Stated

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<sup>6</sup>This assumption is in line with a range of assumptions seen in the market and is reasonable based on Mr. Nowakowski experience and is therefore an actuarially sound assumption.

1 another way, it will take approximately 6.25 years to accumulate a target capital position of \$1  
2 per \$8 of premium for this product when 2% of premium is accumulated each year.

3 The justification for this methodology was also included in the Memorandum.  
4 Coordinated Care believed the contribution to surplus rates were justified because the  
5 assumptions used were “reasonable” and “consistent with contribution to surplus assumptions we  
6 have seen in the market.” It is further justified because Coordinated Care used the same  
7 methodology that was recommended by the OIC to another carrier. This is an actuarially sound  
8 method for calculating the contribution to surplus, contingency charges, or risk charges included  
9 in Coordinated Care’s proposed base rates.

10 The calculation for the contribution to surplus, contingency charges, or risk charges  
11 included in Coordinated Care’s proposed base rates is included at the top and bottom of this  
12 section. See Memorandum, 15. As noted at the top, 5% is made up of the 2% contribution to  
13 surplus assumption and 3% profit assumption. The calculation relating to the 2% contribution to  
14 surplus assumption is provided as follows: “(\$1 capital / \$8 premium) / 2% of premium per year  
15 = 6.25 years.” Or stated another way, it will take approximately 6.25 years to accumulate a  
16 target capital position of \$1 per \$8 of premium for this product when 2% of premium is  
17 accumulated each year.

18 Additionally, the OIC erroneously claims that Coordinated Care’s definition of “profit”  
19 and “contribution to surplus” is inconsistent with WAC 284-43-910(13). That regulation states:

20 “Contribution to surplus, contingency charges, or risk charges”  
21 means the portion of the “projected earned premium” not  
associated directly with “claims” or “expenses.”

22 As Mr. Nowakowski will testify, neither the definitions of “profit” or “contribution to surplus”  
23 runs contrary to the statutory definition. Indeed, the 5% proposed rate represents the projected  
24 earned premium not associated directly with claims or expenses.

**H. Objections 3 and 4 (Missing Exhibits) Are Unfounded.**

On July 25, 2013, Coordinated Care submitted (1) Exhibit 3, which contains the noted calculations and justifications, and (2) Exhibits 4A and 4B, which include the detailed calculations for SG&A and Licensing, Taxes and Fccs. These exhibits were submitted in a document entitled "WA Objection Response Exhibits 20130724.xlsx" which was submitted to the OIC via SERFF as shown below.

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Welcome, Daniel Martínez.  
celticinsurance  
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Tracking Number:

Filings	Plan Management	Messages	Billing	Settings	Filing Rules
My Workfolder	My Open Filings	My Draft Filings	Search	Create Filing	

Add Authors		Update	Create Reminder	Move to Workfolder	PDF Pipeline	Return to Search
						Clone Filing

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<b>Product Name:</b> Ambetter	<b>SERFF Tr Num:</b> CELT-129099669	<b>SERFF Status:</b> Closed-Disapproved
<b>TOI:</b> HOrg02I Individual Health Organizations - Health Maintenance (HMO)	<b>State Tr Num:</b> 257060	<b>State Status:</b> Disapproved
<b>Sub-TOI:</b> HOrg02I.005C Individual - Other	<b>Co Tr Num:</b> 61836WA001-RATE	<b>Co Status:</b>
<b>Filing Type:</b> Rate	<b>Date Submitted:</b> 07/01/2013	<b>Disposition Date:</b> 07/31/2013
<b>Implementation Date Requested:</b> 01/01/2014	<b>Authors:</b> Daniel Martinez, Ashley Schute, Lauren Regnery, Jane Neal, Tracey McMillan, Susan Kohler, Sara Ross	

General Information	Form Schedule	Rate/Rule Schedule	Supporting Documentation	State Specific	Companies and Contact	Filing Fees
				Filing Correspondence		
<input type="button" value="Expand All"/>		<input type="button" value="Collapse All"/>		<b>Schedule Item Status:</b>		
*						

20130725Response

WA Objection Response Exhibits 20130724.xlsx

Washington Objection Response 20130724.pdf

Submitted

Date Submitted: 07/25/2013

By: Daniel Martinez

This submission included:

**Exhibit 3**  
**Coordinated Care Corporation**  
**Washington Individual Rate Filing**  
**Objection 9**  
**Area Factor Development**

Regions	Enrollment	EHB Paid PMPM	Initial Area Factor	Adjusted Area Factor <sup>(1)</sup>	Final Area Factor <sup>(2)</sup>
Washington Rating Area 1	1,854	234.16	0.942	0.947	1.000
Washington Rating Area 2	1,646	259.73	1.045	1.041	1.099
Washington Rating Area 3	-	-			
Washington Rating Area 4	745	223.76	0.900	0.908	0.959
Washington Rating Area 5	2,864	257.89	1.038	1.034	1.092
<b>WA Totals</b>	<b>7,109</b>	<b>\$248.55</b>	<b>1.000</b>	<b>1.000</b>	

Notes:  
(1) Factors adjusted to comply with limit of 1.15 ratio between highest cost area factor and lowest cost area factor (WAC 284-170-250)  
(2) Area factors weighted so that King County (Washington Rating Area 1) is equal to 1.00 (WAC 284-170-250)

**Exhibit 4A**  
**Coordinated Care Corporation**  
**Washington Individual Rate Filing**  
**Objection 11**  
**SG&A Development**

			Notes
(a)	Composite Premium PMPM	\$288.52	Appendix E - Composite Premium PMPM
<i>Percent of Premium</i>			
(b)	Sales Compensation	1.8%	Based on discussions with Centene; see Appendix J for details
(c)	Marketing - Lead Generation	1.6%	Based on discussions with Centene; see Appendix J for details
(d) - (a) x [(b) + (c)]	Subtotal	\$9.87	
<i>Per Member, Per Month</i>			
(e)	Fixed Admin	\$31.81	Based on discussions with Centene; see Appendix J for details
(f)	RxScript Admin	\$0.42	Based on discussions with Centene; see Appendix J for details
(g) - (d) + (e) + (f)	Sales, General and Administrative Expense (SG&A)	\$42.10	

Exhibit 4B  
 Coordinated Care Corporation  
 Washington Individual Rate Filing  
 Objection 11  
 Licensing, Taxes, and Fees Exhibit

		Notes	
(a)	Composite Premium PMPM	\$288.52	Appendix E- Composite Premium PMPM
<i>Percent of Premium</i>			
(b)	Premium Tax	2.0%	Based on RCW 48.14.020 and RCW 48.14.0201
(c)	Assessments	0.0%	No known assessments
(d)	PFE User Fee	0.0%	Per state instructions in 7/17 objections, no PFE User Fee should be assumed
(e)	ACA Annual Fee (2014)	2.1%	See description below (1)
(f) = (a) x [(b) + ... + (e)]	<i>Subtotal</i>	\$11.83	
<i>Per Member, Per Month</i>			
(g)	CER (PCORI) Fee	\$0.17	\$2.00 Per Member Per Year
(h)	Risk Adjustment Admin Fee	\$0.08	\$1.00 Per Member Per Year
(i) = (f) + (g) + (h)	Licensing, Taxes (excluding FIT) and Fees	\$12.08	
Notes:			
(1) Based on study "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans" by Chris Carlson. The author provided a range in the estimated 2014 impact across carriers to be between 1.9% and 2.3%, which we took the midpoint.			

**V. THE OIC'S BINDER FILING OBJECTIONS WERE EASILY REMEDIED**

In its Hearing Brief, the OIC admits that its objections to the binder filing were "simply technical corrections." OIC's Hearing Brief, 19. The OIC does not cite to any statute or regulation that requires the changes it demanded. However, had the OIC raised these issues prior to July 31, Coordinated Care could have remedied these issues fairly quickly. Moreover, none of these binder issues would have significantly changed the plan or offering. These are not legitimate bases to disapprove Coordinated Care's submission.

**VI. THE OIC HAS THE DISCRETION TO PERMIT CORRECTION OF MINOR ERRORS AFTER FILING**

Even if the OIC had not acted outside the bounds of its statutory and regulatory authority in rejecting Coordinated Care's submission, the OIC's had discretion to give Coordinated Care additional time to remedy the issues raised in its objections. The OIC has the discretion to approve a filing containing minor errors. The rules requiring health maintenance organizations (such as Coordinated Care) to utilize SERFF are set forth in WAC 284-46A. WAC 284-46A-070 provides: "The commissioner may reject and close any filing that does not comply with WAC 284-46A-040, 284-46A-050, 284-46A-060." (Emphasis added). RCW 48.44.020 similarly

1 provides that “[t]he commissioner may” disapprove contract forms that are statutorily deficient.  
2 (Emphasis added).

3 Neither the OIC nor the Health Benefit Exchange (“HBE”) is precluded by federal or  
4 state law from permitting Coordinated Care to make changes following the OIC’s self-imposed  
5 filing deadline of July 31, 2013. Indeed, the federal regulations implementing the ACA provide  
6 the state exchanges with broad discretion to design processes for QHP certification. The only  
7 applicable deadline established by federal law is that QHP certification must be completed  
8 before the start of open enrollment on October 1, 2013. 45 CFR § 155.1010. And while the  
9 HBE is required to transmit certain plan data to the Center for Medicare and Medicaid Services  
10 (“CMS”) for financial purposes, there is no deadline in federal law for when the HBE must do  
11 so.

12 The wide discretion regarding timing of the QHP certification process provided to state-  
13 based exchanges is demonstrated by the fact that other states follow an array of deadlines. For  
14 example:

- 15 • Maryland HealthConnection, Carrier Training: Carrier Authorization and Plan  
16 Certification advises that data will go to CMS by August 31, 2013;<sup>7</sup> and
- 17 • Connect for Health Colorado PPACA Form filing procedures for Colorado provides July  
18 31, 2013 as the last date when “Exchange uploads forms to website,” but then allows  
19 issuers to review information to ensure that it is correct from August 1st through  
20 September 30th.<sup>8</sup>

21 In addition, sub-regulatory guidance from CMS on when plan data must be submitted  
22 supports the absence of a rigid deadline. As an example, the CMS presentation on Marketplace

23 <sup>7</sup> (slide 8, available at [http://marylandhbe.com/wp-content/uploads/2013/06/Carrier-Training\\_060413\\_Final1.pdf](http://marylandhbe.com/wp-content/uploads/2013/06/Carrier-Training_060413_Final1.pdf))

24 <sup>8</sup> (slide 2, available at <http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadernamc1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22PPACA+Form+Filing+Procedures+for+CO.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251854873319&ssbinary=true>)

1 Functions Related to Cost-Sharing Reductions and Advance Payments of the Premium Tax  
2 Credit states that state-based exchanges will certify QHPs on August 31, 2013 and will send plan  
3 data to IIHS during July and August 2013.<sup>9</sup> In short, July 31, 2013 was not a federally-  
4 established deadline by which the OIC was mandated to close out all filings.

5 The OIC claims blames the allegedly inflexible HBE for its inability to alter the  
6 deadlines. The OIC's assertion rings hollow, as the HBE has demonstrated its willingness to  
7 consider filings past the original deadline of July 31<sup>st</sup>. Indeed, the OIC briefly reopened a  
8 submission window through August 9, 2013 for the refiling of on-exchange plans after the HBE  
9 communicated its willingness to consider plans filed through that date. The OIC subsequently  
10 changed its position and decided to stay with the original deadline of July 31, 2013, but that  
11 maneuver underscores the flexible nature of the OIC's and HBE's internal deadlines.

12 Furthermore, the HBE Board voted at its meeting on August 21, 2013 to delay certification of  
13 any filed plans until the OIC could address the pending appeals regarding the rejected plans. In  
14 so voting, the HBE expressed its desire to provide carriers with more time to demonstrate that  
15 they can offer plans on the Exchange in order to provide Washington residents with adequate  
16 health insurance options.<sup>10</sup> Far from standing firm on the allegedly inflexible deadline of July  
17 31, 2013, the HBE's actions suggest that it - unlike the OIC - is willing to exercise flexibility to  
18 ensure that the greatest number of conforming plans can be offered on the Exchange.

19 The OIC's discretion to accept filings after July 31, 2013 also extends to allowing  
20 carriers the opportunity to edit plan data after submission. In fact, federal law provides a model  
21 for exactly that type of process. CMS's system for federally-facilitated and state-partnership  
22

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23 <sup>9</sup> (slides 15-17 available at  
24 [http://www.doi.nebraska.gov/aca/companies/ffm/SBE\\_and\\_SPE\\_PM\\_Functions\\_related\\_to\\_CS\\_R\\_and\\_APIC\\_March\\_2013.pdf](http://www.doi.nebraska.gov/aca/companies/ffm/SBE_and_SPE_PM_Functions_related_to_CS_R_and_APIC_March_2013.pdf))

25 <sup>10</sup> See <http://www.wahbexchange.org/news-resources/calendar/board-meeting21/> (HBE  
26 Board website) (last visited Aug. 25, 2013); see also  
[http://seattletimes.com/html/localnews/2021661375\\_acaplanvotexml.html](http://seattletimes.com/html/localnews/2021661375_acaplanvotexml.html) (last visited Aug. 25,  
2013).

1 exchanges includes a period of time expressly intended for the correction of errors in plan data  
2 following submission of data to CMS. CMS's "Plan Preview" process is designed to allow edits  
3 to be made in Health Insurance Oversight System ("HIOS") or SERFF plan submissions over a  
4 two-week period from August 8-23, 2013.<sup>11</sup> Specifically, CMS indicated in a guidance of July  
5 25, 2013 that:

- 6 • Plan Preview will be conducted in August 2013, during which issuers will be able to log  
7 into HIOS and review a selection of their submitted issuer and plan data;
- 8 • All data changes should be submitted into either HIOS or SERFF by August 23, 2013;  
9 and
- 10 • Issuers can appropriately address system errors, issues, and inaccuracies with certain plan  
11 data, ensuring the consumer has correct benefits and premium.<sup>12</sup>

12 Allowing a window of time for modifications following the submission deadline is well  
13 within the OIC's discretion and in full accord with federal guidance. Particularly under the  
14 circumstances presented here, permitting Coordinated Care to quickly make modifications in its  
15 submission is reasonable and appropriate. The OIC's rejection of Coordinated Care's plan was  
16 arbitrary and capricious in light of the OIC's broad discretion to allow prompt corrections  
17 following submission. *See Foster v. King Cnty.*, 83 Wn. App. 339, 347, 921 P.2d 552 (1996)  
18 ("Arbitrary and capricious means willful and unreasoning action, taken without regard to or  
19 consideration of the facts and circumstances surrounding the action.") (internal quotation marks  
20 and citation omitted).

21  
22 <sup>11</sup> Plan Management Plan Preview, Qualified Health Plan (QHP) Certification Series VII  
23 (available at [https://www.regtap.info/uploads/library/PM\\_QHP\\_Slides\\_072513\\_\\_5CR\\_072513.pdf](https://www.regtap.info/uploads/library/PM_QHP_Slides_072513__5CR_072513.pdf))

24 <sup>12</sup> *Id.*; *See also* Letter to Issuers on Federally-facilitated and State Partnership Exchanges,  
25 April 5, 2013, describing timeline including July 31 data submission from federally-facilitated  
26 and state-partnership exchanges with a Plan Preview period to correct submitted data (available  
at [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf))

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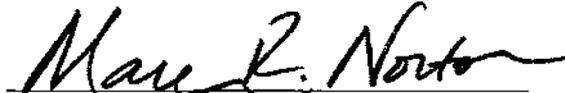
VII. CONCLUSION

For the foregoing reasons, Coordinated Care respectfully requests that the Hearing Officer reverse the decision of the OIC and order the OIC to approve its plans for inclusion in the 2014 Exchange Board.

DATED: August 26, 2013.

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