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Hearings Unit, OIC
Patricia D. Petersen
Chief Hearing Officer

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

INTERVENORS' JOINT MOTION FOR
SUMMARY JUDGMENT

I. INTRODUCTION¹

Seattle Children's Hospital's ("SCH") Demand for Hearing ("Demand") should be dismissed in its entirety on two independent bases. First, SCH lacks standing. SCH has not and cannot demonstrate that it suffered any harm or that any purported harm it alleges is anything other than speculative. Nor is SCH's interest within the zone of interests protected by the Patient Protection and Affordable Care Act, 42 U.S.C. 18001, *et seq.* ("ACA") or applicable state insurance laws. To the contrary, the purpose of these laws is to protect consumers, not healthcare providers. The Intervenor's motion should be granted for this reason alone.

Second, SCH's Demand rests entirely on an incorrect premise — that a carrier's network is *ipso facto* deficient if it does not include SCH. *No law supports this position.* Contrary to SCH's assertion, the ACA does not require carriers to contract with all essential

¹ The Intervenor's are filing a joint brief for administrative convenience for the Court. No Intervenor has direct knowledge of business practices other than their own. Therefore, the factual statements in this brief relating to the business of any Intervenor are made solely by that party; no Intervenor makes any representations as to the factual statements relating to any other Intervenor.

community providers. Indeed, the Secretary may certify a plan that contains a mere ten percent of the essential community providers in the area, and generally must certify a plan that includes twenty percent of the area's essential community providers. Moreover, the ACA expressly provides that a carrier is not required to contract with any specific provider if that provider refuses to accept the generally applicable payment rates of such plan,² as is the case here. Here, the Office of Insurance Commissioner ("OIC" or "Commissioner") correctly found that the Intervenor's plans met all of the network adequacy requirements. If SCH's faulty premise were accepted (which OIC and federal regulators have rejected), all HBE carriers would have to pay SCH whatever charges it wants to impose regardless of the fact that consumers can obtain those very services without SCH's inclusion in their carriers' networks. The result would be increased cost of coverage through the HBE – a result that destroys the balance between the two fundamental goals of the ACA.

Therefore, because there is no legal basis to support SCH's Demand, the Chief Presiding Officer should grant the Intervenor's motion for summary judgment and deny SCH's Demand for Hearing in its entirety.

II. FACTUAL AND PROCEDURAL BACKGROUND

A. The OIC Approved the Intervenor's Plans for the Washington Health Benefit Exchange.

Pursuant to the ACA, and the Washington state statutory scheme enacted pursuant to the ACA, the Washington Health Benefit Exchange ("HBE" or "Exchange") relies exclusively on private health carriers (also known as issuers) such as the Intervenor to provide healthcare insurance to Washington citizens. This same scheme requires the OIC to evaluate and approve health carriers to participate in the HBE.

Under the ACA, Washington has established its own marketplace for residents to apply for and purchase HBE health insurance contracts. *See* 42 U.S.C. § 18031. The OIC is

² *See* 42 U.S.C. § 18031(c)(2).

charged by the ACA and state law to establish Washington's marketplace, the HBE; to determine which health plans are qualified to participate in the HBE; and to ascertain that the content of all health plans offered through the HBE meet strict benefit and quality standards.

See RCW 43.71.005, *et seq.* Among other things, the Exchange is intended to:

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

RCW 43.71.005(a), (c), (d), (g), (h), (i), (j) (emphasis added). "The [HBE] board shall certify a plan as a qualified health plan to be offered through the Exchange if the plan is determined by the commissioner to meet the requirements of Title 48 RCW and rules adopted by the . . . Insurance commissioner pursuant to chapter 34.05 RCW to implement the requirements of Title 48 RCW," and then determined by the HBE "to meet the requirements of the [ACA] for certification as a qualified health plan." RCW 43.71.065(1)(a)-(b).

Once the Commissioner finds that a health plan meets federal minimum coverage requirements and satisfies state insuring requirements, the OIC approves it for certification to the HBE board. The HBE board, in turn, analyzes and then certifies the plan as a qualified

health plan to the federal Department of Health and Human Services (“HHS”). Among the many requirements established by applicable state and federal statutes, the OIC must determine that the plan satisfies the requirements of RCW Title 48.

In 2012, Commissioner Kreidler began the review process for participation in the HBE. The Intervenors, along with other health plans, submitted proposed rates, proposed contract forms, actuarial information, and other information required by the ACA and the OIC. *See* Declaration of Jay Fathi, ¶ 2. Among other things, the OIC required health plans to submit their proposed provider networks for the Commissioner’s review in order to ensure the network contained sufficient providers in each required category of care.

On or about July 31, 2013, the OIC approved both BridgeSpan and Premera for participation in the HBE. The OIC initially declined to approve Coordinated Care’s plan because of, among other reasons, an alleged absence of pediatric specialty providers within Coordinated Care’s proposed network. The OIC noted Coordinated Care’s failure to contract with SCH. *See* Fathi Decl., ¶ 4. The matter went to hearing, and the Findings of Fact, Conclusions of Law, and Final Order entered in the matter on September 3, 2013 concluded that “carriers are not required to include Level 1 Burn Units or pediatric hospitals in their networks.” *Id.* at Ex. A (Final Order), 17 (Conclusion of Law, No. 12 b).³

Ultimately, the OIC approved plans issued by eight health carriers, including the Intervenors, and, during September of 2013, the HBE board certified them to HHS as “Qualified Health Plans.” On October 1, 2013, the HBE launched open enrollment, allowing Washington citizens to apply for and purchase individual health contracts, including the Intervenors’ plans, through the HBE consumer market place website — wahealthplanfinder.org. Coverage began on January 1, 2014. Open enrollment through the

³ Although SCH attempted to intervene in the earlier Coordinated Care proceeding, it waited until the Findings of Fact, Conclusions of Law and Final Order had been entered before making its motion, and the motion was denied. Declaration of Melissa Cunningham, Ex. A (Letter Denying Motion to Intervene).

HBE ends on March 31, 2014. Currently there are approximately 56,625 Washington citizens enrolled with the Intervenors to receive coverage under the HBE. *See* Declaration of Beth Johnson, ¶ 10; Fathi Decl., ¶ 14; Declaration of Kristin Meadows, ¶ 2.

B. Facts Related to Coordinated Care and its Network.

Coordinated Care currently offers three separate plans on the HBE in 14 different counties in Washington State. Fathi Decl., ¶ 6. After a careful review of its network, the OIC approved these plans on September 5, 2013. *Id.* at ¶ 5. The HBE board certified Coordinated Care's plans on September 6, 2013. *Id.* Over 7000 people are enrolled in Coordinated Care's plans to date. *Id.* at ¶ 14.

As noted in its Petition for Intervention, Coordinated Care expended significant time and resources to create HBE network plans that deliver high-quality and affordable healthcare for vulnerable, low-income individuals and families, especially those who move on and off of Medicaid. Coordinated Care currently has a high-quality and robust provider network, which includes over 8,000 providers and 28 hospitals. Its network includes appropriate specialists, hospital services, and ancillary services in every county for which it offers an exchange plan. Enrollees are able to obtain all covered services without unreasonable delay. *Id.* at ¶ 3.

The Coordinated Care network includes many pediatric providers around the state, including pediatric specialists and four hospitals with distinct pediatric specialty care and services. Specifically, Coordinated Care's network includes the Providence Health Services/Swedish system, which provides extensive, in-depth, specialty pediatric care and comprehensive pediatric services at multiple sites statewide, including King County. The network also includes Providence Sacred Heart Children's Hospital in Spokane, which provides specialty and comprehensive pediatric services including cancer and cardiac care, and Shriners Hospital for Children in Spokane, which provides additional specialty pediatric services. *Id.* at ¶ 7. Notably, SCH seeks to revoke the OIC's approval of all of Coordinated Care's HBE plans, not just those in King County where SCH is located.

The hospitals included in Coordinated Care's network are able to provide the majority of the covered pediatric services provided by SCH, and at lower rates. Below are examples of the types of pediatric services that each of Coordinated Care's participating hospitals provide:

Providence Sacred Heart Children's Hospital in Spokane	Pediatrics at Swedish Medical Center in Seattle	Providence Regional Medical Center in Everett	Shriners Hospital for Children in Spokane
Oncology & Hematology	Gastroenterology	Neonatal Intensive Care (Level III)	Orthopedics
Neonatal Intensive Care	Neonatal Intensive Care (Level III)	Pediatric Intensive Care Unit	Cleft Lip and Palate
Pediatric Intensive Care	Pediatric Intensive Care Unit (PICU)	Infant Special Care Unit (ISCU)	Psychology and Psychiatry
Pediatric Level II Trauma	Level II Infant Special Care Unit (ISCU)	Children's Center (for neurodevelopment)	Post-trauma Reconstruction
Neurology	Orthopedics	Providence Regional Cancer Partnership	Nutrition
Cardiac Care	Sport Medicine		Burn Care
Neurosurgery	General Surgery		Spinal Cord Injury
Surgery	Neurology		3D Imaging
Transplant Services	Endocrinology		Research
Adolescent Medicine	Nephrology		Physical and Occupational therapy
Developmental Medicine	Urology		Limb lengthening surgery
Endocrinology	Ear, Nose and Throat		Orthotics and prosthetics
Genetics	Epilepsy		Pain management
Nephrology	Infectious Disease		Speech therapy
Palliative Care	Emergency Room		Care coordination
Psychiatry	Therapy Services		Child life & recreation therapy
Pulmonary	Growth and Integrated Nutrition (GAINS)		Fitness training
Research	Nutrition		
Urology	Hospitalists		
Emergency	Thyroid Program		
Gastroenterology	Procedural Sedation		
	Child Life Specialists		

Id. at ¶ 8. In September and again in November 2013, the Chief Presiding Officer examined the adequacy of Coordinated Care’s provider network and determined that Coordinated Care had shown that its network was adequate, despite the noted absence of SCH from its network. *Id.* at Ex. A (Final Order), pp. 17-18 (¶ b).

Coordinated Care was unable to contract with SCH for its HBE plans because SCH would only accept full commercial rates — the highest payment rates available. On a cost per day basis, SCH charges at least two times the rates found at other facilities for similar services. Paying those rates would unnecessarily drive up the overall cost of the product to members. As a result of the federal subsidies and Coordinated Care’s low prices, many of the consumers who purchase insurance through Coordinated Care (*i.e.*, many who churn on and off of Medicaid) can obtain services without charge. *See id.* at ¶ 9.

The absence of SCH from Coordinated Care’s HBE network does not mean that Coordinated Care will not utilize SCH’s services when necessary to provide covered benefits to its enrollees. As with any network, there may be rare or unique types of care that are not provided by the providers in Coordinated Care’s network. In those cases, the service is covered through a single case agreement. These agreements are not necessarily negotiated in advance. Indeed, in some cases, Coordinated Care is simply billed for the service. Coordinated Care can later negotiate the costs with the provider or pay the invoiced amount. Single case agreements are standard practice in the industry and are a seamless process to provide necessary care through out-of-network providers. A common example is when a consumer is traveling out of his own service area and needs emergency services from an out-of-network provider. *See id.* at ¶ 10. The Chief Presiding Officer expressly held that single case agreements are lawful. *Id.*, Ex. A (Final Order), 18 (¶ c).

Single case agreements do not result in any consumer risk, whether in terms of access to care or additional charges. For example, if a member needs pediatric services only available through an out-of-network provider, that member will receive the covered benefits

from the provider at the same benefit level as if the benefit were obtained from an in-network provider. The members have the same coverage, deductibles, co-pays, co-insurance, and out of pocket maximums as they would if they obtained the service from a network provider. Although carrier approval for such unique care is generally required, no prior approval is required for emergency situations. And the consumer is not required to wait for Coordinated Care to negotiate a contract with the out-of-network provider prior to receiving medical services. The member simply receives the needed care. Coordinated Care will pay for all approved, out-of-network, covered services performed by SCH for its members. *Id.* at ¶ 11.

C. Facts Related to BridgeSpan and its Network.

BridgeSpan offers three separate plans on the Exchange in seven different counties in Washington State. As of January 15, 2013, 1,533 Washington residents have enrolled with BridgeSpan, receiving coverage effective January or February of 2014. *See* Johnson Decl., ¶¶ 10, 11. The BridgeSpan network approved by the OIC includes over 21 hospitals and 10,436 providers, including multiple pediatric specialty providers and a designated pediatric hospital. *Id.* at ¶ 12. In addition to the MultiCare Mary Bridge Children’s Hospital in Tacoma, BridgeSpan is contracted with several other hospitals with specialized in-patient pediatric departments or Level III Neonatal Intensive Care Units. These facilities offer multiple choices for pediatric specialty care throughout Western Washington. *Id.* at ¶ 14, Ex. B. In fact, one BridgeSpan contracted provider in King County, Evergreen Hospital, advertises a pediatric department staffed by many of the same individual providers on staff at the SCH. *Id.* at ¶ 15.

The location of these contracted providers throughout Western Washington allows BridgeSpan to comply with the network adequacy standard limiting the amount of travel required to obtain benefits. Carriers are required to “establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residences of covered persons” and to “make reasonable efforts to

include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits.” WAC 284-43-200 (4). In determining whether a health carrier has complied with this provision, the Commissioner must “give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers.” *Id.* “Relative availability includes the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions.” *Id.*

SCH erroneously argues that the BridgeSpan network is inadequate without a King County hospital solely dedicated to pediatric care. But pediatric specialty care is available at the University of Washington Medical Center and Harborview Medical Center in Seattle, Evergreen Hospital in Kirkland, and Valley Medical Center in Renton, allowing many members to receive pediatric specialty care closer to home than if BridgeSpan was contracted with SCH alone. Johnson Decl., ¶ 14, Ex. B. Moreover, the majority of SCH’s patients travel from outside of King County, which suggests that “relative availability” for a pediatric specialty hospital is no less convenient for many and more convenient for some. *See* Defendant’s Responses to OIC’s First Interrogatories, No. 9. Moreover, to the extent that BridgeSpan’s HBE plan members require unique services available only at SCH, like Coordinated Care, BridgeSpan will cover those services. Johnson Decl., ¶ 9.

Finally, SCH’s absence from the BridgeSpan provider network was addressed prior to OIC approval of the network. BridgeSpan leases the “Real Value” provider network from its parent company, Regence BlueShield. Consequently, the Regence Real Value provider network and the BridgeSpan provider network are identical, a fact that the OIC was aware of at the time the BridgeSpan network was initially filed. *Id.* at ¶ 7. Pediatric specialty care was discussed extensively by Regence BlueShield in developing the Real Value network. The OIC was advised that SCH was not a contracted provider. *Id.* at ¶ 5. The OIC acknowledged

access to SCH would occur only through single case agreements and instructed identification of SCH in the Real Value Form A on that basis. *Id.* at ¶ 6, Ex. A.

D. Facts Related to Premera and its Network.

As of January 10, 2014, 48,092 Washington citizens have purchased and are receiving coverage under HBE plans from Premera and its subsidiary. Meadows Decl., ¶ 2. Premera and its subsidiary are the only health carriers offering a HBE in seven Washington counties: Clallam, Jefferson, Skamania, Klickitat, Lincoln, Garfield, and Asotin. *Id.*

Premera's HBE members have access to a vast, high-quality network for pediatric services. Premera's HBE network, which includes over 87 hospitals and 28,276 providers, has a substantial statewide network of pediatric providers so HBE members have full access to pediatric services. Declaration of Rich Maturi, ¶ 2. Premera's network includes Virginia Mason Hospital in Seattle, Evergreen Hospital in Kirkland, and Valley Medical Center in Renton, among other providers who provide extensive, in-depth, specialty pediatric care and comprehensive pediatric services. *Id.* Premera recognizes that in limited circumstances SCH provides pediatric services that may not be available from other providers. In those circumstances, Premera's members will have in-network access to SCH for services not available at other hospitals, or "unique services," via Premera's existing contract with SCH at the existing contract rate. *Id.*

III. AUTHORITY AND ARGUMENT

A. Standard of Review.

Under WAC 10-08-135, summary judgment is appropriate in administrative hearings where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Questions of fact are determined as a matter of law on summary judgment where reasonable minds could reach only one conclusion. *Smith v. Safeco*, 150 Wn.2d 478, 485, 78 P.3d 1274 (2003).

B. SCH Lacks Standing.

As a threshold matter, SCH's Demand must be dismissed as a matter of law because SCH lacks standing to demand a hearing. "The commissioner shall hold a hearing . . . upon written demand for a hearing made by any person *aggrieved by any act, threatened act, or failure of the commissioner to act*, if such failure is deemed an act under any provision of this code[.]" RCW 48.04.010 (emphasis added). The issue, therefore, is whether SCH was "aggrieved" by OIC's determination that the Intervenors' networks are adequate.

In analyzing this threshold issue, cases addressing standing to obtain judicial review under the Administrative Procedures Act ("APA") are informative, because they too turn on whether the person has been "aggrieved" by the agency action at issue. Under the APA:

A person has standing to obtain judicial review of an agency action if that person is aggrieved or adversely affected by the agency action. A person is aggrieved or adversely affected within the meaning of this section only when all three of the following conditions are present:

- (1) The agency action has prejudiced or is likely to prejudice that person;
- (2) That person's asserted interests are among those that the agency was required to consider when it engaged in the agency action challenged; and
- (3) A judgment in favor of that person would substantially eliminate or redress the prejudice to that person caused or likely to be caused by the agency action.

RCW 34.05.530 (emphasis added). "The first and third conditions are often called the 'injury-in-fact' requirement, and the second condition is known as the 'zone of interest' test." *Wash. Indep. Tel. Ass'n v. WUTC*, 110 Wn. App. 498, 511-12, 41 P.3d 1212 (2002). "[A] person is aggrieved or adversely affected within the meaning of the APA standing test only when the zone of interest *and* injury-in-fact prongs are satisfied." *Allan v. Univ. of Wash.*, 140 Wn.2d 323, 332, 997 P.2d 360 (2000) (emphasis in original, internal citation omitted).

SCH has the burden of satisfying both prongs. *See KS Tacoma Holdings, LLC v. Shorelines Hr. Bd.*, 166 Wn. App. 117, 127, 272 P.3d 876 (2012). For the reasons explained below, it cannot satisfy either.

1. SCH Does Not Demonstrate Injury-in-Fact.

To establish an injury-in-fact, “the person must demonstrate that he or she is (or will be) specifically and perceptibly harmed by the agency action and, moreover, that this injury will be redressed by a favorable decision by the reviewing court.” *Patterson v. Segale*, 171 Wn. App. 251, 254, 289 P.3d 657 (2012). SCH cannot demonstrate such an injury-in-fact: that it has been harmed by the OIC’s decisions or that a judgment in its favor would substantially eliminate or redress any claimed prejudice to SCH.

To begin with, SCH impermissibly seeks standing based on alleged harm suffered by HBE enrollees and SCH’s patients. *See Demand*, 1-2. Specifically, SCH alleges:

Many *patients* enrolled in these exchange plans who require services available only at SCH are likely to present for services at SCH, regardless of its network status, more acutely ill and require more services [sic], and more complex services when they present for care. These *patients* will consume more resources, thereby . . . impairing the ability of SCH to serve the pediatric healthcare needs of the region.

Demand, 1-2 (emphases added). But standing could be conferred only on the basis of harm incurred by *SCH*, not by third parties. *Allan*, 140 Wn.2d at 332-33 (plaintiff lacked standing where “[s]he has not shown a concrete interest of her own,” instead relying on the interests of her husband); *West v. Thurston Cnty.*, 144 Wn. App. 573, 578, 183 P.3d 346 (2008) (“The doctrine of standing prohibits a litigant from asserting another’s legal right.”). Thus, any alleged harm suffered by enrollees and patients, even if it existed, is irrelevant for purposes of determining whether SCH has been “aggrieved.”

The *only* claimed harm to itself that SCH articulates is that “SCH will . . . not be fairly compensated for [] services because of its exclusion from these exchange plan networks.”

Demand, 1-2. That is a purely speculative assertion. It is well-established that this kind of

speculative assertion cannot confer standing. *See Patterson*, 171 Wn. App. at 254 (finding no standing “[w]here a person alleges an injury that is merely conjectural or hypothetical”); *see also KS Tacoma Holdings*, 166 Wn. App. at 129 (“When a person or corporation alleges a threatened injury, as opposed to an existing injury, the person or corporation must show an immediate, concrete, and specific injury to themselves.”); *Allan*, 140 Wn.2d at 332 (holding that plaintiff lacked standing where she could not demonstrate a threat “that is ‘sufficiently real;’ in other words, a threat that is ‘neither imaginary nor speculative.’”) (quoting *Yesler Terrace Comm. Council v. Cisneros*, 37 F.3d 442, 446 (9th Cir. 1994)).

More importantly, SCH’s allegation that the Intervenor will not fairly compensate SCH for its services provided to the Intervenor’s HBE members is simply not true. As to Premera, pursuant to Premera’s existing contract with SCH, Premera will pay claims for services that can only be rendered at SCH as in network at the agreed rate under the parties’ existing contract. Maturi Decl., ¶ 3. With respect to Coordinated Care, the OIC approved Coordinated Care’s network, in part, because Coordinated Care can and will pay SCH for services not otherwise available in its network through single use agreements. Fathi Decl., ¶¶ 10, 11. Finally, BridgeSpan intends to utilize single use agreements or other arrangements to pay for approved services performed by SCH as well. Johnson Decl., ¶ 9.

2. SCH Is Not in the Zone of Interest.

Regardless of whether SCH could demonstrate that it has been harmed as a result of the Commissioner’s decision, the “zone of interest” test requires SCH to show that its “asserted interests are among those that the agency was required to consider when it engaged in the agency action challenged.” RCW 34.05.530(2). “The zone of interest test addresses the concern that mere injury-in-fact is not necessarily enough to confer standing because so many persons are potentially ‘aggrieved’ by agency action.” *St. Joseph Hosp. & Health Care Ctr. v. Dep’t of Health*, 125 Wn.2d 733, 739, 887 P.2d 891 (1995). “The test focuses on whether the Legislature intended the agency to protect the party’s interest when taking the

action at issue,” and “limit[s] review to those for whom it is most appropriate.” *Wash. Indep. Tel. Ass’n*, 110 Wn. App. at 513 (quoting *Seattle Bldg. & Constr. Trades Council v. Apprenticeship & Training Council*, 129 Wn.2d 787, 797, 920 P.2d 581 (1996)).

SCH cannot show that its interests were among those the OIC was charged with considering because the purpose of the ACA and implementing state statutes is to protect consumers, not providers. The network adequacy regulation itself, WAC 284-43-200, is framed entirely around the interests of consumers, ensuring “[s]ufficiency and adequacy of choice” for the benefit of consumers. For example, the regulation protects “covered persons” (*i.e.*, consumers)⁴ by requiring that the networks be sufficient “to assure that all health plan services to *covered persons* will be accessible without unreasonable delay” and to “ensure reasonable proximity of network providers [] to the business or personal residence of *covered persons*.” WAC 284-43-200(1), (4) (emphases added). The purpose of the regulation is to establish networks that provide “adequate choice” for consumers. WAC 284-43-200(1). Nothing in the regulation suggests that it is intended to protect the interests of *providers*.⁵

Similarly, the express purpose of RCW 48.43 is to fully inform *consumers* about their insurance coverage; it is not intended to benefit providers:

It is the intent of the legislature to ensure that all *enrollees* in managed care settings have access to adequate information regarding health care services covered by health carriers’ health plans, and provided by health care providers and health care facilities. It is only through such disclosure that *Washington state citizens* can be fully informed as to the extent of health insurance coverage, availability of health care service options, and necessary treatment.

⁴ See WAC 284-43-130(5) (defining “covered person” as “an individual covered by a health plan including an enrollee, subscriber, policyholder, or beneficiary of a group plan.”).

⁵ The OIC’s website confirms that its focus is the protection of consumers, not the protection of providers. See <http://www.insurance.wa.gov/about-oic/what-we-do/> (last visited Jan. 8, 2014) (“The [OIC] protects insurance consumers. It also oversees the insurance industry, ensuring that companies follow the rules and Washington consumers get what they pay for. We also answer questions and investigate problems for more than 100,000 people a year, and maintain a statewide network of volunteers to advise consumers on health-coverage issues.”).

With such information, *citizens* are able to make knowledgeable decisions regarding their health care.

RCW 48.43.001 (emphases added). And the express purpose of the statutory scheme establishing health maintenance organizations is to promote the rights of *citizens* to access affordable, quality health care:

In affirmation of the declared principle that health care is a right of every *citizen* of the state, the legislature expresses its concern that the present high costs of health care in Washington may be preventing or inhibiting a large segment of the people from obtaining access to quality health care services.

The legislature declares that the establishment of qualified prepaid group and individual practice health care delivery systems should be encouraged *in order to provide all citizens of the state with the freedom of choice between competitive, alternative health care delivery systems* necessary to realize their right to health. It is the purpose and policy of this chapter to provide for the development and registration of prepaid group and individual practice health care plans as health maintenance organizations, which the legislature declares to be in the interest of the health, safety and welfare of the people.

RCW 48.46.010 (emphases added).

SCH asserts that “[t]he OIC’s decisions were not in compliance with 42 U.S.C. § 18031(c)(1)(C),” a provision in the ACA requiring plan networks to include certain “essential community providers.” Demand, 2, § h. But SCH cannot point to anything in the ACA indicating that this requirement was intended to benefit those providers. Rather, the requirement was intended to protect the interests of “enrollees” (*i.e.* consumers) in accessing affordable health care. *See* 42 U.S.C. § 18031(c). In fact, the ACA provides that “[n]othing in paragraph (1)(C),” — the paragraph relied upon by SCH — “shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.” 42 U.S.C. § 18031(c)(2). This provision underscores the fact that it is the consumer’s access to affordable healthcare, not the provider’s “right” to inclusion in the network, that is at the heart of the

ACA's requirements.⁶ *See also* 42 U.S.C. § 18031(c)(1)(B) (requiring that plans "ensure a sufficient choice of providers . . . and provide information to *enrollees and prospective enrollees* on the availability of in-network and out-of-network providers") (emphasis added).

This makes sense. The interests of the consumer may conflict with the interests of a provider, such as SCH, that wishes to obtain the highest profit it can, sometimes to the consumer's detriment. Indeed, the main reason that BridgeSpan and Coordinated Care did not contract with SCH for their HBE plans is because SCH refused to accept anything other than its unilaterally dictated rates. *See* Johnson Decl., ¶ 12; Fathi Decl., ¶ 9. Paying those rates, for services that are available through other providers in the Intervenor's networks, would unnecessarily drive up the overall cost of the product to consumers. *Id.* This is directly contrary to the purpose of the ACA, which is to provide consumers access to affordable healthcare.

The Intervenor's have invested significant resources to develop quality health plans that were found by the OIC to meet the network adequacy standards, while providing more affordable solutions to the consumers. They are able to do so, in part, because they are not forced to contract with SCH at its substantially higher rates. SCH is merely attempting to use this forum to promote its own economic interest, thereby subverting this forum into one for disappointed providers to pursue their own economic interests. That is not the "zone of interest" Congress or the Washington State Legislature intended to protect. SCH's request should be dismissed for lack of standing alone.

C. The OIC Has Found that the Intervenor's Networks Are Legally Adequate.

In its Demand, SCH argues that the Intervenor's plans violate state and federal law because they do not include SCH in their networks as a pediatric specialty provider. SCH's

⁶ In fact, 42 U.S.C. § 18031 is entitled "Affordable choices of health benefit plans," referring to consumer choice, not to alleged rights of providers. *See also* 42 U.S.C. § 18032, entitled "Consumer choice."

argument fails because no law requires the Intervenor to include SCH in their networks. To the contrary, the law only requires health carriers to include certain categories of providers, maintain a base-level network, and provide certain categories of benefits to ensure minimum coverage. As long as a health plan meets these criteria, there is no requirement that a plan include any specific provider in the plan's network. As evidenced by the Intervenor's insurance filings and the Commissioner's subsequent certification, the Intervenor's networks comply with all of these requirements without including SCH in their network.

1. The OIC Has Determined that the Intervenor's Networks Satisfy Washington's Network Adequacy Standards.

The OIC has correctly found that each of the Intervenor's networks provides an adequate and accessible choice of providers as required by the Washington Insurance Code. Carriers are required to maintain a network "sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay" and that "each covered person shall have adequate choice among each type of health care provider." WAC 284-43-200(1); *see also* RCW 48.43.515(1) ("Each enrollee in a health plan must have adequate choice among health care providers."); RCW 48.43.500(2) (providing that enrollees must "[h]ave sufficient and timely access to appropriate health care services, and choice among health care providers."). Carriers may establish sufficiency and adequacy using any reasonable criteria, such as provider-covered person ratios by specialty and primary care, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. WAC 284-43-200(2).

Each of the Intervenor submitted multiple documents to the OIC establishing network adequacy by both specialty and primary care provider-covered person ratios and by

geographic accessibility. See Johnson Decl., ¶¶ 4, 5; Fathi Decl., ¶¶ 2, 12-13; Maturi Decl., ¶ 4. The OIC found the Intervenor's proposed networks adequate and approved the plans.

SCH's claim that many of its providers have more experience providing certain types of specialty care to a pediatric population does not change the outcome. Neither state nor federal law requires health carriers to contract with the provider who has the most experience in providing a certain type of treatment to a certain segment of the population. Nor is there a federal or state requirement to contract with a specialty provider capable of treating every single type of member condition that may arise. In fact, no law requires health carriers to contract with any specific provider. Rather, the network adequacy requirements ensure that plans contract with a sufficient number of providers in certain mandated categories so as to provide *adequate* care options for covered services to the population as a whole. Further, the network adequacy standards do not require that all services be provided by contracted providers. WAC 294-43-200 (3) expressly allows carriers to utilize out-of-network providers for any purpose as long as the consumer is not put in a worse position. In other words, for unique services rendered by SCH to Intervenor's HBE members, the law allows for single case agreements by Intervenor's BridgeSpan and Coordinated Care⁷ and application of Premera's existing contract to treat those services as in network claims.

Here, the OIC has already correctly found that the Intervenor's HBE plans provide adequate care options for pediatric services, and the evidence amply supports this finding.

2. The Intervenor's Plans Provide the Essential Health Benefits as Defined by RCW 48.43.715 and WAC 284-43-849.

As noted, one of the goals of the ACA was to set minimum coverage standards for health plans nationwide. This was achieved by requiring commercial health plans sold on a

⁷ This was confirmed by the Chief Presiding Officer in the Findings of Fact, Conclusions of Law, and Final Order entered in the *In re Coordinated Care Corporation* matter on September 3, 2013. See Fathi Decl., Ex. A (Final Order), 18 ("Virtually all carriers on occasion use 'single payor arrangements' in provision of network services").

state exchange to cover certain “essential health benefits.” Pursuant to the ACA and enabling regulations, the Washington Legislature passed legislation requiring the Commissioner to select a state benchmark plan for the individual and small group markets that includes, at a minimum, all of the ten essential health benefit categories specified in Section 1302 of the ACA. RCW 48.43.715 (3). In Washington, the essential health benefits are defined as follows:

- (1) The benefits and services covered by the selected benchmark plan
- (2) The services and items covered by a health benefit plan that are within the categories identified in Section 1302(b) of PPACA including, but not limited to, ambulatory patient services, 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
- (3) Mandated benefits pursuant to Title 48 RCW enacted before December 31, 2011.

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

Here, the OIC has found that the Intervenor’s health plans include the benefits and services covered by Washington’s selected benchmark plan, as well as the services defined in Section 1302(b) of the ACA. *See* Fathi Decl., ¶ 12. Further, the OIC correctly found that it was not necessary that the Intervenor include SCH in their HBE networks to provide these essential health benefits. *See* WAC 284-43-877(5).

3. The Intervenor's HBE Plans Meet the Federal Requirements for Network Inclusion of "Essential Community Providers."

SCH's theory is that federal law requires a HBE carrier to contract with every "essential community provider" in a given service area. This is contrary to the ACA. The ACA authorizes the promulgation of regulations by the Secretary of HHS for the certification of Qualified Health Plans ("QHPs"), a certification which each of the Intervenor's has received. The Secretary's certification criteria must:

... include within health insurance plan networks those essential community providers, where available, that serve predominantly low-income, medically underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 USC §256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [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). Although SCH is an "essential community provider" as determined by the Centers for Medicare and Medicaid Services ("CMS"), the Secretary's regulations do not require the inclusion of every single "essential community provider" in a service area. Instead, 45 CFR §156.235 provides that: "A QHP issuer must 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 providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards." (Emphasis added).

In an April 2013 letter to HBE plan issuers, CMS provided further clarification on the level of "essential community providers" it considers sufficient under 45 C.F.R. §156.235:

- **Safe Harbor Standard:** An application for QHP certification that demonstrates compliance with the standards outlined in this paragraph will be determined to meet the regulatory standard established by 45 C.F.R. § 156.235(a) without further documentation. First, the application demonstrates that at least 20 percent of available ECP's in the plan's service area participate in the issuer's provider network(s). In addition to

achieving 20 percent participation of available ECP's the issuer offers contracts prior to the coverage year to:

- All available Indian providers in the service area, using the model QHP addendum for Indian providers developed by CMS; and
- At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available.

CMS may verify the offering of contracts after certifications.

- **Minimum expectation:** An issuer application that demonstrates at least 10 percent of available ECPs in the plan's service area participate in the issuer's provider network(s) for that plan will be determined to meet the regulatory standard, provided that the issuer includes as part of its application a satisfactory narrative justification describing how the issuer's provider network(s), as currently designed and after taking into account new 2014 enrollment, provides an adequate level of service for low-income and medically underserved enrollees.

Declaration of Molly Nollette, Ex. F. As the applicable regulations and administrative guidance make clear, HBE carriers do not need to contract with all essential community providers in a given service area. To the contrary — the Secretary may certify a plan as a QHP that contains a mere ten percent of the essential community providers in the area, and generally must certify a plan that includes twenty percent of the area's essential community providers. All of the Intervenors are QHPs. *See, e.g.,* Fathi Decl. ¶ 13.

Furthermore, and wholly in keeping with the ACA's goal of promoting essential health benefits at the most affordable rate, the regulations expressly allow QHP issuers not to contract with an essential community provider where, as here, the provider demands higher rates:

Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

45 C.F.R. §156.235(d). Federal regulators also specifically declined to require the inclusion of specific types of providers (*i.e.*, specialty pediatric hospitals): "we are concerned that mandating inclusion of a list of specified provider types would detract from the larger issue of broadly ensuring access to the full range of covered services (*that is*, essential health benefits)." Final Rule and Interim Final Rule, Network Adequacy Standards, 77 Fed. Reg.

18419 (March 27, 2012) (emphasis in original). In short, SCH's status as an essential community provider does not give it special leverage to force Intervenor to accept its much higher payment rates. Here, because the OIC has found that the Intervenor's networks provide adequate access to all essential health benefits, the Intervenor is free to offer HBE plans that exclude SCH from their networks.

4. The OIC's Inclusion of the Intervenor's Plans Advances the ACA's Purposes.

As its title states, the ACA strikes a careful balance between two fundamental principles: patient protection and affordability. ACA requires patient protection by requiring all participating health plans to cover certain specified categories of benefits. Affordability is fostered by competition among health carriers and among providers. To encourage this competition, the HBE website, wahealthplanfinder.org, includes disclosures concerning price, benefits, and each carrier's network of providers. Although competition may incentivize health carriers to have a large provider network, there is no requirement that a carrier contract with every qualified provider; rather, they are required only to maintain a base level network for every *category* of covered benefit to ensure patient choice. *See* RCW 48.43.045 and WAC 284-43-310.⁸ The Intervenor's HBE plans meet all necessary requirements while advancing the principles of the ACA.

In contrast, not only is SCH's position unsupported by the law, but it also fails to provide any additional protection to Washington consumers. Not every individual who purchases health coverage on the HBE has children, much less children in need of a particular specialty service provided by the SCH. Those who do not have children or who are willing to receive pediatric specialty care from one of the many other qualified providers in Washington are entitled to choose from more affordable plan options on the HBE. Those who have

⁸ 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).

children and wish to receive covered specialty care have options: purchase coverage from one of the health carriers that has made the decision to contract with SCH, or receive SCH services via the Intervenor's HBE plans pursuant to the processes outlined earlier in this brief. Providing consumers with the opportunity to make choices like this is one of the founding principles of the ACA. These choices foster competition among both providers and carriers while staying true to the consumer protection principles embraced in the federal and state network adequacy standards.

IV. CONCLUSION

For the foregoing reasons, the Chief Presiding Officer is respectfully requested to grant the Intervenor's Motion for Summary Judgment.

DATED this 17th day of January, 2014.

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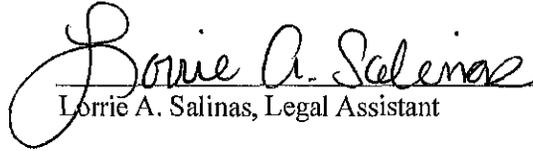
DECLARATION OF SERVICE

I, Lorrie Salinas, under oath hereby declare as follows: I am an employee at Lane Powell, P.C., over the age of 18 years, and not a party to nor interested in this action. On January 17, 2014, I caused to be delivered in the manner indicated a copy of the foregoing document and 5 declarations referenced therein on the following parties at the last known address as stated:

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

DATED this 17th day of January, 2014.


Lorrie A. Salinas, Legal Assistant