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BEFORE THE WASHINGTON STATE OFFICE OF THE INSURANCE COMMISSIONER
Hearings Unit, DIC
Patricia D. Peterson
Chief Hearing Officer

In the Matter of:

**COORDINATED CARE
CORPORATION,**

A Health Maintenance Organization.

Docket No. 13-0232

MOTION OF INSURANCE
COMMISSIONER MIKE
KREIDLER FOR
RECONSIDERATION OF
FINDINGS OF FACT,
CONCLUSIONS OF LAW, AND
FINAL ORDER

I. INTRODUCTION

The Office of the Insurance Commissioner ("OIC") respectfully requests reconsideration of portions of the Findings of Fact, Conclusions of Law, and Final Order in the above-captioned matter, entered on September 3, 2013, ("Final Order"). OIC disapproved the rate, form, and binder filings filed by Coordinated Care Corporation ("Coordinated Care") on July 31, 2013.

First, the Order failed to properly resolve the conflict with a decision on the merits, and instead impermissibly directed settlement. While the Final Order properly concludes that some bases upon which the OIC disapproved Coordinated Care's filings were "valid", the Order failed to resolve the conflict by issuing a determination. Rather, the Order required the OIC to enter into a type of settlement negotiation with Coordinated Care, to result in refiling, approval, and entrance into the Exchange. Such a directive is improper, exceeds the scope of administrative judicial authority, and is unsupported in law.

Second, the Final Order's conclusions rested upon improper admission of evidence of settlement negotiations in unrelated litigation.

Third, the Final Order contains errors of law that effectively force the OIC to permit Coordinated Care to enter the Exchange with an insufficient network based on a contract methodology that is contrary to the laws applicable to health maintenance organizations ("HMOs").

Fourth, the Final Order contains Findings of Fact about communication between Coordinated Care and the OIC during the proceedings that are not supported by an objective evaluation of the record.

Despite the objections described in this motion, the parties have complied with the directives in the Final Order. The OIC recognized that there was no meaningful opportunity to bring this Motion prior to engaging in that work if Coordinated Care's plans were to be approved for the Exchange. Out of respect for the judicial process, the OIC has worked cooperatively with Coordinated Care to resolve those items that the Final Order identified as "valid" bases for disapproval, and the plans that were the subject of the hearing have now been approved for certification by the Washington Health Benefit Exchange.

II. ARGUMENT

A. The Final Order failed to resolve the matter with a decision on the merits, instead improperly directing settlement. In this, the Final Order exceeds administrative judicial authority, and is unsupported by law.

The Final Order does not resolve this matter with a decision on the merits. Instead, that order commands OIC to allow the Company to revise its filings, provide

“reasonable guidance and recommended language” to the Company to correct its deficiencies, and “give prompt and reasonable approval of the Company’s filings provided the Company has addressed the reasons for disapproval...” Final Order, at 22. It goes on to state, “this proceeding shall remain open until the Company has made new/amended filings,” and to require the parties to notify the Hearing Officer of the disposition of those filings.

The Final Order cites no authority in the APA, the Insurance Code, or otherwise, which allows the Hearing Officer to refuse to rule on a matter, instead holding that matter open until a compulsory settlement, the terms of which are dictated by the Hearing Officer, has been reached.

While the APA does strongly encourage informal settlements, it does not compel settlement. *See* RCW 34.05.431(1), WAC 10-08-130(1)(g), and WAC 284-02-070(2)(d)(iv) (allowing for prehearing conferences for settlement or simplification); RCW 34.05.437(1) and WAC 10-08-130(5) (requiring presiding hearing officers to allow parties the opportunity to make offers of settlement); RCW 34.05.060, WAC 10-08-130(5), and WAC 10-08-230 (encouraging informal settlements). However, the APA “does not require any party or other person to settle a matter.” RCW 34.05.060. *See also* CJC 2.6(B) (prohibiting judges from acting “in a manner that coerces any party into settlement.”)

Further, there is no authority in the Administrative Procedures Act (Title 34.05 RCW), the Model Rules of Procedure (WAC 10-08), the Insurance Code (Title 48 RCW), the rules promulgated under the Insurance Code (WAC 284), or the letter delegating authority to Hearing Officer to preside over hearings, that authorizes the Hearing Officer,

or any other Administrative Law Judge, to force the Insurance Commissioner, or his duly appointed Deputy Commissioners and staff to settle matters that they have determined should not be settled, particularly with a carrier whose filings have in fact been found deficient.

Nor is there any authority which allows a Hearing Officer to be privy to - let alone monitor - settlement negotiations. Certainly there is no authority for a judge to dictate the terms of settlement and warn that failure to settle on those terms "would be to invite a consideration that the OIC might have erred in disapproving the Company's filings on July 31." That disapproval was either correct or it was not. The Final Order appropriately sets this forth as the precise issue before the Hearing Officer. "Therefore, most clearly stated, in this proceeding, the Company bears the burden of proving, by a preponderance of the evidence, that on July 31, 2013 the OIC erred in disapproving Coordinated Care Corporation's June 25, 2013 Bronze, Silver and Gold Individual Plan Filings for 2014." Final Order, at 10, ¶2. There is no authority cited, nor could there be, for the proposition that an Administrative Law Judge may change a legal ruling as punishment for one of the parties' failure to cooperate with directives in an Order.

The Hearing Officer clearly has authority to find that the OIC properly disapproved Coordinated Care's July 31 filings. In large part, the Final Order does acknowledge that the OIC's reasons for rejecting Coordinated Care's July 31 filings were valid. There is no question that, had the Hearing Officer found the OIC's reasons for disapproval were all invalid, she has the authority to find that the OIC improperly rejected the filings as they existed on July 31, and order the OIC to accept those filings as they existed at the time. The Hearing Officer arguably even has authority to conduct a

new review using a legal definition or understanding that did not exist, or was not used when the original review was conducted. But the Final Order does not compel the OIC to approve or disapprove the filings as they existed on July 31, or to conduct a new review in light of a new analysis on a question of law. Instead, the Final Order acknowledges that the filings were largely deficient for the reasons asserted by the OIC, but nonetheless compels the OIC to enter into settlement negotiations with Coordinated Care to assist Coordinated Care in amending its filings in order to become acceptable to the OIC. Similarly, the Final Order cites no express or implied statutory authority allowing - let alone compelling - the OIC to draft portions of the very documents and filings that the OIC is compelled to regulate.

The Final Order essentially asserts that because the OIC chose to settle with certain companies, it was required to offer settlement to this company, and then compels the OIC into that settlement, even dictating the terms of that settlement (that OIC was to “promptly review and/or suggest amended language which would meet any remaining concerns that the current language is misleading or does not comply with applicable rules”). See, e.g., Final Order, at 19. However, the Final Order cites absolutely no authority for this command. None exists.

In ordering the OIC to settle its disputes concerning Coordinated Care’s filings, the Final Order creates two dangerous precedents. First, it compels the OIC to not only provide specialized and directed legal advice to a specific private company, but to effectively draft portions of their contracts. Because the OIC regulates those same contracts, the Final Order has essentially created a conflict of interest for the OIC. The Final Order has created the very real potential for Coordinated Care to claim at a future

date, that the OIC cannot take enforcement action against Coordinated Care concerning those contractual provisions, because the OIC itself drafted them.

Further, in compelling settlement with one carrier because the OIC entered into settlement discussions with a wholly separate and unrelated carrier, the Final Order set the dangerous precedent that the OIC is now *compelled* to settle with any carrier who challenges the OIC's disapproval of their network, rate, form, or binder filings. The Final Order effectively broadcasts to every health carrier in the state that, by demanding a hearing on any disapproved filing, they can force the OIC to fix their contracts for them, monopolizing staff time, and unilaterally rearranging the distribution of OIC resources. This is particularly problematic because with the open enrollment deadlines of the ACA, beginning with this year and moving forward, there will always be a deadline for health plans to be approved. Usurping the OIC's resources by compelling settlement negotiations will have potentially devastating effects on the OIC's ability to approve plans. This issue will only get worse, as more carriers and plans enter the exchange, and more plans are subject to the federal deadlines that for this year only apply to plans offered in the Exchange.

What the Final Order attempts to do is compel the OIC's discretion. The Final Order notes, "For the OIC to use its discretion in allowing the Company to quickly make modifications now . . . is reasonable and permissible." Final Order at 22. However, the Hearing Officer does not have authority to compel the Commissioner's discretion, or that of his appointed Deputy Commissioners and staff. The Hearing Officer has authority to review decisions for compliance with the law, and to consider whether staff have *abused* their discretion. But no finding of an abuse of discretion was made in the record, nor was

evidence presented to meet the difficult showing that an agency has abused its discretion. In fact, the Final Order acknowledges that the OIC did the best it could under the unique and difficult circumstances imposed by the Affordable Care Act. Further, the Hearing Officer cannot rely on the OIC's decision not to enter into settlement negotiations as the basis for an abuse of discretion, because there is no legal requirement anywhere to compel the OIC to enter into settlement negotiations. While it may be permissible for the OIC to exercise its discretion in the manner suggested by the Hearing Officer, it is not permissible for a Hearing Officer to compel the exercise of that discretion in keeping with her own preferences.

OIC may be reading too much into the Final Order. The Final Order does state in several places that OIC is being compelled to re-write Coordinated Care's filings for it in light of the extraordinary situation presented by the fact that the Exchanges are an entirely new entity for which federal rules and guidelines were being promulgated even as the OIC was attempting to review plans for compliance with them. See, e.g., Final Order at 3, ¶3. The Final Order appropriately states that "it must be recognized that the specific situation involved in this particular review of the Company's filings is unique." Final Order, at 21.

It may be that such is the Hearing Officer's reasoning behind the directives in the Final Order, and is meant to apply only to Coordinated Care and only in this one, unique situation. If so, OIC urges the Hearing Officer to reconfigure the Final Order, making that abundantly clear. While the OIC stands behind its objections, the agency acknowledges that such a clarification would at least avoid the perils presented by reference to the Final Order as precedent.

B. The Final Order's conclusions rest upon improper admission of evidence of settlement negotiations in unrelated litigation.

OIC respectfully submits that the challenged directives in the Final Order rely on factual errors that 1) are supported solely by evidence of settlement negotiations introduced by the Hearing Officer, not by either party, and which should have been barred by ER 408, and 2) are not supported by the evidence in the record.

Over the OIC's objection, the Final Order relies on evidence that the OIC had entered into settlement negotiations with carriers in unrelated matters. Final Order at 8. Under Evidence Rule ("ER") 408, this information should never have been admitted into evidence, or considered by the Hearing Officer, in the Coordinated Care hearing.

ER 408 prohibits the admission of settlement negotiations for the purpose of proving liability. Although the Rules of Evidence are not strictly adhered to in administrative proceedings under the Administrative Procedures Act, Title 34.05 RCW ("APA"), they cannot be wholly ignored. RCW 34.05.452(2) still requires that a presiding hearing officer "shall refer to the Washington Rules of Evidence as guidelines for evidentiary rulings."

It is reversible error to admit evidence of settlement negotiations with third parties and in unrelated proceedings. *Grigsby v. City of Seattle*, 12 Wn.App. 453, 458, 529 P.2d 1167 (1975). In *Grigsby*, the plaintiff was a passenger in an automobile accident. *Id.* at 454. He settled with the driver of the car he was in, and subsequently sued the City of Seattle for negligent design, construction, and maintenance of the street. *Id.* The Court of Appeals found it was reversible error for the jury to be informed that the Plaintiff had settled with the driver. *Id.* at 458.

ER 408 does permit evidence of settlement negotiations for limited purposes, such as to prove bias, prejudice of a witness, negating claims of undue delay, or proving obstruction of justice. None of those claims were present in this case. In fact, the Hearing Officer found that the OIC witnesses were "credible, and presented no apparent biases." Final Order at 9-10. Nor was this presented by the OIC to negate claims of undue delay. No other exceptions to the prohibitions in ER 408 are present in the record.

Further, the APA provides that a "presiding officer shall not base a finding exclusively on such inadmissible evidence unless the presiding officer determines that doing so would not unduly abridge the parties' opportunities to confront witnesses and rebut evidence. The basis for this determination shall appear in the order." RCW 34.05.461. Here, the Final Order contains no such determination regarding the evidence presented by the Hearing Officer about settlement negotiations with other parties. On the contrary: the evidence of the OIC's settlement discussions with other carriers was not submitted by either party, but by the Hearing Officer herself. The Final Order cites no testimony or exhibit demonstrating the OIC's settlement negotiations with other carriers; Coordinated Care was apparently unaware of the OIC's settlement discussions with other carriers until the Hearing Officer introduced the subject. The OIC could only object; it had no opportunity to confront the Hearing Officer as a witness. She was not sworn in, and could not be questioned about basis for her conclusions that settlement talks with other carriers were relevant to this case, even though those carriers may have had entirely different licensure, filing deficiencies, or ability to promptly correct the problems in their filings.

The Hearing Officer's decision to not only consider, but inject, evidence of the OIC's settlement discussions in other proceedings as evidence that the OIC mishandled Coordinated Care's filings, also calls the Hearing Officer's impartiality into question. The Code of Judicial Conduct (CJC), though not binding on administrative law judges, is instructive to the extent it sets out the standards for judicial conduct in the State of Washington. Further, the APA provides that "Any individual serving or designated to serve alone or with others as presiding officer is subject to disqualification for bias, prejudice, interest, or any other cause provided in this chapter or for which a judge is disqualified." RCW 34.05.425(3). CJC 2.11(a) provides that "A judge shall disqualify himself or herself in any proceeding in which the judge's impartiality might reasonably be questioned", particularly in several specific circumstances. For example, when a judge has "personal knowledge of facts that are in dispute in the proceeding," or is "likely to be a material witness in the proceeding," that judge is obligated to recuse him or herself. CJC 2.11(1), (2)(d). By presenting the evidence of the OIC's settlement negotiations, the Hearing Officer essentially made herself a material witness concerning disputed factual allegations. In doing so, she has called into question her own partiality concerning this and every case involving the OIC's denial of a carrier's rate, form, and binder filings.

Impartiality by a judge and improper testimony by a witness both constitute grounds for granting a CR 59 motion for retrial or reconsideration on the basis of irregularity in the proceeding. *Edwards v. Le Duc*, 157 Wn.App. 455, 460, 238 P.3d 1187 (2010) (finding a CR 59 motion appropriate where the trial court demonstrated partiality repeatedly during the trial.); *Storey v. Storey*, 21 Wn.App. 370, 375, 585 P.2d

183 (1978) (finding a witness' testimony regarding inadmissible evidence a grounds for granting a CR 59 motion).

Because the Hearing Officer's presentation and admission of evidence of the OIC's settlement negotiations was improper under RCW 34.05.452(2), RCW 34.05.461, ER 408, and CJC 2.11, the Final Order should be reconsidered, omitting this improperly admitted information and the directives based upon it.

C. The Final Order contains errors of law that effectively force the OIC to permit Coordinated Care to enter the Exchange with an insufficient network, contrary to the laws applicable to health maintenance organizations.

In addition to improperly compelling settlement, the Final Order compels the acceptance of an inadequate network, in violation of the law.

Concerning the adequacy of Coordinated Care's network, the Final Order makes two legal errors. First, it erroneously conflates Coordinated Care's unchallenged Medicaid network as an "adequate network" for commercial products that, unlike Medicaid, must provide for 10 essential health benefits. Unfortunately, the Final Order does not provide its statutory or legal basis for the conclusion that a Medicaid network is automatically adequate for a commercial policy. Apparently, the Final Order misconstrues the provision of WAC 284-43-200, which provides that evidence of compliance with network standards for public purchasers "may be used to demonstrate sufficiency" to mean that, if a carrier has a Medicaid network for its Medicaid products, it has by operation of law demonstrated compliance with network standard for public purchaser concerning every service provided under the carrier's commercial contracts, regardless of whether public purchasers are required to include those services or providers. **This is particularly important for Medicaid carriers whose Medicaid**

plans do not have to offer all of the ten essential health benefits required under the ACA. Those ten essential health benefits are further defined by the state benchmark plan, and the rules promulgated by the OIC and the federal government. There is no discussion in the Final Order demonstrating that Coordinated Care's Medicaid plan, and Medicaid network, cover all of the essential health benefits required by law. Without such a determination, the existence of Coordinated Care's Medicaid network cannot demonstrate an adequate network for purposes of its commercial products.

In addition, the network Coordinated Care filed for its commercial products, and that was reviewed by the OIC, **was not Coordinated Care's Medicaid network.** The testimony and evidence at the hearing demonstrate that while the network filed by Coordinated Care was intended to include its Medicaid providers, it was a network built by Coordinated Care expressly for its Exchange plans. That is why the Company was contracting with HealthWays to include some of its providers in the new network, evidence of which was introduced and admitted without objection. It is because Coordinated Care's commercial network was not identical to its Medicaid network that the OIC was reviewing the network in the first place.

The second error the Final Order makes concerning Coordinated Care's network is to order the OIC to allow an HMO to satisfy its obligations to provide essential health benefits through non-networked providers. This is an express violation of RCW 48.46.030. The statutes governing HMOs require that to be licensed as an HMO, a carrier must provide:

comprehensive health care services to enrolled participants on a group practice per capita prepayment basis or on a prepaid individual practice plan and provide[] such health services either directly or through

arrangements with institutions, entities, and persons which its enrolled population might reasonably require as determined by the health maintenance organization in order to be maintained in good health . . .

RCW 48.46.030(1). Providing all covered services either directly, or through contracted providers, is a requirement for licensure as an HMO. Both Coordinated Care and the Final Order ignore this fundamental requirement for HMOs. Compelling the OIC to permit Coordinated Care to refuse to contract with the only facilities that can provide certain services that are covered by Coordinated Care's plans, forces the OIC to violate the law by licensing a carrier as an HMO that does not meet the requirements to be one.

OIC respectfully requests that the final order be revised in order to avoid forcing the OIC to take actions that are contrary to law in the future.

D. The Final Order contains Findings of Fact about communication between Coordinated Care and the OIC during the proceedings that are not supported by an objective evaluation of the record.

The Final Order contains the erroneous factual conclusion that OIC improperly refused to communicate with Coordinated Care following the July 31, 2013 denial. The Order moreover states that the OIC informed Coordinated Care that "the OIC was prohibited from communicating with the company because the Company had filed a Demand for Hearing," states that the OIC acted disingenuously in making this alleged statement, and scolded the OIC for failing to properly inform Coordinated Care of an alleged policy of refusing to communicate after a Demand for Hearing is filed. Final Order at 7-8.

There is no testimony in the record as to a policy of refusing to communicate. Dr. Fathi testified as to his understanding that OIC staff refused to communicate with

Coordinated Care because it was “against the law” to talk to a party during a hearings process. This reflects a layman’s understanding of the situation, and the OIC refuted his claim. The OIC never stated it had a “policy” of refusing to communicate with carriers in litigation, or that the law prohibits the OIC from doing so. *See* Final Order at 8 and 12.

There is no such policy. Rather, as demonstrated by counsel for the OIC, both staff attorney Andrea Philhower and Deputy Commissioner AnnaLisa Gellermann, the OIC, facing impending expedited litigation, reasonably required the company to direct its discussions solely to the legal affairs staff that would be handling that litigation. This requirement is based upon Rule of Professional Conduct (“RPC”) 4.2, a ubiquitous standard that is immediately put in place by any attorney representing any party in litigation.

Generally, RPC 4.2 also limits client discussions with parties known to be represented. *See* RPC 4.2, comment 7. This entirely reasonable direction provided Coordinated Care with a meaningful avenue to address its concerns, and utilized OIC’s limited staff resources in the most efficient manner possible. Neither Coordinated Care, nor the Final Order cite to any authority that contravenes the Rules of Professional Conduct, or mandates that a party who is subject to litigation, participate in discussions concerning the subject of that litigation, without counsel present.

Because the findings that the OIC “refused” to communicate with Coordinated Care, and changed its reasoning for doing so, are not supported in the record, the Final Order should be reconsidered without these erroneous and unsupported findings, and the directives based upon them should be stricken.

III. CONCLUSION

Because the Final Order rests on significant but erroneous conclusions of fact and law, that stemmed from irregularities in the hearing process, the OIC respectfully requests that the Final Order be reconsidered.

DATED this 6th day of September, 2013.



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