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STATE OF WASHINGTON  
OFFICE OF THE INSURANCE COMMISSIONER

In re

Seattle Children's Hospital's Appeal of  
OIC's Approvals of HBE Plan Filings

NO. 13-0293

BRIDGESPAN HEALTH COMPANY'S  
HEARING MEMORANDUM

**I. INTRODUCTION**

The BridgeSpan Health Company ("BridgeSpan") provider network meets all state and federal requirements. The network ("RealValue") was reviewed and approved by the Office of the Insurance Commissioner ("OIC") in 2012. It was reviewed again in 2013 and approved. The RealValue network provides access to covered medical services through (a) provider agreements (WAC 284-43-200(1), (2) and (b) single case agreements (WAC 284-43-200(3)). Seattle Children's Hospital's ("SCH") request to reverse the OIC approval should be declined.

**II. BACKGROUND**

The passage and implementation of the Patient Protection and Affordable Care Act ("ACA") is an national reform of the private health insurance market. As its title states, the two fundamental principles of the ACA are patient protection and affordability. Patient protection is improved by requiring health carriers to include certain categories of benefits. Affordability is fostered by subsidies, innovations designed to incentivize innovation in health care purchasing and delivery, and reimbursement rate negotiations between health plans and providers.

1 BridgeSpan worked extensively with the Office of Insurance Commissioner (“OIC”)  
2 in the years and months leading up to the launch of the Washington Health Benefit Exchange  
3 (“HBE” or “Exchange”) to develop a health insurance network and product which complied  
4 with quality and coverage requirements of the ACA while meeting the consumer need for  
5 lower premiums. These efforts led to the approval of BridgeSpan as a qualified health plan  
6 available in six Washington counties, with a current provider network that includes over 21  
7 hospitals and 10,436 providers, including multiple pediatric specialty providers and a  
8 designated pediatric hospital.<sup>1</sup>

9 SCH’s challenge fails for two reasons. First, SCH lacks standing because its interests  
10 are not within the zone of interests protected by the ACA or applicable state insurance laws,  
11 and it does not allege a redressable injury. Second, neither the ACA nor Washington law  
12 requires a carrier to contract with a specific provider like SCH. Contrary to SCH’s assertion,  
13 the ACA does not require carriers to contract with all essential community providers, nor does  
14 it require health carriers to contract with a provider simply because it offers essential health  
15 benefits that are not widely available. Rather, the ACA and state law require carriers to  
16 provide the consumers with all covered benefits, and to ensure coverage and consumer access  
17 to those benefits by provider contract or arrangement.

### 18 III. FACTUAL AND PROCEDURAL BACKGROUND

#### 19 A. The Affordable Care Act and the Regulatory Role of the OIC.

20 As required by the ACA, the Washington Health Benefit Exchange relies exclusively  
21 on private health carriers (also known as issuers) such as BridgeSpan to provide healthcare  
22 coverage to Washington citizens. This scheme requires the OIC to evaluate and approve  
23 health carriers to participate in the HBE. Under the ACA, Washington has established its own  
24 marketplace for residents to apply for and purchase HBE health insurance contracts. See 42  
25

26 <sup>1</sup> Declaration of Beth Johnson, ¶ 12.

1 U.S.C. § 18031. The OIC is charged by the ACA and state law to establish Washington's  
2 marketplace, the HBE; to determine which health plans are qualified to participate in the  
3 HBE; and to confirm that health plans offered through the HBE meet strict benefit and quality  
4 standards. See RCW 43.71.005, *et seq.*

5 Among other things, the exchange is intended to:

- 6 a) Increase access to quality affordable health care coverage, reduce  
7 the number of uninsured persons in Washington state, and increase  
8 the availability of health care coverage through the private health  
9 insurance market to qualified individuals and small employers; . . .  
10 \* \* \*
- 11 c) Create an organized, transparent, and accountable health insurance  
12 marketplace for Washingtonians to purchase affordable, quality  
13 health care coverage; . . .
- 14 d) Promote consumer literacy and empower consumers to compare  
15 plans and make informed decisions about their health care and  
16 coverage; . . .  
17 \* \* \*
- 18 g) *Create a health insurance market that competes on the basis of  
19 price, quality, service, and other innovative efforts; . . .*
- 20 h) Operate in a manner compatible with efforts to improve quality,  
21 contain costs, and promote innovation;
- 22 i) Recognize the need for a private health insurance market to exist  
23 outside of the exchange; and
- 24 j) Recognize that the regulation of the health insurance market, both  
25 inside and outside the exchange, should continue to be performed by  
26 the insurance commissioner.

19 RCW 43.71.005(a),(c), (d), (g), (h), (i), (j) (emphasis added). The HCA delegates the review  
20 and approval to the states: "The [HBE] board shall certify a plan as a qualified health plan to  
21 be offered through the exchange if the plan is determined *by the commissioner* to meet the  
22 requirements of Title 48 RCW and rules adopted by the ... Insurance commissioner pursuant  
23 to chapter 34.05 RCW to implement the requirements of Title 48 RCW," and then determined  
24 by the HBE "to meet the requirements of the [ACA] for certification as a qualified health  
25 plan." RCW 43.71.065(1)(a)-(b) (emphasis added). As the ACA does not pre-empt state  
26

1 health insurance law, the OIC must also determine that the plan satisfies the requirements of  
2 RCW Title 48. 42 U.S.C. §18041(d).

3 Once the Commissioner finds that a health plan meets federal coverage requirements  
4 and state insuring requirements, the OIC approves it for certification to the HBE board. The  
5 HBE board certifies the plan as a qualified health plan to the federal Department of Health  
6 and Human Services (“HHS”).

7 **B. The Approval of BridgeSpan as a QHP for Sale on the Washington Health**  
8 **Benefit Exchange.**

9 In 2012, Commissioner Kreidler began the review process for participation in the  
10 HBE. BridgeSpan and other health plans submitted proposed rates, proposed contract forms,  
11 actuarial information, and other information required by the ACA and the OIC. This required  
12 health plans to file provider networks for the Commissioner’s review in order to ensure the  
13 network contained sufficient providers in each required category of care.

14 BridgeSpan, a subsidiary of Regence BlueShield, contemplated creating a new  
15 provider network but backlog in the OIC review process caused BridgeSpan to use the  
16 RealValue network, a high-value network which could support the premium rates that  
17 BridgeSpan had already submitted to the OIC for use on the Exchange. *See* Declaration of  
18 Melissa J. Cunningham, Exh. 1 – Deposition of Beth Johnson, pp. 30:35-37:21; 44:17-45:12;  
19 Declaration of Beth Johnson filed January 17, 2014, ¶ 7.

20 The RealValue network was developed for use by the Regence BlueShield RealValue  
21 plan in 2012. Johnson Dec., ¶ 5. At the time it was approved by the OIC in 2012, the  
22 RealValue network did not include SCH or MultiCare Mary Bridge Children’s Hospital in  
23 network. *Id.* Consumer access to pediatric specialty care was discussed extensively by  
24 Regence BlueShield and the OIC. The OIC was aware that the RealValue network did not  
25 include either pediatric specialty hospital in network. *Id.* at ¶ 6. The OIC acknowledged  
26 access to SCH would occur where specialized services were not available in-network through

1 single case agreements. The OIC instructed Regence to include SCH in the RealValue Form  
2 A on that basis. *Id.*<sup>2</sup>

3 BridgeSpan ended up utilizing the RealValue Network and referenced it on all  
4 Exchange network filings for the 2014 plan year. *Id.* at ¶2; *See* Dec. of Cunningham, Exh. 1 –  
5 Deposition of Beth Johnson, pp. 35:5-36:12. The OIC conducted an extensive review of these  
6 filings and required some supplementation of the network to comply with the ACA. On July  
7 31, 2013, the OIC approved BridgeSpan for participation in the HBE.

8 The BridgeSpan RealValue network exceeded state and federal requirements when it  
9 was approved as a qualified health plan and has increased in breadth since that date. *Johnson*  
10 *Decl.*, ¶8. In addition to the MultiCare Mary Bridge Children’s Hospital in Tacoma,  
11 BridgeSpan is contracted with several other hospitals with specialized in-patient pediatric  
12 departments or Level III Neonatal Intensive Care Units. These facilities offer BridgeSpan  
13 members multiple choices for pediatric specialty care throughout Western Washington.  
14 *Johnson Dec.* at ¶ 14, Ex.B. Since January 1, 2014, less than five (5) BridgeSpan enrollees  
15 have required access to SCH. Dec. of Cunningham, Exh. 2 – Deposition of Dennis  
16 Hagemann, pp. 13:2-21, 15:5-12.

17 **C. Coordinated Care Matter**

18 While the OIC approved the BridgeSpan network, it disapproved several others. The  
19 OIC declined to approve health carrier Coordinated Care’s plan in July of 2013 because of,  
20 among other reasons, an alleged absence of pediatric specialty providers within Coordinated  
21 Care’s proposed network. As an example, the OIC noted Coordinated Care’s failure to  
22 contract with SCH. The matter went to hearing. After Coordinated Care agreed to provide  
23 pediatric specialty care pursuant to WAC 284-43-200(3), the network was approved.  
24 Coordinated Care agreed to utilize the BridgeSpan single case agreement form. The Findings  
25

26 <sup>2</sup> A Form A is the health plan’s monthly OIC filing showing providers available to enrollees.

1 of Fact, Conclusions of Law, and Final Order entered on September 3, 2013 concluded that  
2 “carriers are not required to include Level 1 Burn Units or pediatric hospitals in their  
3 networks.” Declaration of Jay Fathi filed January 17, 2014, Ex. A (Conclusion of Law, No.  
4 12 b, p. 17).

5 In September and again in November 2013, the OIC Presiding Officer examined the  
6 adequacy of Coordinated Care’s provider network and determined that Coordinated Care had  
7 shown that its network was adequate under Washington law without SCH in its network. *Id.*,  
8 Ex. A (Final Order, pp. 17-18 (¶ b)).

9 **D. Open Enrollment on the Exchange**

10 Ultimately, the OIC approved plans issued by eight health carriers. On October 1,  
11 2013, the HBE board certified them to HHS as “Qualified Health Plans.” On that day, the  
12 HBE launched open enrollment, allowing Washington citizens to apply for and purchase  
13 individual health contracts, including BridgeSpan’s plans, through the HBE consumer market  
14 place website – wahealthplanfinder.org. Coverage began on January 1, 2014, and open  
15 enrollment ended on March 31, 2014. Currently there are over 1,500 members enrolled in a  
16 BridgeSpan Exchange Product.

17 **IV. LEGAL ARGUMENT**

18 **A. Standard of Review.**

19 As the party challenging the validity of the OIC’s action, SCH bears the burden of  
20 proof in this matter. *See Schaffer v. Weast*, 546 U.S. 49, 57 (2005)(“[w]e therefore begin with  
21 the ordinary default rule that plaintiffs bear the risk of failing to prove their claims”). Because  
22 the OIC is the agency charged with interpreting and enforcing the Insurance Code, its  
23 interpretation of the Code deserves deference, “so long as that interpretation is not contrary to  
24 the plain language of the statute.” *Port of Seattle v. Pollution Control Hearings Bd.*, 151  
25 Wn.2d 568, 612, 90 P.3d 659 (2004). Similarly, as the agency which promulgated the state  
26

1 network adequacy regulations, the OIC's interpretation of those regulations is also entitled to  
2 deference. *Id.* at 631.

3 **B. SCH Lacks Standing to Bring This Action Under RCW 48.04.010.**

4 BridgeSpan renews its motion to dismiss for lack of standing under RCW 48.04.010  
5 and incorporates by reference many of the arguments therein.<sup>3</sup> In support of these BridgeSpan  
6 witnesses will testify that there have been no member complaints filed with BridgeSpan or the  
7 OIC regarding SCH. As a result, SCH's contention that it is aggrieved by the administrative  
8 burden of executing single case agreements is irrelevant. Nevertheless, the evidence will show  
9 that there has been only a handful single case agreements executed between BridgeSpan and  
10 SCH since January 1, 2014. Lastly, SCH can present no evidence that is suffering financial  
11 harm as a result of OIC approval of the BridgeSpan health plan.

12 **C. The OIC Correctly Determined That the BridgeSpan Health Plan and RealValue  
13 Network Met All Federal and State Requirements When it Approved BridgeSpan  
14 as a Qualified Health Plan in July of 2013.**

15 **1. The BridgeSpan Health Plan and RealValue network met all network  
16 adequacy requirements under state law.**

17 The evidence will show the OIC correctly determined that the BridgeSpan RealValue  
18 network complied with state network adequacy requirements in effect in 2013. Washington  
19 law requires carriers to maintain a network "sufficient in numbers and types of providers and  
20 facilities to assure that all health plan services to covered persons will be accessible without  
21 unreasonable delay" and that "each covered person shall have adequate choice among each  
22 type of health care provider." WAC 284-43-200(1); *see also* RCW 48.43.515(1) ("Each  
23 enrollee in a health plan must have adequate choice among health care providers."); RCW  
24 48.43.500(2) (providing that enrollee's must "[h]ave sufficient and timely access to  
25 appropriate health care services, and choice among health care providers."). Carriers may

26 <sup>3</sup> See Intervenor's Motion For Summary Judgment, p. 11-16; BridgeSpan's Reply in Support of Motion to Vacate Chief Presiding Officer Petersen's Orders, p. 3.

1 establish sufficiency and adequacy using any reasonable criteria, such as provider-covered  
2 person ratios by specialty and primary care, geographic accessibility, waiting times for  
3 appointments with participating providers, hours of operation, and the volume of  
4 technological and specialty services available to serve the needs of covered persons requiring  
5 technologically advanced or specialty care. WAC 284-43-200(2).

6 In determining whether a health carrier has complied with this provision, the  
7 Commissioner must “give due consideration to the relative availability of health care  
8 providers or facilities in the service area under consideration and to the standards established  
9 by state agency health care purchasers.” *Id.* “Relative availability includes the willingness of  
10 providers or facilities in the service area to contract with the carrier under reasonable terms  
11 and conditions.” *Id.*

12 Consistent with the emphasis on consumer access, the state network adequacy rule  
13 allows for an adequate carrier network even where “the health carrier has an absence of or  
14 insufficient number or type of participating providers or facilities to provide a particular  
15 covered health care service,” provided the carrier ensures “the covered person obtains the  
16 covered service from a provider or facility within reasonable proximity of the covered person  
17 at no greater cost to the covered person than if the service were obtained from network  
18 providers and facilities,” or if the carrier “makes other arrangements acceptable to the  
19 commissioner.” WAC 284-43-200(3).

20 There is no requirement under Washington law that a health carrier contract with  
21 every interested provider.<sup>4</sup> Whether to contract with a particular provider and the terms of  
22 such a provider contract are left to negotiation between the carrier and the provider. While  
23 carriers must contract with every general *category* of covered provider and must have a base  
24 level network to provide covered benefits and ensure patient choice, the size and scope of the

25 \_\_\_\_\_  
26 <sup>4</sup> Health carriers are allowed to utilize non-contracted providers for some specialty care so long as the carrier ensures it is provided at “no greater cost to the covered person.” WAC 284-43-200(3).

1 carrier's network is otherwise left to the marketplace. *See* RCW 48.43.045 and WAC 284-43-  
2 310.

3 The evidence will show that the OIC reviewed BridgeSpan's RealValue network,  
4 correctly determined that the RealValue network provided an adequate and accessible choice  
5 of providers as required by state law, and approved BridgeSpan's policy by which it ensures  
6 member access to covered benefits not available in network at no greater cost to the  
7 consumer. This is all state law required.

8 **2. The BridgeSpan Health Plan and RealValue Network met all**  
9 **requirements under the ACA.**

10 (a) **The ACA does not require an Exchange carrier to contract with**  
11 **every "essential community provider" in a given service area.**

12 The BridgeSpan provider network also complied with federal network adequacy  
13 requirements implemented under the ACA. SCH claims that federal law requires an Exchange  
14 carrier to contract with every "essential community provider" in a given service area. This is  
15 contrary to the ACA. Although SCH is an "essential community provider" as determined by  
16 the Centers for Medicare and Medicaid Services ("CMS"), the ACA does not require the  
17 inclusion of every single "essential community provider" in a service area. The ACA  
18 authorizes the promulgation of regulations by the Secretary of HHS for the certification of  
19 Qualified Health Plans ("QHPs"), a certification which each of these Intervenors has received.

20 The Secretary's certification criteria must:

21 . . . include within health insurance plan networks those essential community  
22 providers, where available, that serve predominantly low-income, medically  
23 underserved individuals, such as health care providers defined in section  
24 340B(a)(4) of the Public Health Service Act [42 USC §256b(a)(4)] and  
25 providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act  
26 [42 USC § 139r-8(c)(1)(D)(i)(IV)] as set forth by section 221 of Public Law  
111-8, except that nothing in this subparagraph shall be construed to require  
any health plan to provide coverage for any specific medical procedure.

42 U.S.C. 18031(c)(1)(C).

1 SCH's contention that the ACA mandates the inclusion of all essential community  
2 providers directly conflicts with the Secretary's interpretation of the ACA as set forth in 45  
3 C.F.R. §156.230 and 45 C.F.R. §156.235. A federal agency's interpretation of a statute which  
4 it is charged with administering is controlling "unless [it is] arbitrary, capricious, or  
5 manifestly contrary to the statute." *Chevron U.S.A. Inc. v. Nat'l Res. Def. Council*, 467 U.S.  
6 837, 843-44, 104 S. Ct. 2778 (1984). The regulatory preambles to both the proposed rule and  
7 the final rule at 45 C.F.R. §156.235 show that the Secretary of HHS did **not** interpret the ACA  
8 to require a QHP to contract with all essential community providers in a given service area:

9 Although the Affordable Care Act requires inclusion of essential community  
10 providers in QHP networks, the Act does not require QHP issuers to contract  
11 with or offer contracts to all essential community providers. The statute refers  
12 to "those essential community providers, where available," and "that serve  
13 predominantly low-income and medically-underserved," **which suggests a**  
14 **requirement that QHP issuers contract with a subset of essential**  
15 **community providers.** We considered establishing broad contracting  
16 requirements where QHP issuers would have to offer a contract to all essential  
17 community providers in each QHP's service area, or establishing a requirement  
18 for issuers to contract with essential community providers on an any-willing  
19 provider basis...**However, such a requirement may inhibit attempts to use**  
20 **network design to incentivize higher quality, cost effective care by tiering**  
21 **networks and driving volume towards providers that meet certain quality**  
22 **and value goals.**

23 Proposed Rule, 76 Fed. Reg. 41866, 41899 (July 15, 2011).

24 **Comment:** HHS received many comments seeking clarity on the proposed  
25 standard in § 156.235(a) that QHPs include in their provide networks a  
26 "sufficient" number of essential community providers. *Many commenters*  
*recommended that QHP issuers include in their provider networks all*  
*essential community providers in the area; contract with any willing essential*  
*community provider; or contract with certain types of providers, such as*  
*family planning providers...*In contrast, other commenters supported the  
proposed rule and urged HHS to maintain a broad definition of "sufficient"  
that allows Exchanges to establish standards appropriate for their States.

**Response:** Based on comments received, we believe that additional  
clarification of the "sufficiency" standard is necessary. Accordingly, we have  
modified final § 156.235(a) to direct that each QHP's network have a sufficient  
number and geographic distribution of essential community providers, where  
available, to ensure reasonable and timely access to a broad range of such

1 providers for low-income, medically underserved individuals in the QHP's  
2 service area, in accordance with the Exchange's network adequacy standards.  
3 We believe that this approach more clearly articulates our expectations with  
4 respect to sufficiency than the standard included in the proposed rule with  
5 respect to essential community providers *while continuing to balance the*  
6 *accessibility of essential community providers with network flexibility for*  
*issuers*. We emphasize that Exchanges have the discretion to set higher, more  
*stringent standards with respect to essential community provider*  
*participation, including a standard that QHP issuers offer a contract to any*  
*willing essential community provider.* [Emphasis added.]

7 Final Rule and Interim Final Rule, Network Adequacy Standards, 77 Fed. Reg. 18310, 18421  
8 (March 27, 2012).

9 (b) The OIC was entitled to rely on the essential community provider  
10 "safe harbor" standard contained in the CMS "Letter to Issuers"  
11 as a reasonable interpretation of federal regulations by the agency  
12 which promulgated them.

13 A court must give deference to an agency's interpretation of its own ambiguous  
14 regulation unless the interpretation is "plainly erroneous or inconsistent with the regulation."  
15 *Auer v. Robbins*, 519 U.S. 452, 461 (1997) (quoting *Robertson v. Methow Valley Citizens*  
16 *Council*, 490 U.S. 332, 359 (1989)). **This is true even if the manifestation of the agency's**  
**interpretation does not have the "force of law."**<sup>5</sup>

17 In 2013, CMS issued a "Letter to Issuers" with operational and technical guidance to  
18 those health plans seeking to participate in federally facilitated exchanges ("FFE's") during  
19 the 2014 plan year. Declaration of Molly Nollette filed January 15, 2014, Ex. F. The 2013  
20 guidance indicated that CMS would use issuer accreditation status or identify states with  
21 review processes at least as stringent as those identified in 45 C.F.R. 156.230(a) to determine  
22 compliance with the regulation in the 2014 plan year. *Id.* at 6. The 2013 guidance also

23  
24 <sup>5</sup> See *Auer*, 519 U.S. at 462 (deferring to Secretary of Labor's non-binding interpretation of its own  
25 regulation in an *amicus curiae* brief); *Decker v. Northwest Environmental Defense Center*, 133 S. Ct. 1326, 1337  
26 (2013) (deferring to the EPA's non-binding interpretation of its regulations in an *amicus curiae* brief.) See also  
*Bassiri v. Xerox Corp.*, 463 F.3d 927, 930 (9th Cir. 2006) ("[W]here an agency interprets its own regulation, even  
if through an informal process, its interpretation of an ambiguous regulation is controlling under *Auer* unless  
'plainly erroneous or inconsistent with the regulation.'").

1 indicated that any issuer that demonstrated that **at least 20 percent** of available ECP's in each  
2 plan's service area were in the provider network would have satisfied the regulatory standard  
3 for "a sufficient number" of ECP's. *Id.* at 7.

4 Even though this guidance itself was not directed towards state-based exchanges and  
5 potentially lacks the "force of law" in Washington's state-based exchange, it is still an  
6 interpretation of the regulations by the agency which promulgated the regulations, and as such  
7 is entitled to deference unless "plainly erroneous or inconsistent with the regulation." The  
8 evidence will show that the OIC relied on the CMS guidance regarding the ECP regulatory  
9 standard, and determined that BridgeSpan's RealValue network complied with this  
10 requirement as it was contracted with significantly more than 20 percent of ECP's located in  
11 BridgeSpan's service area.

12 (c) **The BridgeSpan health plan includes the essential health benefits**  
13 **required by the ACA and state law.**

14 As noted, one of the goals of the ACA was to set minimum coverage standards for  
15 health plans nationwide. This was achieved by requiring commercial health plans sold on a  
16 state exchange to cover certain "essential health benefits." Pursuant to the ACA and enabling  
17 regulations, the Washington Legislature passed legislation requiring the Commissioner to  
18 select a state benchmark plan for the individual and small group markets that includes, at a  
19 minimum, all of the ten essential health benefit categories specified in Section 1302 of the  
20 ACA. RCW 48.43.715(3). In Washington, the essential health benefits are defined as follows:

- 21 (1) The benefits and services covered by the selected benchmark  
22 plan
- 23 (2) The services and items covered by a health benefit plan that are  
24 within the categories identified in Section 1302(b) of PPACA  
25 including, but not limited to, ambulatory patient services,  
26 emergency services, hospitalization, maternity and newborn  
care, mental health and substance abuse services, including  
behavioral health treatment, prescription drugs, rehabilitative  
and habilitative services and devices, laboratory services,  
preventive and wellness services and chronic disease  
management, and **pediatric services, including oral and  
vision care, and**

1 (3) Mandated benefits pursuant to Title 48 RCW enacted before  
2 December 31, 2011.

3 WAC 284-43-865 (emphasis added). The regulation makes clear that although health carriers  
4 are prohibited from limiting the scope of the essential health benefit category based on the  
5 type of provider delivering the service, “[t]his obligation does not require an issuer to contract  
6 with any willing provider.” WAC 284-43-877(5).

7 Here, the evidence will show that the OIC correctly determined that the BridgeSpan  
8 Health Plan covered the same benefits and services covered by Washington’s selected  
9 benchmark plan, as well as the services defined in Section 1302(b) of the ACA. Further, the  
10 OIC correctly evaluated compliance with the essential health benefit requirements by looking  
11 at the benefits that each plan offered consumers, not by whether a plan was contracted with  
12 every provider of those essential health benefits.

13 **3. The ACA Does Not Preempt State Network Adequacy Standards.**

14 An underlying theme of SCH’s argument is that ACA network adequacy standards are  
15 different and more stringent than state network adequacy standards. However, nothing in Title  
16 I of the ACA<sup>6</sup> is to be construed to preempt any state law that does not prevent the application  
17 of the provisions of the Title. 42 U.S.C. §18041(d). The preamble to the final network  
18 adequacy rule 45 C.F.R. §156.230 indicates the Secretary interpreted the ACA as allowing  
19 states to continue to apply their own network adequacy rules and promulgated the rule  
20 accordingly, with the understanding that the regulation would provide a minimum national  
21 standard:

22 **Comment:**...Finally, a few commenters generally requested that HHS clarify  
the meaning of “sufficient number” of providers.

23 **Response:** A number of competing policy goals and considerations come into  
24 play with examinations of network adequacy: that QHPs must provide  
25 sufficient access to providers; *that Exchanges should have discretion in how*

26 <sup>6</sup> Title I of the Affordable Care Act includes all portions of the law related to the reform of the private health insurance market, including the establishment of the exchanges and the individual mandate.

1 *to ensure sufficient access; that a minimum standard in this regulation*  
2 *would provide consistent consumer protections nationwide; that network*  
3 *adequacy standards should reflect local geography, demographics, patterns*  
4 *of care, and market conditions; and that a standard in regulation could*  
5 *misalign standards inside and outside of the Exchange.* In balancing these  
6 considerations, we have modified § 156.230(a) (2) in this final rule to better  
7 align with the language used in the NAIC Model Act. *Specifically, the final*  
8 *rule establishes a minimum standard that a QHP's provider network must*  
9 *maintain a network of a sufficient number and type of providers, including*  
10 *providers that specialize in mental health and substance abuse, to assure that*  
11 *all services will be available without unreasonable delay....* We note that  
12 nothing in the final rule limits an Exchange's ability to establish more rigorous  
13 standards for network adequacy. We also *believe that this minimum standard*  
14 *allows sufficient discretion to Exchanges to structure network adequacy*  
15 *standards that are consistent with standards applied to plans outside the*  
16 *Exchange and are relevant to local conditions.* Finally, placing the  
17 responsibility for compliance on QHP issuers, rather than directing the  
18 Exchange to develop standards, is more consistent with current State practice.

19 **Comment:** Several commenters urged HHS to codify the potential additional  
20 standards listed in the preamble to the proposed rule (access without  
21 unreasonable delay, reasonable proximity of providers to enrollees' homes or  
22 workplaces, ongoing monitoring process, and out-of-network care at no  
23 additional cost when in-network care is unavailable), with the largest number  
24 of commenters expressing support for the provision of out-of-network care at  
25 no additional cost when in-network care is unavailable. Other commenters  
26 recommended specific alternatives to these elements, such as a "60 minutes or  
60 miles" or "15-20 minutes" standard.

**Response:** Based on comments, we have modified § 156.230(a) (2) in this final  
rule to codify the standard that services must be available without unreasonable  
delay. *With respect to the other specific suggestions offered by commenters,*  
*we are concerned that the proposed standards may not be compatible with*  
*existing State regulation and oversight in this area.* We believe that the  
modification to final § 156.230(a)(2) strikes the appropriate balance between  
assuring access for consumers and *recognizing the historical flexibility and*  
*responsibility given to States in this area.* [Emphasis added.]

Final Rule and Interim Final Rule, Network Adequacy Standards, 77 Fed. Reg. 18310, 18418-  
19 (March 27, 2012).

The federal regulations allow for the Commissioner to implement standards more  
relevant to the state insurance market, such as approving the use of single-case agreements or

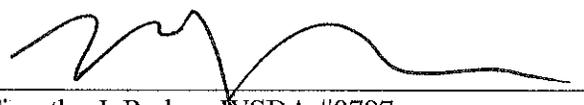
1 “other arrangements” pursuant to WAC 284-43-200(3), as long as the consumer has access to  
2 a “sufficient” number and types of providers under 45 C.F.R. §156.230(a)(2).

3 **V. REQUESTED RELIEF**

4 BridgeSpan respectfully requests this tribunal to rule that the OIC correctly applied  
5 state and federal law when it approved BridgeSpan’s participation in the Exchange without  
6 the inclusion of SCH in the BridgeSpan RealValue network. In the event that this tribunal  
7 determines the OIC failed to correctly apply the law, BridgeSpan requests that the approval  
8 decision be remanded back to the OIC for additional review and consideration consistent with  
9 this tribunal’s ruling.

10 DATED this 11<sup>th</sup> day of August, 2014.

11 CARNEY BADLEY SPELLMAN, P.S.

12  
13  
14 By 

15 Timothy J. Parker, WSBA #8797

16 Melissa J. Cunningham, WSBA #46537

17 Attorneys for BridgeSpan Health Company

CERTIFICATE OF SERVICE

I, Christine Williams, under oath hereby declare as follows: I am an employee at Carney Badley Spellman, P.S., over the age of 18 years, and not a party to nor interested in this action. On August 11, 2014, I caused to be delivered via e-mail and U.S. mail a copy of the foregoing document on the following parties at the last known address as stated:

<p>OIC Hearings Unit – ORIGINAL  Office of the Insurance Commissioner  5000 Capitol Boulevard  Tumwater, WA 98501  Email: <a href="mailto:kellyc@oic.wa.gov">kellyc@oic.wa.gov</a></p> <p>Hon. George Finkle (Ret.)  Email: <a href="mailto:gfinkle@jdrllc.com">gfinkle@jdrllc.com</a>  <a href="mailto:forbes@jdrllc.com">forbes@jdrllc.com</a></p>	<p><u>Attorney for Seattle Children’s Hospital</u>  Michael Madden  Carol Sue Janes  Bennett Bigelow &amp; Leedom, P.S.  601 Union Street, Suite 1500  Seattle, WA 98101  Email: <a href="mailto:mmadden@bbllaw.com">mmadden@bbllaw.com</a>  <a href="mailto:csjanes@bbllaw.com">csjanes@bbllaw.com</a></p>
<p><u>Legal Affairs Division</u>  Charles Brown  Legal Affairs Division  Office of the Insurance Commissioner  P.O. Box 40255  Olympia, WA 98504-0255  Email: <a href="mailto:charlesb@oic.wa.gov">charlesb@oic.wa.gov</a></p>	<p><u>Attorney for Premera Blue Cross</u>  Gwendolyn C. Payton  Lane Powell PC  1420 Fifth Avenue, Suite 4100  Seattle, WA 98101-2338  Email: <a href="mailto:paytong@lanepowell.com">paytong@lanepowell.com</a></p>

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF WASHINGTON THAT THE FOREGOING IS TRUE AND CORRECT.

DATED this 11th day of August, 2014, at Seattle, Washington.

Christine Williams, Legal Assistant

FILED

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MC

STATE OF WASHINGTON  
OFFICE OF THE INSURANCE COMMISSIONER

In re  
Seattle Children's Hospital's Appeal of  
OIC's Approvals of HBE Plan Filings

NO. 13-0293  
DECLARATION OF MELISSA J.  
CUNNINGHAM IN SUPPORT OF  
BRIDGESPAN HEALTH COMPANY'S  
HEARING MEMORANDUM

I, Melissa J. Cunningham, declare as follows:

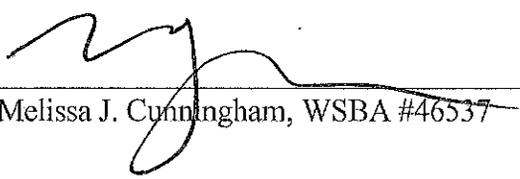
1. I am one of the attorneys for BridgeSpan Health Company, am over the age of 18 and makes this declaration based on my personal knowledge.

2. Attached hereto as Exhibit 1 are true and correct excerpts of the Deposition of Beth Johnson taken July 24, 2014.

3. Attached hereto as Exhibit 2 are true and correct excerpts of the Deposition of Dennis Hagemann taken July 23, 2014.

I DECLARE UNDER PENALTY OF PERJURY OF THE LAWS OF THE STATE OF WASHINGTON THAT THE FOREGOING IS TRUE AND CORRECT.

DATED this 11th day of August, 2014.

  
Melissa J. Cunningham, WSBA #46537

CERTIFICATE OF SERVICE

I, Christine Williams, under oath hereby declare as follows: I am an employee at Carney Badley Spellman, P.S., over the age of 18 years, and not a party to nor interested in this action. On August 11, 2014, I caused to be delivered via e-mail and U.S. mail a copy of the foregoing document on the following parties at the last known address as stated:

<p>OIC Hearings Unit – ORIGINAL  Office of the Insurance Commissioner  5000 Capitol Boulevard  Tumwater, WA 98501  Email: <a href="mailto:kellyc@oic.wa.gov">kellyc@oic.wa.gov</a></p> <p>Hon. George Finkle (Ret.)  Email: <a href="mailto:gfinkle@jdrllc.com">gfinkle@jdrllc.com</a>  <a href="mailto:forbes@jdrllc.com">forbes@jdrllc.com</a></p>	<p><u>Attorney for Seattle Children’s Hospital</u>  Michael Madden  Carol Sue Janes  Bennett Bigelow &amp; Leedom, P.S.  601 Union Street, Suite 1500  Seattle, WA 98101  Email: <a href="mailto:mmadden@bblaw.com">mmadden@bblaw.com</a>  <a href="mailto:csjanes@bblaw.com">csjanes@bblaw.com</a></p>
<p><u>Legal Affairs Division</u>  Charles Brown  Legal Affairs Division  Office of the Insurance Commissioner  P.O. Box 40255  Olympia, WA 98504-0255  Email: <a href="mailto:charlesb@oic.wa.gov">charlesb@oic.wa.gov</a></p>	<p><u>Attorney for Premera Blue Cross</u>  Gwendolyn C. Payton  Lane Powell PC  1420 Fifth Avenue, Suite 4100  Seattle, WA 98101-2338  Email: <a href="mailto:paytong@lanepowell.com">paytong@lanepowell.com</a></p>

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF WASHINGTON THAT THE FOREGOING IS TRUE AND CORRECT.

DATED this 11th day of August, 2014, at Seattle, Washington.

Christine Williams, Legal Assistant

# **EXHIBIT 1**

July 24, 2014

IN RE: SEATTLE CHILDREN'S HOSPITAL

Beth Johnson

1 STATE OF WASHINGTON

2 OFFICE OF THE INSURANCE COMMISSIONER

3 In re

4 Seattle Children's Hospital's  
5 Appeal of OIC's Approvals of  
6 HBE Plan Filings,

COPY

6

7

8

9

) DOCKET No. 13-0293

10

11 DEPOSITION UPON ORAL EXAMINATION OF

12 BETH JOHNSON

13

14 12:00 p.m.

15 Thursday, July 24, 2014

16 1420 Fifth Avenue

17 Seattle, Washington

18

19

20

21

22

23

24

25 LISA R. MICHAUD, CCR



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1 the OIC. And as you can imagine, in the provider  
 2 world there's daily, weekly, monthly changes to a  
 3 provider file.  
 4 A chiropractor moves their office  
 5 location and we have to update that. A provider  
 6 retires and closes their practice and we terminate  
 7 them from the network. So there's day-to-day  
 8 activity that happens in the provider system, and  
 9 that is the Form A pulls from that provider system.  
 10 So it's a pretty much a living document from month  
 11 to month.  
 12 So any submission is -- the  
 13 submissions are done on a monthly basis -- on a  
 14 continuous monthly basis, but there's going to be  
 15 changes in each of those months based on the  
 16 circumstances I just said. So there was no whole  
 17 scale stop, redo the network, refile the network.  
 18 It would have just been a work  
 19 process of make -- you know, adding a contracting  
 20 effort to reach out to the chiropractors and add  
 21 them to the network system that would pull into the  
 22 Form A and push to the OIC. And that just would  
 23 have been a process that was ongoing.  
 24 Q Were there any other categories of  
 25 providers that the OIC required Regence to add to

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1 Real Value in order -- before it would allow it to  
 2 begin reselling the product, for example,  
 3 acupuncture and massage therapy?  
 4 A I truly don't remember. I know the issue  
 5 was about some category of complimentary and  
 6 alternative medicine, but I can't tell you with  
 7 certainty what those were. But my recollection was  
 8 it was around ancillary providers.  
 9 So the OIC was looking at our network  
 10 filings, and at some point in time deemed them  
 11 inadequate for some type of ancillary network. We  
 12 remedied the situation, continued the submission of  
 13 the Form A filings, and, again, it's my  
 14 understanding that the product continued to be sold  
 15 in the marketplace.  
 16 Q Now, the product terminated in first of  
 17 this year with -- because it couldn't meet ACA  
 18 requirements; is that right?  
 19 A That's my recollection as well that we  
 20 would have given discontinuation notices to those  
 21 individuals enrolled according to the regulatory  
 22 guidelines sometime in the August, September of 2013  
 23 in advance of 2014 notifying people on those plans.  
 24 Wasn't just that plan. I think it was every single  
 25 individual plan that Regence had was discontinued

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1 and had to be, you know, redone.  
 2 Q So is it correct that as Regence was --  
 3 well, actually let me back up.  
 4 A Sure.  
 5 Q The exchange products that are marketed --  
 6 let me back up some more.  
 7 A Go ahead.  
 8 Q BridgeSpan Health is --  
 9 A We can be confusing.  
 10 Q BridgeSpan Health is a subsidiary of  
 11 Regence; correct?  
 12 A I'm sure that's the correct terminology.  
 13 It's some affiliate subsidiary. Yes.  
 14 Q And BridgeSpan is the entity that provides  
 15 qualified health plan coverage through the exchange  
 16 here in Washington; is that correct to your  
 17 understanding?  
 18 A That's my understanding. Yes.  
 19 Q And were you involved with the planning  
 20 and regulatory filings as pertained to network for  
 21 the BridgeSpan exchange product?  
 22 A Yes, I was.  
 23 Q Is it correct BridgeSpan intended to use  
 24 the Regence Real Value network as its -- as the  
 25 network for its exchange products?

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1 A Regence had a desire to utilize the  
 2 BridgeSpan company as its exchange vehicle and that  
 3 was very a protracted regulatory process. There was  
 4 also a desire to build a specific network for the  
 5 exchange called "focus network." And that would  
 6 have been -- that was Regence's/BridgeSpan's Plan A  
 7 for the exchange.  
 8 Q Can you tell me how we get to -- well, let  
 9 me put a boundary on the other end.  
 10 A Sure.  
 11 Q For purposes of its rate and form filing  
 12 for the exchange products, BridgeSpan proposed to  
 13 use certain networks; correct? So I'm talking about  
 14 we get to the --  
 15 A So April, May, whatever we are of 2013 for  
 16 2014?  
 17 Q Yes.  
 18 A Yes, I'm following you. Yes.  
 19 Q What networks did you actually submit with  
 20 the rate and form filings as the networks that would  
 21 support the BridgeSpan exchange products?  
 22 A I didn't actually file the filings. But  
 23 what Regence's intent in the filings was in the  
 24 individual line of business, BridgeSpan was on  
 25 exchange accessing Real Value. Regence product and



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1 network off exchange for individual was Regence  
 2 BlueShield and the PPO preferred network.  
 3 Q I think I understand. So for the -- the  
 4 plan was that Regence would offer individual plans  
 5 outside of the exchange?  
 6 A Correct.  
 7 Q And for the Regence individual  
 8 non-exchange products, the preferred network would  
 9 be utilized?  
 10 A Correct.  
 11 Q So the plan was -- is this correct? The  
 12 plan was for BridgeSpan in its exchange products to  
 13 use Real Value?  
 14 A That's correct.  
 15 Q So now we got that boundary. Can you  
 16 explain to me, and at a high level, how you got from  
 17 Plan A, the focus network to using Real Value or  
 18 proposing to use Real Value?  
 19 A Sure. I think I can. All right. So time  
 20 line, summer of 2013, lots of communication from the  
 21 Office of Insurance Commissioner about product and  
 22 network filings for the exchange. Lots of internal  
 23 discussions and strategy sessions within Regence  
 24 exchange strategy.  
 25 Regence had a desire to continue to

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1 offer affordable health plans particularly in the  
 2 exchange. And there was a desire to have some type  
 3 of PCP plan that had referral and authorization  
 4 requirements. And an ability to have, again,  
 5 referrals and authorizations for care outside of a  
 6 primary care provider's office so there was an  
 7 opportunity to manage care and manage cost in what  
 8 was an unknown marketplace.  
 9 So we developed network contract. We  
 10 met with the Office of Insurance Commissioner. And  
 11 I'm not going to get these dates exact, but we met  
 12 with Beth Berendt and her team sometime in late  
 13 October. It was pre-Thanksgiving time frame of 2013  
 14 to explain to the OIC what our goal was around the  
 15 filings for the exchange both with PCP plans,  
 16 referral and authorizations. That we had had  
 17 conversations with providers in our network, that we  
 18 had providers who wanted to participate. Were in an  
 19 interesting time where there are more providers than  
 20 there had been in the past in the 90s in those  
 21 managed care contract days who wanted to have  
 22 patients assigned to them so that they could be  
 23 incented around cost and quality contracts.  
 24 When we met with Beth Berendt,  
 25 Ms. Berendt, she was quite concerned that Regence

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1 was alerting her of this strategy and plan later  
 2 than she would have liked. She expressed concern  
 3 that we had not yet filed the network and expressed  
 4 concern that the time that would be required to  
 5 approve and for Regence to contract those networks.  
 6 So we assured her that we were ready  
 7 to file the network -- excuse me, not file the  
 8 network. File the contracts. That concurrent with  
 9 that, we were in the process of negotiating those  
 10 contracts with providers. And so pretty soon upon  
 11 approval of the contracts, we would be able to file  
 12 a network for this product.  
 13 And I very much remember those  
 14 conversations because Beth Berendt did not say we  
 15 were too late, go home, and forget about it. It was  
 16 I'm concerned about the time line. Hurry up and get  
 17 them in.  
 18 So I remember that time frame because  
 19 we turned it around to the OIC in a matter of days  
 20 for the filing. I won't go into all the details,  
 21 but it was a monumental work task to get that done  
 22 in the time line that was requested or suggested.  
 23 So we submitted the contract through the SERRF  
 24 system and we were pretty insistent in following up  
 25 about approvals. Have you gotten it? Have you read

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1 it? Are there initial concerns?  
 2 And again, I'm going by memory on all  
 3 of this. So my time lines might be a little bit  
 4 off, but there was a rejection of the contract back  
 5 to Regence and I, again, might be getting my terms  
 6 wrong. Suspended might be the right term.  
 7 Suspended back to Regence for some  
 8 fixes. We fixed those fixes within 24 or 48 hours  
 9 and resubmitted it. And then we never got a  
 10 response on was the contract approved or  
 11 disapproved. It was never disapproved. And in the  
 12 filing system, they can suspend it. It's usually a  
 13 use and lose -- we might lose, file and use, and  
 14 we -- but once it hit suspense, again, I probably  
 15 might not get my terminology all correct, but they  
 16 had to actively approve it.  
 17 It was never actively approved nor  
 18 actively disapproved. And I'll get to the  
 19 disapproval, but I think we finally got disapproval  
 20 like March 31st of 2014. Again, my date might be a  
 21 little bit wrong on that. So we were -- please go  
 22 right ahead.  
 23 Q You're very helpful, but you might be off  
 24 a year, '14 or '13?  
 25 A '13. Thank you. Because it would have

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1 been pre-filing for '14. Thank you for that. Yes,  
 2 you're correct.  
 3 Q Sorry to interrupt.  
 4 A No, no, no. I appreciate the correction.  
 5 So this was kind of getting into the holidays and it  
 6 was like holy cow, we need to file for the exchange.  
 7 Our contracts aren't approved yet. So there was a  
 8 lot of internal scrutiny. Then I also had a meeting  
 9 with Beth that I clearly recollect.  
 10 There was an all filers meeting and  
 11 our senior executives, up to our CEO Mark Ganz had  
 12 been into meet with Mike Kreidler to talk about the  
 13 various things. I wasn't in the meeting, but I know  
 14 the meeting occurred. About various plans  
 15 particularly about Regence's plan for BridgeSpan and  
 16 needing the OIC's approval for the BridgeSpan  
 17 company before that could even be filed.  
 18 And Beth Berendt told the executive  
 19 team that Regence had not yet filed our provider  
 20 contract for the exchange. And a couple days later  
 21 I was in an all filers meeting and Beth came up to  
 22 me personally and apologized and said I gave the  
 23 wrong information. Your contract was filed. You  
 24 know, it's still sitting in suspense. And so there  
 25 was very high level of engagement of both

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1 organizations of can you give us a decision on our  
 2 contracts? They're in suspense. You know, reject  
 3 them if you're going to so we can figure out where  
 4 we're going or approve them so we can get moving.  
 5 We didn't get a decision on the  
 6 provider contracts until March, and that was  
 7 escalated to Jonathan Hensley, who was the plan  
 8 president at the time. And with Commissioner  
 9 Kreidler saying we need to, you know, holy cow  
 10 they're due and you still haven't given us, you  
 11 know -- and so our direction from the OIC at that  
 12 time, both from Beth Berendt, and, again, I wasn't  
 13 in the meeting, but from Commissioner Kreidler to  
 14 Jonathan Hensley was it's too late.  
 15 You can't use new contracts, new  
 16 networks, you must use an existing network. And so  
 17 we quickly came to plan B, which was to use the Real  
 18 Value network for BridgeSpan and only file in those  
 19 counties where we had approved network for Real  
 20 Value which is why BridgeSpan is limited to the  
 21 counties they're in because we only ever filed the  
 22 Real Value network in those counties.  
 23 And we had only contracted with  
 24 providers for the Real Value network in those  
 25 counties. And so we were limited to the ability to

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1 only issue the BridgeSpan program in those counties  
 2 where we had Real Value contracts. I need to take a  
 3 breath.  
 4 Q I think I was following that.  
 5 A I hope so because I'm not sure I could say  
 6 it all again.  
 7 Q So you made the decision to use the Real  
 8 Value network?  
 9 A Yes.  
 10 Q And that limited the BridgeSpan offering  
 11 to the counties where you had Real Value providers?  
 12 A Correct.  
 13 Q Did you have any -- once you made the  
 14 decision to use the Real Value network for the  
 15 BridgeSpan exchange products, did you have any  
 16 further discussions with the OIC about the adequacy  
 17 of the Real Value network for that purpose?  
 18 A I don't specifically recall any  
 19 conversations with the OIC at that point in time.  
 20 Q Do you recall any discussion with  
 21 Ms. Berendt about the issue of -- that had come up  
 22 previously, namely that you didn't have Children's  
 23 or Mary Bridge participating providers?  
 24 MR. PARKER: Time frame?  
 25 Q (By Mr. Madden) Again, where after you had

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1 made this decision to use Real Value to support the  
 2 BridgeSpan exchange product.  
 3 A No. I don't recollect any conversations  
 4 with Beth Berendt on that.  
 5 Q The Form A that you were filing for Real  
 6 Value, it's a monthly filing as you said --  
 7 A Correct.  
 8 Q So as of May 2013, did it list Children's  
 9 and Mary Bridge as participating providers?  
 10 A Yes, it would have because there would  
 11 have been no whole scale change from when we  
 12 submitted it in February or March or April or May.  
 13 It would have continuously been the same except for,  
 14 as I was talking about, those little bit of changes  
 15 that happen each month.  
 16 Q Certainly. Are you aware that there's a  
 17 filing required for exchange products called the --  
 18 the OIC calls "the binder"?  
 19 A I have heard of the binder, but I was not  
 20 involved in putting the binder together at Regence.  
 21 Q You anticipated my next couple of  
 22 questions and moved a couple of things off the  
 23 table.  
 24 A Good.  
 25 Q Did you learn at some point that the OIC



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1 believed when it approved the BridgeSpan exchange  
 2 filings that Seattle Children's and Mary Bridge were  
 3 in network?  
 4 A For BridgeSpan?  
 5 Q Yes.  
 6 A I didn't understand anything about that  
 7 until I saw Beth Berendt's deposition.  
 8 Q What, as best you can recall -- just, and  
 9 let's limit it to King County --  
 10 A Okay.  
 11 Q -- what hospitals as of July last year,  
 12 year ago 2013, what hospitals in King County were in  
 13 the Real Value network?  
 14 A Let me -- we filed the Real Value network  
 15 for BridgeSpan for the exchange in whatever the  
 16 filing deadline was. April or May, I don't  
 17 recollect. And during that time we were in  
 18 termination discussions with the Franciscans in  
 19 Pierce County.  
 20 And so I don't remember when we  
 21 changed and I understand your question is for King  
 22 County, and I'm speaking Pierce County, but I just  
 23 want to -- there were some changes to the network  
 24 that occurred over the summer for 1/1 of 2014 and I  
 25 just don't remember exactly when those happened. So

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1 Virginia Mason was in the Real Value network prior  
 2 to BridgeSpan accessing it for the exchange.  
 3 They were not in it for the exchange,  
 4 you know, come 1/1 of 2015 because there was a  
 5 little bit of transition in the networks. So I  
 6 think you're trying to understand which hospitals  
 7 were in when we filed. And I want to make sure I'm  
 8 answering your question because there was some  
 9 changes at some point over the summer, and I want to  
 10 make sure I'm accurately answering your question.  
 11 I'm not muddying the waters.  
 12 Q I appreciate that. Actually what -- and  
 13 you may not be able to answer it the way I'm going  
 14 to frame the question, but the approval date I  
 15 believe is July 31st of '13 or thereabouts, so as of  
 16 that date?  
 17 A As of that date, again, to the best of my  
 18 recollection, in King County it would have been  
 19 Evergreen Hospital, Overlake Hospital, I think  
 20 Valley Medical Center. I don't think Auburn was in,  
 21 but I could be mistaken. Virginia Mason was in.  
 22 Highline was in. Northwest Hospital, I believe, was  
 23 in.  
 24 I know that UW Medicine -- UW MC was  
 25 not. I know that Swedish downtown was not and I

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1 know that Children's was not. It's probably easier  
 2 for me to say it that way. And then most of the  
 3 others I believe were in, but I might be mistaken on  
 4 one or two.  
 5 Q And you got there by working up from  
 6 Pierce County. You were starting to tell me that  
 7 Franciscans was in transition.  
 8 A Right. So during the time that it was the  
 9 Real Value product, prior to the exchange,  
 10 Franciscans was in and Multicare was out. When --  
 11 in the Real Value network starting with the exchange  
 12 for BridgeSpan for 1/1 of 2014, Franciscans was out  
 13 and Multicare, including Mary Bridge Children's  
 14 Hospital was in.  
 15 And there was also a change in King  
 16 County that Virginia Mason was out and the  
 17 University of Washington Medical Center was in.  
 18 There might have been a couple other changes, but  
 19 those are the ones that I recall.  
 20 Q For '14?  
 21 A For '14.  
 22 Q So UW contracts, to your understanding,  
 23 are facility specific rather than system wide?  
 24 A Yes.  
 25 Q So Harborview is out?

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1 A You know what, I think Harborview was in,  
 2 but someone would have to correct me on that. I  
 3 believe Harborview had been in all the time.  
 4 Q Let me hand you a copy of what's already  
 5 been marked as Exhibit 96. While we're at it --  
 6 A Give me more paper?  
 7 Q These two go together.  
 8 A Okay.  
 9 Q This is Exhibit 97.  
 10 A So I'm looking at 96 and 97?  
 11 Q Right.  
 12 A Okay. I remember these.  
 13 Q I'm going back to -- do you have  
 14 recollection of a conversation with Molly Nollette  
 15 of the OIC on the topic here of the inclusion of  
 16 Seattle Children's on the Form A filing for Real  
 17 Value?  
 18 A Yes, I do.  
 19 Q Tell me what you can recall of the  
 20 conversation with Ms. Nollette?  
 21 A You know, again, don't recall the exact  
 22 time line, but I do recall Molly reaching out to me  
 23 to say I understand -- something to the effect, this  
 24 isn't verbatim conversation. You know, something to  
 25 the effect of, you know, do you know that Seattle

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1 Children's -- and I guess that would be more the  
 2 issue because Mary Bridge was now in network -- is  
 3 on your Form A filing for the Real Value network and  
 4 I said well, yes, I do. And she says why is that?  
 5 I said because Beth Berendt told us  
 6 to. And so she wanted to have some conversation,  
 7 and I believe I forwarded her some emails that  
 8 showed her that conversation. And subsequent to  
 9 that she asked that we remove Seattle Children's  
 10 from our Form A filing, of which we complied with  
 11 that request.  
 12 Q Did Ms. Nollette indicate to you one way  
 13 or another whether she thought that -- that Seattle  
 14 Children's was in network for purposes of the  
 15 BridgeSpan exchange products?  
 16 A I have never recalled a conversation with  
 17 anyone at the OIC, Molly included, that ever  
 18 understood Children's to be in our BridgeSpan  
 19 network. It was very commonly understood at the OIC  
 20 that Seattle Children's was not in the Real Value  
 21 network.  
 22 Q Have you been involved in discussions with  
 23 Seattle Children's about joining the Real Value  
 24 network?  
 25 A Yes, I was.

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1 Q And what was your -- what was your role in  
 2 those discussions?  
 3 A My role would have been to direct the  
 4 team, to come up with a proposal to submit to  
 5 Seattle Children's for inclusion in the Real Value  
 6 network.  
 7 Q And I understand from testimony yesterday  
 8 that those -- or a proposal was made?  
 9 A Yes.  
 10 Q And that was at your direction?  
 11 A Correct.  
 12 Q Do you recall -- well, let me back up.  
 13 The rate proposal that was made for Real Value, that  
 14 was less than the -- would have paid Seattle  
 15 Children's less than the amount under the preferred  
 16 contract?  
 17 A That's correct.  
 18 MR. PARKER: Let me interject a second.  
 19 Beth, I just want you to be aware through these  
 20 proceedings, Regence and Premera and the  
 21 commissioner's office and Children's Hospital  
 22 have been very cautious not to put trade secret  
 23 information in the record.  
 24 And I think it would be sensitive, and  
 25 although you got it all in your head because

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1 you used to work for Regence, we still don't  
 2 want it in the public record so I don't believe  
 3 Mr. Madden's questions are going to delve into  
 4 that.  
 5 A That's fine because I won't remember the  
 6 numbers anyway. So yeah, I wish my mind was that  
 7 sharp, but thank you for that.  
 8 Q (By Mr. Madden) Sure. And Mr. Parker is  
 9 correct in his statement. But what I was interested  
 10 to know is how the Real Value network proposal or  
 11 proposals to Children's were developed. In other  
 12 words, how did Regence, because I guess Regence is  
 13 doing the negotiation --  
 14 A Sure.  
 15 Q -- how did Regence come up with the  
 16 reimbursement proposal that it made?  
 17 A Sure. In developing the Real Value  
 18 network, even prior to the exchange, the overriding  
 19 strategic direction for developing that network and  
 20 product was to provide a premium price point in the  
 21 market that was lower than existing premium price  
 22 points for individual insurance to provide  
 23 individuals with an opportunity who might not be  
 24 able to afford insurance.  
 25 That same strategy was carried

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1 through in the exchange, that there was now going to  
 2 be a marketplace of individuals purchasing insurance  
 3 on their own more than maybe had been in the past.  
 4 And that price was going to be a sensitive issue in  
 5 their selection of a network and a product.  
 6 And so there was deliberate strategy  
 7 to get to a premium that was affordable. And so in  
 8 developing the Real Value network initially and in  
 9 the continuation of the Real Value network was to  
 10 contract with providers particularly hospitals for a  
 11 lower reimbursement than was afforded to them in the  
 12 preferred -- in the preferred contract.  
 13 There are some hospitals who are more  
 14 affordable than others and maybe didn't have a  
 15 differential in their reimbursement. Most hospitals  
 16 agreed to a differential in their reimbursement to  
 17 participate in the Real Value network as a way to  
 18 work with us to have cost efficient premium in the  
 19 marketplace.  
 20 We filed the premium in, again  
 21 whatever time line that was, April, May of 2013 or  
 22 2014, with -- you're going to tax my actuarial  
 23 ability here, you know, at a rate that our contracts  
 24 supported. And as you might know when products are  
 25 filed -- and this is on the fringe of my



# **EXHIBIT 2**



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1 directly or through its affiliate, BridgeSpan,  
 2 planned to utilize the Real Value network to support  
 3 its exchange product?  
 4 A That was my understanding. Yes.  
 5 Q And the Real Value network -- strike that.  
 6 Before the exchange products were offered, the Real  
 7 Value network was in place and operating; was it  
 8 not?  
 9 A Correct.  
 10 Q Seattle Children's is not a part of that  
 11 network?  
 12 A Correct.  
 13 Q And what product line or lines did the  
 14 Real Value network serve?  
 15 A The real value Product.  
 16 Q And how would you describe that product if  
 17 you can? What was the scope of coverage under the  
 18 real value product?  
 19 A My understanding was it was for limited  
 20 income folks. It was a low-touch product limited  
 21 network and limited defined services. That is the  
 22 general understanding I have of that.  
 23 Q You used the term, if I heard it  
 24 correctly, "low-touch product"?  
 25 A My jargon.

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1 Q What does that mean?  
 2 A In attempt to get services provided to a  
 3 broader population, the benefit level may have  
 4 differed from the traditional people or product from  
 5 traditional commercial plan. That's what I was  
 6 trying to get at.  
 7 Q The real value product went away, did it  
 8 not, in the end of 2013?  
 9 A Don't know when it went away, but, yes,  
 10 you're correct it went away.  
 11 Q And it went away because it didn't meet  
 12 the minimum requirements under the ACA?  
 13 A That may be the case.  
 14 Q Let's take a quick look at if you --  
 15 strike that. I want to ask one more question. The  
 16 famous one more question about Exhibit 117. The  
 17 addendum -- the Real Value addendum that's  
 18 referenced in the email, I assume did that -- not  
 19 assume, did that contain a reimbursement proposal,  
 20 had reimbursement terms in it?  
 21 A Yes.  
 22 Q Prior to September 2013, had Regence made  
 23 a specific reimbursement proposal to Seattle  
 24 Children's for the Real Value network?  
 25 A Again, I'm not trying to split hairs, but

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1 by "specific" what are you driving at?  
 2 Q That would -- you know, and I'm trying not  
 3 to reveal confidential information, but that would  
 4 allow someone to say that a hospital or you to  
 5 calculate what the hospital would be paid for a  
 6 given service?  
 7 A Trying to recall over the course of 2013  
 8 when we might have discussed a number without  
 9 revealing the number. I have an understanding that  
 10 there was some rate discussion. Yes.  
 11 Q The discussion with Seattle Children's  
 12 about joining the Real Value network, Regence's side  
 13 of that discussion was you can join at a discount  
 14 from the preferred provider rates?  
 15 A That's a correct statement.  
 16 MR. PARKER: Let's go off the record for a  
 17 second.  
 18 (Discussion off the record.)  
 19 Q (By Mr. Madden) The question I want to --  
 20 where I want to go and I'm sorry because I'm  
 21 fumbling. I'm just trying see how much I can try to  
 22 shorten this up a little bit.  
 23 Are you knowledgeable about the  
 24 frequency with which Seattle Children's has served  
 25 BridgeSpan exchange enrollees?

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1 A Some knowledge of it.  
 2 Q On how many occasions, and if you can give  
 3 me a rough approximation will be just fine, on how  
 4 many occasions have BridgeSpan enrollees have  
 5 required services at Seattle Children's?  
 6 A Over what period of time?  
 7 Q Well, the -- the coverage went into effect  
 8 2014, so we have to present; correct?  
 9 A Okay. I'm aware of fewer than half a  
 10 dozen, fewer than a handful.  
 11 Q And how many single case agreements have  
 12 there been?  
 13 A Again, I have limited knowledge of that.  
 14 I can speak to three that I am aware of.  
 15 Q That have been approved?  
 16 A Approved by whom?  
 17 Q By Regence on behalf of BridgeSpan.  
 18 A Yes, and accepted by Children's. In other  
 19 words, if your question is were these single case  
 20 agreements that the parties had agreed to, the  
 21 answer is yes.  
 22 Q Are you knowledgeable about the process  
 23 that Regence utilizes to decide whether to offer a  
 24 single case agreement for a BridgeSpan exchange  
 25 enrollee?



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1 A I have read the policies that cover that  
 2 process. Yes.  
 3 Q So perhaps we could work what might be a  
 4 simple hypothetical. A pediatrician who is a member  
 5 of your Real Value network refers a patient to  
 6 Seattle Children's for specialty care or  
 7 hospitalization, what's the process that Regence  
 8 follows to determine whether it will pay for the  
 9 care?  
 10 A Hypothetically?  
 11 Q Yes.  
 12 A There are a number of steps. The first  
 13 step would be a utilization review, basically a UM  
 14 review whether or not these benefits are authorized.  
 15 The second step would be trying to find, if  
 16 possible, an alternative to a non-contracted  
 17 provider.  
 18 If none can, in fact, be provided,  
 19 then the third step would be a discussion between  
 20 Seattle Children's and a case manager to determine  
 21 the expansive services and maybe even payment terms.  
 22 The fourth step, assuming that there  
 23 is an agreement, then a template single case  
 24 agreement is forwarded by Regence, normally by the  
 25 case manager, directly to Children's. That is then

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1 executed and we have an agreement.  
 2 Q I asked how many single case agreements  
 3 there have been and you gave me your estimate.  
 4 A Yes.  
 5 Q Flip side, have there been instances where  
 6 there's been a referral to Seattle Children's or a  
 7 request from Seattle Children's for a single case  
 8 agreement that Regence has disapproved?  
 9 A Yes.  
 10 Q How many of those?  
 11 A I can't give you a number. I'm aware of  
 12 maybe one or two.  
 13 Q And in those one or two instances, taking  
 14 the steps along the way, can you tell me why the  
 15 request was disapproved?  
 16 A Because an alternative in network provider  
 17 was found for those services that the member needed.  
 18 Q And do you know in those instances whether  
 19 the member went to the alternative provider and  
 20 received the service?  
 21 A I don't know. I can't speak to that  
 22 specifically.  
 23 Q In attempting to identify an alternative  
 24 provider, does Premera have a -- any geographic  
 25 limit that beyond which it considers it would be

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1 unreasonable to send the member?  
 2 A I think you meant to say and ask me about  
 3 Regence, not Premera.  
 4 Q I apologize.  
 5 A Don't worry about it. That's okay.  
 6 Q I think we -- off the record.  
 7 (Discussion off the record.)  
 8 Q (By Mr. Madden) Does Regence have a  
 9 geographical limit beyond which it considers it  
 10 unreasonable to refer the member to an in network  
 11 provider?  
 12 A I think we would undoubtedly follow  
 13 whatever is required in the WAC, whatever network  
 14 adequacy rules there may be for geographical  
 15 referral distances.  
 16 Q So for instance, and I'm sitting here not  
 17 going to be able to come up with a good example of a  
 18 service, but if there's a request to -- for service  
 19 at Seattle Children's that could be provided at Mary  
 20 Bridge, and the member resides in north King County,  
 21 would Regence consider it reasonable to send the  
 22 member down to Tacoma to Mary Bridge?  
 23 A I can't really speak to that. That might  
 24 be a question better for a case manager.  
 25 Q Is the utilization review separate from

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1 the process of determining whether it would be  
 2 appropriate to have the service delivered at Seattle  
 3 Children's?  
 4 A I think the utilization review is part of  
 5 that process.  
 6 Q So it's a single unitary process; the  
 7 provider submits the request, utilization review  
 8 looks at coverage and medical necessity; correct?  
 9 A Correct.  
 10 Q And then from that then the next steps  
 11 you've described, is there an available in network  
 12 provider? Can we get an agreement with the  
 13 hospital? That's a single process from the provider  
 14 side of things?  
 15 A It's a single process from the Regence  
 16 side of things. I'm not sure about provider side.  
 17 Q So let me refine the question. Under the  
 18 process that Regence utilizes to determine whether  
 19 it will enter into a single case agreement or offer  
 20 a single case agreement to a BridgeSpan enrollee  
 21 who's requesting services at Seattle Children's,  
 22 does the hospital have to call someone to get a  
 23 review of the utilization and then call someone else  
 24 or correspond with someone else to determine whether  
 25 a single case agreement would be offered?

