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August 13, 2013

VIA EMAIL AND FIRST-CLASS MAIL

Hearings Unit
Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255
Email: hearings@oic.wa.gov

Re: Demand for Hearing

To Whom It May Concern:

We represent Coordinated Care Corporation. We write to request a hearing to challenge the Office of Insurance Commissioner's disapproval of Coordinated Care's Bronze, Silver and Gold Individual Plan Filings for 2014.

The OIC's decision to reject Coordinated Care's filing deprives low-income individuals in the state of Washington of affordable options in the 2014 Health Benefit Exchange. This is in direct conflict with the underlying goals of the Affordable Care Act, does not advance the objectives of the OIC or the HBE, and is contrary to the public interest.

The OIC's decision was wrong for three general reasons:

1. Some of the findings were made in error and based on the timing of the OIC's disposition, we had no opportunity to discuss and resolve them.
2. Some of the findings were simple administrative issues that were raised for the first time on July 31st, thus preventing any opportunity to resolve them.
3. Some of the findings were inconsistent with prior OIC feedback and disposition; because the OIC's new position on these issues was not offered until July 31st, we did not have an opportunity to resolve them.

As outlined in more detail below, each of the findings were in error for one of those reasons. Specifically:



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Network Findings:

Per RCW 48.46.030 and WAC 284-43-200 Coordinated Care Corporation (Coordinated Care) is required to demonstrate it has adequate arrangements in place to ensure reasonable proximity to a contracted network of providers and facilities to perform services to covered persons under its contracted plans. The Insurance Commissioner's office (OIC) has reviewed Coordinated Care's Provider Network Form A [WAC 284-43-220(1)], Access Plan, and GeoNetwork Report and determined the network does not have sufficient contracted providers and facilities in place to support the services set forth in the product.

This is in error because the Coordinated Care network contracted for the exchange plans (the "Network") is an extensive provider network that includes 30 hospitals and 8396 participating providers, and will provide reasonable proximity to contracted facilities and providers.

The Access Plan states Coordinated Care has an inadequate number and types of in-network providers to provide medically necessary services and requests to utilize Single Case Agreements and prior authorization requirements to manage access. These arrangements are an alternative service delivery system [WAC 284-43-200(3)] subject to acceptance by this office. The Insurance Commissioner's office does not approve these requests for new product offerings. Alternative delivery systems are considered by this office only when a carrier has a material provider or integrated delivery system termination that impacts delivery of care in established networks.

This is in error because the Network includes sufficient numbers and types of providers to provide medically necessary services. With respect to the rarely used and highly specialized types of services that are not offered by the Network providers that Coordinated Care has currently contracted, the alternative approach authorized by WAS 284-43-200(3) is an adequate arrangement. The WAC is not limited to established networks. Such occasional out-of-network arrangements are common to all provider networks.

Coordinated Care has further identified its network is dependent upon its contracting relationships with specialty company arrangements. Opticare Managed Vision, Inc. is reported as the statewide vision care network to support vision services in the product. The OIC disapproved this provider contract on December 31, 2012 [state tracker id: 248035] as such, Coordinated Care has no approved vision network.



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This is in error because Opticare is not Coordinated Care's vision provider. Coordinated Care has direct contracts with an adequate network of vision providers.

In addition to the above general statements, the specific reasons cited for disapproving the filing were likewise in error. More specifically:

Rate Filing:

1. You did not add the counties you offer these plans in onto the rate schedule or a separate document on the Rate/Rule Schedule tab.

This finding was made for the first time on July 31st and prior to that Coordinate Care was not aware of any such requirement. Given the timing, Coordinated Care was unable to provide the information.

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

This finding was in a previous objection letter and completely addressed by Coordinated Care in its resubmission.

3. You did not submit the calculations and justification of the area factors. You mentioned that Exhibit 3 describes the expected reimbursement level as a percentage of Medicare and rating factors by rating area. However, there is no Exhibit 3 attached to the rate filing.

This is in error because the calculations and justifications were submitted, and Exhibit 3 was attached to the rate filing.

4. You did not provide the supporting documentation and calculations for the figures used to calculate the Index Rate to Base Rate in Appendix E. You mentioned that Exhibits 4A and 4B include detailed calculations for SG&A and Licensing, Taxes and Fees. However, there are no Exhibits 4A and 4B attached to the rate filing.

This is in error because the supporting documentation and calculations were provided, and Exhibits 4A and 4B were attached to the rate filing.



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Form Filing:

5. The definition of eligible service is confusing and misleading [RCW 48.46.060(3)(a)] because it does not clearly notify the enrollee that in addition to in-network cost-share requirements they will be subject to "balance billing" by the provider or facility.

This finding was in a previous objection letter and completely addressed by Coordinated Care in its resubmission.

6. The "Adding An Adopted Child" provision is still too restrictive in conflict with RCW 48.01.180 and RCW 48.46.490. First, it is unclear why Coordinated Care has added additional language defining conditions of "placement". Second, it is unclear what the "written notice" is a parent must provide regarding the intent to adopt the child. The enrollee is only required to apply for coverage for the new dependent.

This finding was in a previous objection letter and completely addressed by Coordinated Care in its resubmission.

7. The "For Dependent Members" provision is too restrictive and contains language that may conflict with RCW 48.46.320. A carrier may not require a dependent child be "... continuous total incapacity ..." to qualify for coverage.

This finding was in a previous objection letter and completely addressed by Coordinated Care in its resubmission.

8. The "Family Planning Services" provision is too restrictive per RCW 48.46.060(3)(a) and (d) and A.C.A. A carrier may not place restrictions on access to any FDA approved contraceptive drugs or devices.

This finding was in a previous objection letter and completely addressed by Coordinated Care in its resubmission.

9. The "Home Health Care Service Benefits" provision is too restrictive in conflict with WAC 284-43-878(1) because it contains limitations services and supplies that may be required to provide medically necessary care in a home setting.

This finding was in a previous objection letter and completely addressed by Coordinated Care in its resubmission.



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

This finding was made for the first time on July 31st, thus preventing any opportunity to cure.

11. The Pharmacy benefit defines Mail Order drugs have a "3 times retail cost sharing" requirement. This language is confusing and ambiguous per RCW 48.46.060(3)(a). You must specifically define the cost share obligation to the member in the policy.

This finding was made for the first time on July 31st, thus preventing any opportunity to cure.

12. The "Premiums" section is still too restrictive in conflict with RCW 48.43.005(31).

This finding was in a previous objection letter and completely addressed by Coordinated Care in its resubmission.

Binder Filing:

13. The Pharmacy Benefit Template, Plans and Benefits template and policy do not match. For example, HIOS Plan ID 61836WA0030001 defines it will use Formulary ID WAF003. Formulary ID WAF003 is a 4-tier pharmacy option utilizing copay cost share requirements. The Schedule of Benefits for this Bronze Product defines certain drug tiers are subject to coinsurance. WAF003 does not include any coinsurance requirements.

This finding was made for the first time on July 31st, thus preventing any opportunity to cure.

14. You do not rate based on tobacco use. Therefore, cell K10 should read "Not Applicable" in the Rating Business Rules template.

This finding was made for the first time on July 31st, thus preventing any opportunity to cure.

15. You do not have a tobacco-use factor. The Rate Data template should not include a tobacco rate column.



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This finding was made for the first time on July 31st, thus preventing any opportunity to cure.

Given that the OIC's findings were in error, Coordinated Care seeks regulatory certification from the OIC to be presented to the Washington State Health Benefits Exchange as a qualified health plan for 2014.

Very truly yours,

Maren R. Norton

cc: Barbara Nay
Jay Fathi, Coordinated Care
Katie Rogers, Coordinated Care