DECLARATION OF MOLLY NOLLETTE IN SUPPORT OF MOTION TO DISMISS ADJUDICATIVE PROCEEDING

OIC CASE NO. 13-0293

EXHIBIT B

Via Email mollyn@oic.wa.gov

PREMERA | BLUE CROSS

September 19, 2013

Ms. Molly Nollette
Deputy Insurance Commissioner
Rates & Forms Division
Washington State Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255

Dear Molly,

As you and I agreed last week, I am sending you this letter in response to your request for language in our contracts with Children's and Harborview Medical Center (HMC) that would prohibit these institutions from balance-billing individuals covered by Premera and its affiliates and subsidiaries ("Premera") whose products utilize our new Heritage Signature network ("Signature Members").

As we have previously discussed, neither Children's nor HMC will be in the Heritage Signature network, but both are contracted providers with Premera. A straightforward analysis of Premera's agreements with Children's and HMC supports our position that both will be entitled to their agreed-upon commercial rates (i.e., Heritage Network rates covering over 1 million Premera members) but will be prohibited from balance-billing.

Signature Members are Enrollees pursuant to Premera's agreements with Children's and HMC

The analysis of Premera's agreements with Children's and HMC begins with the definition of the term "Enrollee," since the respective obligations of Premera, Children's, and HMC are tied to this term. The following step-by-step analysis traces the definitions in order to show that Signature Members are Enrollees. Because the definitions in the Children's and HMC agreements are similar, they are discussed in parallel. References are to the current agreements, as amended.

1. Enrollees are defined as any Subscriber or dependent of a subscriber who is enrolled under a Subscriber Agreement.

    a. The Children's agreement defines an Enrollee to include "a Subscriber or a dependent of a Subscriber who is properly enrolled under a Plan Subscriber Agreement..." (§ 1.11)

    b. The HMC agreement defines an "Enrollee" as "either a subscriber or a dependent of a subscriber who is enrolled under a subscriber agreement." (§ I.B.)

2. A Subscriber Agreement is any agreement that entitles the Enrollee to Covered Services.

    a. The Children's agreement defines a "Subscriber Agreement" as "any agreement entered into by a Plan [Premera], with or for the benefit of an Enrollee, entitling the Enrollee to receive benefits for Covered Services." (§ 1.31)

b. The HMC agreement defines a "Subscriber Agreement" as "any contract issued by the PLAN...entitling the enrollee to receive benefits from the PLAN for covered services designated therein." (§ I.K.)

3. Covered Services are medically necessary medical and hospital services for which benefits are provided pursuant to the applicable Subscriber Agreement.

   a. The Children's agreement defines "Covered Services" as "those medically necessary medical and hospital services, supplies and accommodations for which an Enrollee is eligible under the terms of the applicable Subscriber Agreement and are customarily provided by the Facility [Children's]." (§ 1.09)

   b. The HMC agreement defines "Covered Services" as "those services for which benefits are provided under a subscriber agreement. The fact that a service is a covered service does not make it medically necessary." (§ I.A.)

The definition of Enrollee does not require that Children's or HMC be "in-network" for the Enrollee. Therefore, Signature Members are Enrollees who are entitled to receive Covered Services pursuant to both Children's and HMC's contracts with Premera.

Children's and HMC have agreed not to balance-bill Enrollees and in return Premera pays them directly

Children's and HMC have both agreed that they will treat Premera's Enrollees and will accept as full payment the negotiated rates for Covered Services specified by their respective contracts (the "Allowed Amount"). The relevant contract language makes no distinction between Enrollees who are in-network or out-of-network. In return, Premera has agreed to pay both facilities directly for such services rather than paying the Enrollee directly as Premera would do for non-contracted providers.

1. In the Children's agreement, it agrees to:

   a. "provide Covered Services to Enrollees in compliance with the terms of this Agreement" (§ 3.01); and

   b. "seek payment solely from the Enrollee's Plan for Covered Services rendered to that Plan's Enrollees, and shall accept as full payment the Allowed Amount(s) set forth in the applicable Product and Compensation Addenda attached to this Agreement...Facility's charge to the Enrollee for Deductibles, Copayments or Coinsurance as set forth in the Subscriber Agreement, in combination with the Plan's payment, will not exceed the Allowed Amount for Covered Services." (§ 4.01)

2. In the HMC agreement, it agrees to:

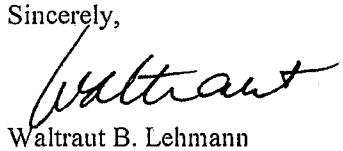
   a. "provide medically necessary covered services to enrollees in accordance with the applicable subscriber agreement and this Agreement" (§ III.A.); and

b. "seek payment solely from the PLAN for the provision of medically necessary covered services to all eligible enrollees, and shall accept as full and final payment for such medically necessary covered services rendered to eligible enrollees the amount set forth in Exhibit A attached to this Agreement and incorporated by reference herein. (§ IV.A., see, also, 1992 amendment)

In summary, both Children's and HMC have agreed to provide Covered Services to Premera Enrollees at agreed upon rates. Neither agreement predicates these rates upon the network status of either Children's or HMC with respect to the Enrollee. Premera will uphold its obligations under the agreements, and it trusts that Children's and HMC will do likewise.

We appreciate the opportunity to respond to you on these issues. If you need any additional information or have questions about this letter, please let me know.

Sincerely,



Waltraut B. Lehmann
Manager, Regulatory Affairs

DECLARATION OF MOLLY NOLLETTE IN SUPPORT OF MOTION TO DISMISS ADJUDICATIVE PROCEEDING

OIC CASE NO. 13-0293

EXHIBIT C

Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

RECEIVED

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INSURANCE COMMISSIONER
RATES & FORMS

November 1, 2013

Molly Nollette
Deputy Insurance Commissioner
Rates & Forms Division
Washington State Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255

Re: Response to September 19, 2013 Letter from Premera regarding Seattle Children's Hospital and Premera's Heritage Signature Network

Dear Ms. Nollette:

We are writing in response to the letter you received from Premera dated September 19, 2013 (the "Premera Letter") and forwarded to our attention. In the Premera Letter, Premera asserts that Seattle Children's Hospital ("Seattle Children's") will not be a member of Premera's new Heritage Signature network; however, Seattle Children's would not have the right to balance bill enrollees of Premera's Heritage Signature product because Seattle Children's is otherwise a contracted provider with Premera.

In reviewing the Premera Letter, it is impossible not to note the inconsistencies in and omissions from Premera's analysis. We hope to illuminate these inconsistencies and omissions in the Premera Letter and demonstrate that Premera's position is akin to having its cake and eating it too, i.e., Seattle Children's is a contracted Premera Preferred Provider who must comply with its obligations under the PremeraFirst Facility Agreement, related addendums, and administrative rules and procedures, while at the same time Seattle Children's is not entitled to the benefits of being a Preferred Provider as it pertains to Premera's Heritage Signature product.

Seattle Children's and Premera are parties to a PremeraFirst Facility Agreement dated January 1, 2001 (the "Agreement") as subsequently amended by, among other things, the Amendment to PremeraFirst Facility Agreement dated January 1, 2001 (the "2001 Amendment," attached as Exhibit A), the Amendment to PremeraFirst Facility Agreement dated January 1, 2012 (the "2012 Amendment," attached as Exhibit B), and the Premera First Facility Agreement Compensation Exhibit A dated March 1, 2009 (the "2009 Compensation Exhibit," attached as Exhibit C).

We agree with Premera that under the Agreement, Seattle Children's is obligated to provide Covered Services to Enrollees in compliance with the terms of the Agreement. (Section 3.01 of the Agreement as amended in the 2001 Amendment.) We further agree that under the Agreement, Seattle Children's may seek payment "solely from the Enrollee's Plan for Covered Services rendered to that Plan's Enrollees and shall accept as full payment the Allowed Amount(s) set forth in the applicable Product and Compensation Addenda attached to this Agreement." (Section 4.01 of the Agreement, as amended by the 2001 Amendment).[1]

[1] Underlined terms are defined terms from the Agreement as amended.

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Seattle, WA 98105
TEL 206-987-2000

For these obligations to apply, however, the Plan and associated products must be included in the Product and Compensation Addenda. The Product and Compensation Addenda is defined in the Agreement and means "the attached addendum designating (1) the Plan program under which Covered Services [are] provided by Facility pursuant to this Agreement and (2) the related Compensation. The Product and Compensation Addendum is incorporated into, and made part of, this, (sic) Agreement." (Section 1.28 of the Agreement.)

The Agreement provides specifically for how new products of the Plan can be added to and incorporated into the Agreement: "Plan may establish new products, or Facility may develop or initiate new health services which are not currently available to Enrollees. Upon such an event, a written notification will be sent to the other party no less than 60 days prior to the proposed implementation date. Subject to a Plan determination that any such services/products are Covered Services, the parties agree to negotiate in good faith an acceptable level of reimbursement for such services/products, and the product amendment will be updated in writing, with required signatures by both parties." (Section 7.01 C. of the 2001 Amendment.)

The most recent Product and Compensation Addendum that would list current products is the 2009 Compensation Exhibit. The 2009 Compensation Exhibit lists the following Plans and products for Washington:

Premera Blue Cross	Preferred Participating Dimensions
LifeWise Health Plan of Washington	(nothing specified)

Thus, if Premera is correct that the Agreement applies to the Heritage Signature product, it is because of the 2009 Compensation Exhibit and the Heritage Signature product must be part of the Plans and products listed above. Therefore, if the Agreement applies, as Premera asserts, then Seattle Children's must be treated as "in-network." Please note that the concept of in-network versus out-of-network is not clearly defined anywhere in the Agreement as amended, nor, to the best of our knowledge, in Premera's Administrative Rules and Procedures.

What is clear is that Seattle Children's is a Preferred Provider pursuant to the Agreement: "[Premera] agrees to list [Seattle Children's] as a Preferred Provider in all directories and other similar Preferred Provider listings. [Premera] agrees to print and distribute these directories to its covered Enrollees, and make best efforts to update these directories at least annually." (Section 2.06 of the Agreement as amended by the 2001 Amendment.) Premera has the further obligation to "develop and actively market [its] Participant panels." (Section 2.02 of the Agreement.) We also note that the Health Care Authority, in describing plans sold on the Exchange, does not recognize a distinction between in-network and preferred providers: "Plans use the term in-network, preferred, or participating for providers in their networks." (See Exhibit D.)

Again, the only conclusion that can be drawn from examining the Agreement as a whole is that if Premera's assertion is correct that the Agreement covers enrollees under the Heritage Signature

product then Seattle Children's is a Preferred Provider for that product and Premera has an obligation to market Seattle Children's as such and include it as an in-network facility. Failure to do so would be a material breach of the Agreement.

The only alternative to this conclusion is that the Agreement does not cover enrollees under the Heritage Signature product, in which case the restrictions in the Agreement on balance billing would not apply. As pointed out above, the only way for Premera to add additional products to the Agreement is pursuant to an amendment signed by both parties. Seattle Children's has not agreed to nor signed any amendment to the Agreement that would authorize Seattle Children's to be an out-of network provider for the Heritage Signature product, but otherwise subject to the Agreement.

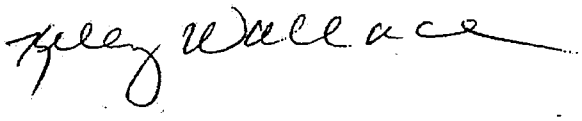
Premera simply cannot have it both ways.

In conclusion, Seattle Children's is willing to agree with Premera's interpretation that the Agreement applies to the Heritage Signature product, but only so long as both Seattle Children's and Premera have to abide by all their respective rights and obligations under the Agreement; to wit, Premera must treat Seattle Children's as an in-network, Preferred Provider for Enrollees of Premera's Heritage Signature product. The only alternative is that the Agreement does not apply, and Seattle Children's will bill Premera for Heritage Signature enrollees at a percent of charges, with the balance being billed to the enrollee. Accounting for the enrollee's obligation to pay these balances may require recalculation of the actuarial estimate for coverage of costs in Premera's Exchange products, and could result in them not qualifying for listing on the Exchange. Obviously, this second alternative is not in the best interests of anyone. Seattle Children's has attempted to engage Premera in dialogue regarding these issues for several months, and remains willing to do so. We are not, however, simply willing to acquiesce to Premera's incorrect, self serving interpretation of the Agreement that benefits no one except Premera.

Thank you for your time and attention to this matter.

Very Truly Yours,

SEATTLE CHILDREN'S HOSPITAL



Kelly Wallace
Chief Financial Officer

Attachments

cc: Eileen O'Connor King, Sr. Director, Contracting and Payor Relations
Jeff Sconyers, General Counsel
Donald Black, Esq.

DECLARATION OF MOLLY NOLLETTE IN SUPPORT OF MOTION TO DISMISS ADJUDICATIVE PROCEEDING

OIC CASE NO. 13-0293

EXHIBIT D

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

Phone: (360) 725-7000
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FILED

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Hearings Unit, OIC
Patricia D. Petersen
Chief Presiding Officer

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BEFORE THE STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

In the Matter of **COORDINATED CARE CORPORATION,** A Health Maintenance Organization.	**Docket No. 13-0232** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER**

TO: Jay Fathi, M.D., President and Chief Executive Officer
Coordinated Care Corporation
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Tacoma, WA 98402

Katie Rogers, Vice President of Compliance and Reg. Affairs
Coordinated Care Corporation
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Barbara Nay, Esq.
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900 SW Fifth Ave., Suite 2600
Portland, OR 97204-1268

COPY TO: Mike Kreidler, Insurance Commissioner
James T. Odiorne, J.D., CPA, Chief Deputy Insurance Commissioner
Molly Nollette, Deputy Commissioner, Rates and Forms Division
AnnaLisa Gellermann, Esq., Deputy Commissioner, Legal Affairs Division
Charles Brown, Senior Staff Attorney, Legal Affairs Division
Andrea Philhower, Staff Attorney, Legal Affairs Division
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255

Pursuant to RCW 34.05.434, 34.05.461, 48.04.010 and WAC 10-08-210, and after notice to all interested parties and persons the above-entitled matter came on regularly for hearing before the Washington State Insurance Commissioner commencing at 9:00 a.m. on August 26, 2013, and continued on August 27 and 28, 2013 until its conclusion. All persons to be affected by the above-entitled matter were given the right to be present at such hearing during the giving of testimony, and had reasonable opportunity to inspect all documentary evidence. The Insurance Commissioner appeared pro se, by and through Andrea Philhower, Esq., Staff Attorney, and Charles Brown, Senior Staff Attorney, in his Legal Affairs Division. Coordinated Care Corporation appeared by and through its attorneys Maren Norton, Esq. and Gloria Hong, Esq. of Stoel Rives LLP.

NATURE OF PROCEEDING

The purpose of the hearing was to take testimony and evidence and hear arguments as to whether the Insurance Commissioner's July 31, 2013 disapproval of Coordinated Care Corporation's form, rate and binder filings submitted on July 25, 2013 for its Bronze, Silver and Gold Individual Plan Filings (Health Maintenance Organization Agreements) for 2014 sales through the new Washington State Health Benefits Exchange was in compliance with applicable rules and therefore the disapproval should be upheld, or whether the disapproval was not in compliance with applicable rules and therefore should be set aside.

FINDINGS OF FACT

Having considered the evidence and arguments presented at the hearing, and the documents on file herein, the undersigned presiding officer designated to hear and determine this matter finds as follows:

1. The hearing was duly and properly convened and all substantive and procedural requirements under the laws of the state of Washington have been satisfied. This Order is entered pursuant to Title 48 RCW and specifically RCW 48.04; Title 34 RCW, and regulations pursuant thereto.

2. The Affordable Care Act ("ACA") was placed into law on March 23, 2010. [Testimony of Jennifer Kreitler, Senior Insurance Policy and Compliance Analyst, Rates and Forms Division, Office of the Insurance Commissioner.] Very briefly, the ACA mandates a much wider accessibility to health care coverage in all states through the availability of health plans contemplated in the ACA (identified as "Exchange Plans"). In compliance with the ACA's mandate, Washington state has chosen to have its state Exchange plans governed by a public/private partnership called the Washington State Health Benefits Exchange ("Exchange"). Under this process, disability carriers, health maintenance organizations and health care service contractors licensed by the Washington State Insurance Commissioner ("OIC") who wish to sell health plans to Washington residents through the Exchange must submit their form, rate and

binder filings pertinent to each plan they seek to sell, to the OIC. The OIC is responsible to review the form, rate and binder filings for each plan and 1) apply the federal rules pertaining to Exchange plans and also 2) apply the correct provisions of the Washington State Insurance Code and regulations which pertain to the particular type of health contract being filed for approval (e.g., disability insurance contract, health maintenance organization agreement, health care service contract). If the OIC determines that these filings comply with federal and state statutes, regulations, guidelines and interpretations thereof, the OIC is to approve these filings and transmit them to the Exchange. The Exchange then reviews the filings, certifies them as Exchange products if appropriate, and sends them to the federal government with the advice that those certified filings will be the Exchange plans which carriers will offer in this state through the Exchange. [Testimony of Kreitler.]

3. The ACA includes time frames for states' compliance which are fairly short given that the ACA requires that carriers wishing to sell their plans through the Exchange must 1) submit their form, rate and binder filings relevant to each plan to the OIC for approval; 2) have them comprehensively reviewed by the OIC; 3) have them approved by the OIC; 3) have them certified by the Exchange; and 4) have them approved by the federal government, all in time to have them on the market in this state by October 1, 2013. As part of its review process, the OIC and all states are required to apply federal rules and interpretations in developing their own procedures for filing and review of these proposed Exchange Plans. In addition, beginning some time after enactment of the ACA, on 100 or more occasions the various federal agencies and divisions of the federal government have drafted, adopted and even amended federal regulations, held meetings with states by telephone, webinar and in person, and have published and distributed guidelines, question and answer series and other materials interpreting the requirements of the ACA and have published later documents changing their interpretation of some of the federal rules and including different or new requirements for states to receive, understand and apply in their review of Exchange filings. [Testimony of Kreitler.] For this reason, states have been challenged to remain current in receiving, clarifying and applying these federal rules in the states' review process. Changes have been received by the OIC from the federal government since at least 2012 through at least June 2013. [Testimony of Kreitler.] For these reasons, and specifically because the federal government did not finally establish clear deadlines for this process for some time, the OIC was unable to provide clear deadlines to carriers for filing with the OIC until December 2012 and carriers could not make their initial filings for comprehensive review and approval by the OIC until April 2012. [Testimony of Kreitler.] In addition, while it has no authority to adopt regulations because it is not a public agency, the Exchange did establish its own guidelines for compliance, requiring the OIC to have reviewed, approved or disapproved, and submitted those approved filings to the Exchange for certification by July 31, 2013 so that it could review and submit them to the federal government in time to meet its own deadline. Apparently, however, according to statements made by OIC counsel during the hearing, the Exchange has extended its deadline for the OIC to submit approved plans to the Exchange from July 31 until September 4 and thereby has implicitly extended the July 31 deadline for carriers to submit/amend filings with the OIC and for the OIC to approve them.

4. Since enactment of the ACA, the OIC has presented many training sessions, presentations, publications and personal assistance to carriers to inform them about what these Exchange plans must include and how their form filings, rate filings and binders should be filed with the OIC. Indeed the OIC has presented sessions and distributed publications on the federal changes when they have occurred as well. [Testimony of Kreitler; Ex. 20, OIC's List of Training Seminars with dates presented; Exs. 21 through 38, OIC publications assisting carriers in making Exchange plan filings from June 6, 2012 to current.] Of significance, in presentations and publications, the OIC cautioned carriers to concentrate on making certain they had adequate networks associated with the Exchange filings. [Testimony of Kreitler; Ex. 23, p.22, July 10, 2012 OIC publication to carriers.]

5. Coordinated Care Corporation ("Company") was formed in 2012 and is authorized by the OIC to do business in Washington as a health maintenance organization. To date, the Company has offered and sold health plans associated with Washington's Medicaid programs. Although the Company has not submitted filings for, or conducted, health maintenance organization agreements outside of the Medicaid arena in Washington state before, the Company has had Exchange plans certified and approved by other states. In addition, its parent company is Centene, a large Indiana health care entity with health plans currently approved and being sold in many states (although not Washington). [Testimony of Dr. Jay Fathi, President and CEO, Coordinated Care Corporation.]

6. One or more representatives of Coordinated Care Corporation ("Company") attended all training sessions presented by the OIC. [Testimony of Kreitler.] In addition, the Company hired consultant Ginny McHugh of McHugh Consulting Firm to assist it in preparing its form, rate and binder filings for the OIC's approval to sell through the Exchange. [Hereinafter, the Company's form, rate and binder filings submitted to the OIC for approval to sell through the Exchange are referred to collectively as the Company's "filings" or "filing" unless otherwise noted.]

7. On or about December 6, 2012 the OIC published its "key dates for filings" providing that carriers could make their first filing on April 1, 2013 with the form, rate and binder filings all completed by May 1 and specified that July 31 would be the OIC's final date for approval of the filings. [Testimony of Kreitler.] These dates were not firm deadlines, but just suggested by the OIC. [Testimony of Kreitler.] Therefore, carriers had four months under these guidelines to file and have their Exchange filings approved by the OIC. [Testimony of Kreitler.] In fact, the OIC moved these timelines by Beth Berendt, then Deputy Commissioner of the OIC's Rates and Forms Division, to as late as possible because many carriers had problems with their filings, e.g., developing their networks. [Testimony of Kreitler; Ex. 21, pgs. 15-20.]

8. In compliance with the timelines published by the OIC in December 2012, the Company made its first filing with the OIC on the first day carriers were able to submit their filings, April 1, 2013. [Ex. 40.] This filing was "not accepted" by the OIC on April 3. The technical reason for this action was that the company code was not correctly specified and so apparently the OIC System for Electronic Rate and Form Filing ("SERFF") could not download the filing. Filings with the OIC are required to be made on the OIC's SERFF computer system, a national system

adopted by all 50 state insurance departments to use; the goal of SERFF is ease of filing for both carriers and the state. (The OIC also requires filings by .pdf so the filings are available for public disclosure.) For this reason, the filings were not even transmitted to OIC staff reviewing these filings. [Ex. 40; Testimony of Kreitler.]

9. The Company made a new filing (its second filing) on April 4 and the OIC disapproved and closed this filing on April 23. The Company had changed the company code to one that was recognizable by the OIC and the SERFF system. However, the filing was made as if the Company were licensed as a disability insurance company and the filing was a disability insurance policy, with the drafter applying the sections of the Insurance Code and regulations specifically pertaining to disability insurance policies when in fact the Company is only licensed as a health maintenance organization and so authorized only to file health maintenance organization agreements which are subject to different sections of the Insurance Code and regulations. [Ex. 40; Testimony of Kreitler.] Because these two types of health contracts are so different, the OIC could not conduct a comprehensive review of this filing. [Testimony of Kreitler.] In response to Exchange filings, the OIC sends Objections letters to carriers whose filings appear to the OIC to be close to approvable, stating the OIC's objections and allowing the carrier a window of time in which to address the objections by amending the wording of their filings. If the OIC believes the filings are not close to approvable due to, e.g., too many OIC concerns, then the OIC simply sends the carrier a Disapproval Letter and closes the filing, which requires the carrier to make a new filing if it chooses to continue to pursue approval. [Testimony of Kreitler.] Two or three Objection Letters are commonly sent relative to a single filing and at times nine to ten Objection Letters are sent. The Company asserts, and it was uncontested, that Group Health Cooperative received some eight Objection Letters in the course of its Exchange filings; as shown below, the Company received just one, on July 25, 2013 when the deadline for making the required changes and having the filing approved was July 31, 2013.

10. The Company made a new filing (its third filing) on May 2 and the OIC disapproved and closed this filing on May 10. As with its April 4 filing, this filing was made applying those sections of the Insurance Code and regulations pertaining specifically to disability insurance policies and not applying those sections of the Insurance Code and regulations pertaining to health maintenance organization agreements, and the filing included brackets which were not allowed in such filings. [Ex. 41, Testimony of Kreitler.] The OIC staff did, however, conduct a complete review of the filing including a first network review, and was able to identify various categories of concern about the filing, most specifically the adequacy of the Company's network. [Ex. 42.] On May 10, Beth Berendt, Deputy Commissioner for Rates and Forms, contacted the Company and arranged for a meeting to be held between the OIC and the Company. Deputy Commissioner Berendt, Kreitler and perhaps other OIC staff met with the Company staff and also its hired consultant Ginny McHugh on May 13. The OIC addressed some of its concerns in general categories but did not go through each concern due to time limitations. The OIC expressed concern about the Company's network. The Company was the only carrier proposing to construct its own network, which it believes will keep costs for consumers down, rather than "rent a network" as the other carriers did. [Testimony of Kreitler; Ex. 42, Kreitler's notes from May 13 meeting.]

11. At or before this time, it was undisputed that the OIC suggested that at least for the first year the Company should "rent a network" because the time frame for approval was short and to review the network adequacy of the Company – when it did not "rent a network" – was much more time intensive than if the OIC simply had to identify the network rented and approve its adequacy by already knowing the extent and nature of that rented network. Although the Company considered this suggestion, because its plan model includes its building its own "narrow network" – and thereby keep its rates for consumers less than the Company's commercial carrier counterparts – the Company determined to continue to build its own network. [Testimony of Jay Fathi, President and CEO of Coordinated Care Corporation; Testimony of Ross.]

12. The Company made a new filing (its fourth filing) on May 31 and the OIC disapproved and closed this filing on June 25. [Ex. 43; Testimony of Kreitler.] Although the Company had removed the brackets in this new filing it had mistakenly left one or two brackets in. Although the OIC kenw the Company intended to delete all brackets in this filing, the OIC felt it could not delete them itself. [Testimony of Sara Ross, Manager of New Products and Program Operations, Coordinated Care Corporation; Testimony of Kreitler.] In addition, the OIC conducted a second network review. [Testimony of Kreitler.]

13. On June 27, Kreitler and perhaps other OIC staff again met with the Company, discussed its position that the remaining bracket(s) were prohibited and again raised its concern about the adequacy of the Company's network. [Testimony of Kreitler; Ex. 44, Kreitler notes from June 27 meeting.]

14. The Company made a new filing (its fifth filing) on July 1. In response to the OIC's continuing concerns about the Company's network adequacy, the Company contracted with Healthway, a network of some providers it would "rent" in order to address the OIC's concern that the network the Company had constructed was inadequate as to some types of providers. The Company submitted this Agreement to the OIC on July 9, 2013 to be considered along with its May 31 filing. [Ex. 48, Network Access Agreement between the Company and Healthways WholeHealth Network, Inc. ("Healthways").] Healthways is a network other carriers current "rent" as well. On July 10 the OIC conducted a third network review, wrote a Network Review report on that date and provided this report to the Company on July 11. [Testimony of Kreitler; Ex. 45, OIC's Network (Form A) Review dated July 10.] The Company responded to the OIC's Network Review on July 15. [Ex. 46, Company's Response to OIC's Network Review.] Through this process, including an earlier June 28 email between the parties [Ex. 47, June 28 email], the parties were able to resolve many of the OIC's issues about the Company's network adequacy [Testimony of Kreitler] and on July 15 the Company submitted its Access Plan to the OIC. [Ex. 2, Company's Geo Network Report indicating location of pediatric specialty hospitals and Access Plan.] The OIC apparently still had some concerns, however, as shown below.

15. The OIC did not disapprove and close the Company's July 1, 2013 filing after review, but instead wrote the Company an Objection Letter dated July 17 containing numbered Objections to

the Company's July 1 rate filing and binder, and on July 22 wrote the Company an Objection Letter to the Company's form filings. [Testimony of Kreitler; Ex. 57, OIC's Objection Letter re Company's rate filing; Ex. 52, OIC's Objection Letter re Company's Binder filing; Ex. 53, OIC's Objection Letter to Company's rate filing.] As detailed above, the purpose of an Objection Letter is - instead of simply closing the filing on the date of disapproval - to provide carriers with the reasons why their filings were not approved and to allow those carriers a period of time to remedy these objections (by e.g., furnishing new language or more justification for their the currently filed language) and to thereby have those current filings approved. [Testimony of Kreitler.]

16. When the Company received the OIC's July 17 and 22 Objection Letters to its July 1 filing, under the current guidelines from the Exchange it had only until July 31 to file changes, provide explanations and otherwise remedy the OIC's objections. Accordingly, after receiving the OIC's July 17 and 22 Objection Letters, on July 25 the Company made changes and/or provided additional justification to its July 1 filing in a prompt attempt to address the OIC's concerns expressed in these Objection Letters. [Testimony of Fathi; Ex. 58, Company's 7/25 response to OIC objections re rate filing; Ex. 56, Company's 7/25 response to OIC objections re binder filing; Ex. 54, Company's 7/25 response to OIC objections re form filing.]

17. The Company resubmitted its July 1, 2013 filing on July 25 with changes the Company believed the OIC required based on the language of the OIC's July 17 and 22 Objection Letters and prior communications with the OIC. [Testimony of Ross; Testimony of Fathi; Ex. 25.] However, on July 31, the OIC disapproved the Company's filings yet again (these filings being those originally filed July 1 and resubmitted with OIC's required changes on July 25), for reasons set forth in the OIC's Disapproval Letter to the Company dated July 31. [Ex. 4, OIC's Disapproval Letter dated 7/31/13.]

18. As of the July 31 date the OIC disapproved the Company's filings, the OIC maintained that the OIC could not accept more amendments or new filings from the Company, for the reason that the Exchange had set July 31 as its deadline for the OIC to submit approved filings to it.

19. Since July 31, 2013 when it received telephone notice that its July 25 filings had been again disapproved, the Company has been attempting to communicate with the OIC to clarify some of the reasons for the OIC's disapproval as stated in the Disapproval Letter dated July 31, and to find out what it can do to address the OIC's reasons for disapproving its filings, e.g., change language in the filing/provide additional justification for its language, etc. However, it is uncontested, and is here found, that the OIC has been unwilling to communicate with the Company since the July 31 date of disapproval. [Testimony of Fathi.]

20. Thereafter, on August 13, 2013 the Company filed its Demand for Hearing to contest the OIC's disapproval of its July 25 filings. [Ex. 1, Demand for Hearing dated August 13, 2013.] The Company also attempted to schedule a meeting to communicate with the OIC to clarify what it could do to address the OIC's remaining reasons for disapproving its July 25 filings. At that time, and as OIC counsel agrees, the OIC advised the Company that the OIC was prohibited

from communicating with the Company because the Company had filed a Demand for Hearing and so now the parties were in litigation; because the parties were in litigation, the OIC advised the Company, the OIC was prohibited from communicating with the Company (apparently even if the Company had its attorney present). No reason was given why the OIC refused to communicate with the Company from July 31 when the OIC disapproved its filings until August 13 when it filed its Demand for Hearing. [Testimony of Fathi.] In addition, the OIC states that it is prohibited from accepting new filings after July 31 and so, the OIC argues, when the OIC disapproved the Company's filing on July 31 there was no opportunity for the Company to amend the filing, or make a new filing, to address the OIC's either continuing or new reasons for disapproval set forth in the July 31 Disapproval Letter. [Testimony of Fathi.] However, the Company testified at hearing, and it was acknowledged by OIC counsel, and is therefore here found, that the OIC has in fact entertained communications, settlement negotiations and new/amended filings with other similarly situated carriers whose filings it disapproved on July 31 even though it has refused to allow any communications with Coordinated Care. [Testimony of Fathi.] When questioned about whether the OIC is not violating its own stated policy prohibiting it to communicate/negotiate with carriers in litigation, the OIC then changed its reason for not communicating with Coordinated Care: the OIC states that it has chosen to communicate only with those carriers whose filings appear to the OIC to be close to being able to be approved. In addition therefore, the OIC would then also be allowing those selected carriers to make new filings after the July 31 deadline in violation of its own stated rule. While there may be some justification for distinguishing between carriers in this way, the OIC would not state how many other carriers were selected for additional negotiation or how many others were being treated in the same manner in which Coordinated Care is being treated, yet the OIC did advise that it selected those carriers with which to continue negotiations based upon the OIC's appraisal, on or about July 31 after it disapproved all or most of the subject filings, of how far apart each carrier was from the OIC's requirements: whether that is sufficient justification is not the subject of this proceeding. Finally, no authority was presented as to how the OIC could violate its stated policy of not communicating with carriers in litigation as to some carriers but not with Coordinated Care, and how it could allow some carriers to violate the OIC's stated filing deadline of July 31 but not Coordinated Care. Coordinated Care argues that it is being treated unfairly in comparison with other carriers. [Coordinated Care Prehearing Brief filed August 26; Testimony of Fathi.]

21. The OIC believes it is possible that Objections 6, 7, 8, 9, possibly 11 and possibly 12 of the total of 15 Objections which were the bases of its disapproval of the Company's July 25 filings could be redrafted and/or reworked so that these filings could be approved. The OIC would have allowed the Company more time to redraft and/or rework these sections had it felt there was enough time before July 31 to accomplish this work and approve the filings. [Testimony of Kreitler.]

22. The OIC believes that Objections 5, 10 and 13 of the total of 15 Objections which were the bases upon which it disapproved the Company's July 25 filings are major obstacles to these filings being approved. [Testimony of Kreitler.]

23. The OIC did not present evidence regarding the level of importance or correctability of its concerns, expressed in its July 31 Disapproval Letter, about the Company's rate filing and binder filing.

24. Contrary to the Company's assertions, there is insufficient evidence to show that the OIC intended only to approve commercial carriers or that the OIC exercised unfair treatment of some carriers over others. The OIC's actions included no intentional malfeasance or ill intent in treatment of this Company. Both the OIC and the Company were both working with their best intentions with complicated new federal laws and regulations which were constantly being reinterpreted and which included nearly impossible time frames. In short, both parties did the best they could in the circumstances with the exception, perhaps, of OIC's refusal to communicate with the Company beginning on July 31 to the current time when at the same time, it was found above, the OIC was communicating with some -- but not all – similarly situated carriers and allowing them to file amendments/make new filings after the July 31 deadline; whether or not the OIC's justification for such selective treatment is valid is not necessary to determine herein.

25. Jay Fathi, MD, President and Chief Executive Officer of Coordinated Care Corporation, appeared as a witness for the Company. Dr. Fathi presented his testimony in a detailed and credible manner and presented no apparent biases.

26. Sara Ross, Manager of New Products and Program Operations for Coordinated Care Corporation, appeared as a witness for the Company. Ms. Ross presented her testimony in a detailed and credible manner and presented no apparent biases.

27. Jason Nowakowski, a principal of Milliman, Inc. and a consulting actuary for the Company, appeared as a witness for the Company. Mr. Nowakowski presented his testimony in a detailed and credible manner and presented no apparent biases.

28. Molly Nollette, Deputy Commissioner for the Office of Insurance Commissioner, Rates and Forms Division, appeared as a witness for the OIC. Although Ms. Nollette has been in this position for just a few weeks, and therefore did not include great detail, she presented her testimony in a detailed and credible manner and presented no apparent biases.

29. Shirazali Jetha, Actuary for the Office of Insurance Commissioner, Rates and Forms Division, appeared as a witness for the OIC in regard to the OIC's review of the Company's rate filing. Mr. Jetha was not involved in the process at issue herein and was not the individual who reviewed the Company's filing. The actuary who did review the Company's rate filings, Lichiou Lee, was unavailable to testify on the hearing date. Because of this, while his testimony was of less value, Mr. Jetha presented his testimony in a detailed and credible manner and presented no apparent biases.

30. Jennifer Kreitler, Senior Insurance Policy and Compliance Analyst, Rates and Forms Division, Office of the Insurance Commissioner, appeared as a witness for the OIC. Ms. Kreitler

was the analyst assigned to review the Company's filings and was the individual directly involved in each step of the OIC's review process of the Company's filings. Ms. Kreitler has substantial, detailed and current knowledge of this process. She presented her testimony in a detailed and credible manner and presented no apparent biases.

CONCLUSIONS OF LAW

Based upon the above Findings of Facts, it is hereby concluded:

1. The adjudicative proceeding herein was duly and properly convened and all substantive and procedural requirements under the laws of the state of Washington have been satisfied. This Order is entered pursuant to Title 48 RCW and specifically RCW 48.04; Title 34 RCW; and regulations pursuant thereto.

2. This matter is governed by Title 34 RCW, the Administrative Procedures Act. The parties agree, correctly, that the Company bears the burden of proof in this matter. As both parties also argue in their presentations at hearing and as case law under Title 34 RCW dictates, the standard of proof to be applied in this matter is preponderance of the evidence. Finally, as stated in the Company's Demand for Hearing, in the Notice of Hearing, as acknowledged by the OIC and also by the Company in its Response to OIC Staff's Motion to Determine Order and Burden of Proof, the central issue in this proceeding is whether on July 31, 2013 the OIC erred in disapproving the Company's binder, form and rate filings for its Bronze, Silver and Gold Individual Exchange Plan Filings for 2014. Therefore, most clearly stated, in this proceeding, the Company bears the burden of proving, by a preponderance of the evidence, that on July 31, 2013 the OIC erred in disapproving Coordinated Care Corporation's June 25, 2013 Bronze, Silver and Gold Individual Plan Filings for 2014.

3. The OIC argues that its review of health plan filings is "Pass or Fail." In other words, the OIC argues, if one section of the filing is not in compliance with applicable statues or regulations, then the entire contract must be disapproved. In fact, the OIC argues that it has no authority to approve a plan which contains even one section which is noncompliant, and argues that it has no option but to disapprove the plan filing. Therefore, the OIC argues, the only question for the undersigned to decide in this matter is whether every section of the Company's July 25, 2013 Exchange plan filings (those most recently disapproved) were in compliance with all applicable federal and state statutes and regulations as of July 31, 2013. The OIC argues that if the undersigned concludes that even one section of these filings was noncompliant on July 31 then the undersigned must uphold the OIC's disapproval of these filings. The OIC's argument has merit, i.e., the OIC certainly cannot approve a filing on the basis of a carrier's statement that it "intends" to contract to have certain providers in its network. However, as set forth above, the central issue in this proceeding is whether on July 31 the OIC erred in disapproving the Company's filings. This contemplates not only whether all sections of the filings comply with all applicable statutes and regulations (hereinafter collectively "rules" unless otherwise noted), but also whether the OIC's process of review was reasonable. If review were based only on whether any single section of the filings violates any rule - in complete disregard of the agency's

review process no matter what the agency did or failed to do - then one can imagine endless scenarios of agency abuse which might occur. While it has been found above that the OIC's actions included no ill intent in treatment of this Company, a determination of the central issue herein must of necessity include not only whether the filings were in compliance with applicable rules but also must include some basic consideration of the review process which the agency conducted; this is particularly true where, as here, the Company raises significant issues regarding the review process and claims that process unreasonably restricted its opportunity to have its filings approved. Indeed, while the OIC argues that the only issue is whether the Company's filings are fully compliant with all applicable rules, at the same time the OIC spent far more time – literally hours – presenting written documents and oral testimony solely regarding its process of reviewing these Exchange filings, both in general and with regard to this Company's filings. Therefore, the OIC itself seems to contemplate that its review process is relevant to determination of the central issue herein.

4. As found above, the OIC would most likely have allowed the Company more time to amend its July 25, 2013 filings to resolve the OIC's remaining concerns had the OIC thought the Company still had time to file these amendments. However, on July 25 when the Company submitted its filings for the sixth time, including more changes it believed the OIC was requiring, because the OIC believed there was not enough time for the Company to amend its filings by the Exchange's July 31 deadline, it simply disapproved the filings. [Testimony of Kreitler.] At the same time, as found above, after the July 31 disapproval the Company contacted the OIC in a strong effort to be able to clarify the OIC's remaining concerns and to be able to file either amendments or a new filing in which the Company intended to include new revisions the Company understood the OIC required. If the OIC had been willing to communicate with the Company then , the Company would have had from July 31 to the current time (over four weeks) to make the changes it understood the OIC to be requiring, because the Exchange is still accepting approved plans from the OIC even now which is over four weeks after its July 31 "deadline."

5. The OIC had discretion to give the Company additional time to remedy the issues raised in its objections. E.g., the rules requiring health maintenance organizations to utilize SERFF are set forth in WAC 284-46A, which provides that "*The Commissioner may reject and close any filing that does not comply with WAC 284-46A-040, -050, and -060.*" [Emphasis added.]

6. RCW 48.44.020 similarly provides that "*[t]he commissioner may*" disapprove contract forms that are statutorily deficient. [Emphasis added.]

7. Further, neither the OIC nor the Exchange is precluded by federal or state law from permitting the Company to make changes following the Exchange's July 31, 2013 deadline/guideline for the OIC to send approved health plans to the Exchange for certification. Federal regulations implementing the ACA provide the Exchange with broad discretion to design processes for QHP certification, and the only applicable deadline established by federal law is that QHP certification must be completed before the start of open enrollment on October 1, 2013. 45 CFR Sec. 155.1010. And while the Exchange is required to transmit certain plan data to the

Center for Medicare and Medicaid Services ("CMS") for financial purposes, there is no deadline in federal law for when the Exchange must do so. In short, July 31 was not a federally-established deadline by which the OIC was mandated to begin 1) refusing to allow amendments to existing filings; 2) refusing to allow new filings; or 3) refusing to communicate with carriers whose filings had been disapproved by the OIC on July 31 or another time. Indeed, the OIC itself opened a submission window through August 9, 2013 for the refiling of on-exchange plans after the Exchange communicated its willingness to consider plans filed through that date. Although the OIC subsequently changed its position and decided to stay with the original July 31 deadline, that activity indicates that the OIC's and Exchange's internal deadlines are somewhat flexible. Furthermore, the Exchange Board voted at its August 21 meeting to delay certification of any filed plans until the OIC could address the pending appeals regarding the disapproved plans, agreeing to meet again on September 4, 2013. This activity indicates that the Exchange desires to provide carriers with more time to demonstrate that they can offer Exchange plans in order to provide Washington residents with adequate health insurance options. The Exchange's actions suggest that it is willing to exercise flexibility to ensure that the greatest number of conforming plans can be offered on the Exchange.

8. The OIC's discretion to accept filings after July 31 also extends to allowing carriers the opportunity to edit contract language and plan data after submission. Indeed, federal law provides a model for this, providing a period of time expressly intended for the correction of errors in plan data following submission of data to CMS which is called the "Plan Preview" process.

9. The OIC's advice to the Company that it was prohibited from communicating with the Company because the Company had filed a Demand for Hearing is not supported by law. Applicable law allows the OIC staff (not formal counsel) to communicate with entities after they have filed a Demand for Hearing although courtesy – not law – might require that the OIC staff communicate only in the presence of (or with the permission) of the entity's attorney. Perhaps the OIC meant that its policy, not a law, was to refuse to communicate with entities after they have filed a Demand for Hearing; if this is the situation, although it would regrettably impede any possibility of settlement, the OIC should have made it clear to the Company that it has a policy of refusing to communicate after a Demand for Hearing is filed because to advise that a law prohibits the OIC from such communication is disingenuous.

10. When reviewing the OIC's reasons for disapproval of these filings as set forth in its July 31, 2013 Disapproval Letter, the Company's evidence showed that the Company does not disagree with the amount and type of coverage which must be covered. The parties' differences were in those sections where the Company believed its language was clear and the OIC did not believe it was clear. While the OIC's reasons for disapproval of several sections were valid in that the language is indeed unclear and/or misleading (see below), in each case both parties intend the same result and the Company has stood ready to amend its language to meet the OIC's concerns since July 31. As found above, the OIC has selected some other carriers with which it will communicate – and has communicated – after July 31 and is allowing those other carriers to make changes after July 31 to remedy the OIC's concerns expressed in their July 31 Disapproval

Letters. While this selective process may have reasonable bases, the recognition that the differences between the OIC's concerns and the Company's positions - including its willingness to amend its language to address the OIC's concerns – leaves this selective process in question in this specific situation. Therefore in order to ensure the Company is given similar opportunities to amend its language as other carriers have been given, the parties should promptly work together to amend the Company's language to the satisfaction of the OIC but applying the guidance in the Conclusions below. Further, the OIC should allow amendments to its July 25 filings (including allowing a new filing to be made if that is the proper mechanism to allow amendments since the OIC actually disapproved this July 25 filing on July 31) so that the Company has the opportunity - along with other similarly situated carriers whose filings were disapproved on July 31 and at least some of whom also appealed their disapprovals - to have its filings approved. Said conference between the parties on the wording of these sections, filing of amendments/new filing and approval should be done promptly so that the Company's filings might be approved and presented to the Exchange for certification for sale in 2014. While approval of the Company's filings is still within the authority of the OIC, the review process at this point must be governed by the Order herein. The OIC is expected to incorporate the Conclusions below, i mmediately meet and/or otherwise communicate with the Company to discuss OIC's remaining concerns, review language, provide recommendations for language to the Company and review the Company's filings (incorporating the Conclusions below into the OIC's requirements). Given that the Company has indicated it is anxious to make the amendments the OIC requires - and just asks that the OIC make clear what changes it is requiring (so long as they are consistent with the Conclusions below) so that it can make the changes - it is expected that the OIC can approve these filings in short order provided the Company does make the changes the OIC requires at this time.

11. As above, the OIC believes that Objections 6,7, 8, 9, and possibly 11 and 12, of the total of 15 Objections which were the bases of its disapproval of the Company's July 25 filings could be redrafted so that these filings could be approved. [Testimony of Kreitler; Ex. 4.]

> *6. The "Adding An Adopted Child" provision is still too restrictive in conflict with RCW 48.01.180 and RCW 48.46.490. First, it is unclear why* [the Company] *has added additional language defining conditions of "placement". Second, it is unclear what the "written notice" is a parent must provide regarding the intent to adopt the child. The enrollee is only required to apply for coverage for the new dependent.*
>
> While the OIC's above reason for its disapproval of this section is unclear, at hearing the OIC advises that at this time its only objection is that the Company needs to require the consumer to send an "application" to the Company to secure coverage rather than requiring to send the Company "written notification." However, the applicable statute, RCW 48.46.490, requires the consumer to provide "written notice" to the Company. Indeed, requiring "written consent" is actually less restrictive for the consumer and not more restrictive. Therefore, that remaining portion of OIC's Objection No. 6 is of no merit and the Company is in

compliance with RCW 48.46.490. In its testimony the OIC presents no other remaining argument that this section is noncompliant.

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

While the OIC's above reason for disapproval of this section is unclear, both parties intended that these plans cover dependent members as required by RCW 48.46.320. While the Company asserts it intends to cover dependent members in all situations required by RCW 48.46.320, the OIC's concern is valid: the current language is unclear and leads the consumer to believe that a dependent child over age 26 can remain on the parents' policy only if that child had a "continuous total incapacity." To provide clear language that indicates that dependent member coverage is broader and in compliance with RCW 48.46.320, the OIC should promptly review and/or suggest amended language which would meet its concern that the current language is misleading.

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

While it was not clear in the OIC's July 17, 2013 Objection prior to disapproving the filing or in its July 31 Disapproval Letter, in its brief and at hearing the OIC argues that this provision violates RCW 48.46.060(3)(a) and (d) and the ACA in that a carrier may not place restrictions on access to any FDA-approved contraceptive drugs or devices and the Company's proposed method of limiting provision of brand name drugs vs. generics is appropriate but when it does this it must still accommodate any individual for whom generic drugs or brand name drugs would be medically inappropriate. Therefore, the OIC advises the language must include a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version in these situations and the Company's contract does not. The Company does not disagree, arguing that its language does not place restrictions on access to <u>any</u> FDA approved contraceptive drugs or devices, and under a plain reading of this provision all "prescription drug contraceptives" are covered under the plan without exception. The Company also argues that the note at the bottom of that contract page also does not limit the types of services and, to the contrary, it explains to the consumer how she can have prescription birth control pills covered at 100% rather than the cost-sharing percentage normally required for these types of drugs. While the OIC's objection about lack of waivers for cost-sharing is new as of July 31, the Company believes that is already addressed to the extent it is required. The OIC should promptly review and/or suggest amended language which would meet any remaining

concerns that the current language is misleading or does not comply with RCW 48.46.060(3)(a) and (d) and the ACA.

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

The OIC first brought up the fact that its concern here was that this section unreasonably limits the type of durable medical equipment covered for individuals on home health care in its pre-hearing brief filed long after the date of its disapproval of these filings. Prior to this time, the OIC's concern had been in regard to Ambulatory Care and not Home Health Care Service Benefits. [Ex. 53, July 22 OIC Objection Letter.] However, directing the OIC's concern relative to the Health Care Service Benefits provision, the OIC's argument that this provision is misleading is valid. As the OIC asserts, this issue would be fairly quickly cured if the Company cross-referenced this section and the Durable Medical Equipment section of the contract or otherwise made minor changes to this wording so it is clear that an adequate amount and variety of durable medical equipment is covered in this contract for individuals on home health care. The OIC should promptly review and/or suggest amended language which would meet its valid concern that the current language is misleading or does not comply with WAC 284-43-878(1).

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

While the OIC raised this concern for the first time in its July 31, 2013 Disapproval Letter, the Company advises that the OIC has mistakenly characterized this coinsurance maximum as a deductible which it is not, that the $350 does not represent a deductible nor is it an additional amount that is charged to the consumer. Here, the consumer would be obligated to pay a certain percentage of the bronze product and specialty drugs under the policy regardless of this provision and the maximum just places a cap on that amount. It has no impact on the deductible; coinsurance is paid in addition to the deductible. Therefore, the Company argues that it has not obligation to make any revisions to the filings. The Company's interpretation of the requirements of RCW 48.46.060(3)(a) appear reasonable. If, however, there is any language which the OIC believes would make this provision more clear to the reader then the OIC should promptly review and/or suggest amended language which would meet any

remaining concerns that the current language is misleading or does not comply with RCW 48.46.060(3)(a).

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

While the OIC is correct that the wording in this section is misleading at best and is a major concern, at the same time it can be quickly corrected.. The OIC raised this concern for the first time in its Hearing Brief. [OIC Hearing Brief, p. 18.] As argued there, the OIC believes that the Premiums section of the contract violates RCW 48.43.005(31) and RCW 48.46.064(1)(a) because 1) the inclusion of the phrase "[f]rom time to time, we will change the rate table used for this contract form" is not a true statement because rates may only be changed yearly. The OIC is correct and this concern is valid. The OIC also argues 2) that the inclusion of the phrase "[t]he contract, and age of members, type and level of benefits, and place of residence on the premium due date are some of the factors used in determining your premium rates" is incomplete because it does not expressly list the five reasons included in RCW 48.46.064(1)(a)(i-v). The OIC is correct and this concern is valid. While the Company argues that neither concern is valid, had the OIC advised it that it required a change in this language it would have done so quickly. As above, the Company should be given the time to promptly change the wording in 1) above to make clear that the rates for the contract can change only yearly, and 2) to advise the consumer all the factors considered in determination of rates (by cross-reference or other means).

12. The OIC believes that Objections 5, 10 and 13 of the total of 15 Objections which were the bases upon which it disapproved the Company's July 25 filings are major obstacles to these filings being approved. [Testimony of Kreitler.]

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

This is the network adequacy issue, which was the subject of very substantial evidence presented by both parties. As found above, the OIC conducted two Network Reviews of the Company's network, and on July 10, 2013 conducted another Network Review, had multiple discussions with the OIC about its requirements and remaining concerns, filed its Network Access Agreement with Healthways which "rented" some network providers such as other carriers were doing, filed its Network Access Plan with the OIC, and were by these efforts able to clear up many of the concerns the OIC had with the Company's network adequacy. After lengthy argument and testimony, at hearing the OIC advised that its remaining concerns about this issue are 1) the Company has no massage

therapists in its provider network; 2) the Company has no Level 1 Burn Unit or pediatric specialty hospitals in its network; and 3) the Company is not allowed to use "spot contracts" or "single payer agreements" to complete its network of providers because, e.g., the Providers under the Company's plan are prohibited from balance billing the consumer (which those "spot contract" providers would do).

a) No massage therapists in network. Massage therapists are included in the Company's network as required. This has been done through the Company's Network Access Agreement with Healthways. By either July 30 or 31 – i.e. before disapproval of the filings – the Company's Network Access Agreement with Healthways had been deemed approved by the OIC pursuant to RCW 48.46.243(3)(b). Although the Plan Summary did not include massage therapists when describing the Healthways providers available to the consumer, the Plan Summary is not part of the contract between the Company and Healthways. However because the Plan Summary does provide information to the consumer and does mistakenly fail to include massage therapists in its list of included providers, the Plan Summary must be corrected immediately to clarify that the Company's network (through Healthways) does in fact include massage therapists.
b) Lack of specialty hospitals providing Level I Burn Unit and pediatric services in network. As the Company argues, carriers are not required to include Level I Burn Units or pediatric hospitals in their networks. Rather, pursuant to WAC 284-43-200, carriers are required to include sufficient facilities to ensure that all health plan services, including Level 1 burn services, are accessible to consumers without unreasonable delay and within reasonable proximity to the business or personal residence of covered persons, taking into consideration the relative availability of health care providers or facilities in the service area under consideration and the standards established by state agency health care purchasers (such as the Medicaid program in which the Company currently participates). Under WAC 284-43-200(2), sufficiency and adequacy of choice may be established by the carrier with reference to any reasonable criteria, including provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation and the volume of services available to serve the needs of covered persons requiring this specialty care. WAC 284-43-200(2) provides that evidence of compliance with the network adequacy standards that are substantially similar to standards established by state agency purchasers (e.g. Medicaid) may also be used to demonstrate sufficiency. For these reasons, and the fact that the Company's network is substantially similar to the

standards established by Medicaid - which the OIC agrees it does, and which is demonstrated in its Network Access Plan – the Company has shown that its network is adequate as to these specialty demonstrates its network sufficiency. .

c) The OIC argues that the Company is not allowed to use "spot contracts" aka "single payor agreements" to complete its network of providers. The OIC argues that this prohibition is primarily because the consumer is not protected in those situations from being balance billed by the provider hired under the "single payor agreement." Further, the OIC argues that the Company's contract language does not protect the consumer from balance billing either. Virtually all carriers on occasion use "single payor arrangements" in provision of network services, e.g., when the consumer is traveling out of his own service area; in the case of an emergency; when the type of services rendered by that provider are not commonly required. Indeed, at hearing the OIC read language from a Regence health contract which specifically allowed for such "single payor agreements" and described one such type of services as those rendered by pediatric specialty hospitals. [Testimony of Kreitler.] The Company does include sufficient facilities to ensure that all health plan services – including pediatric and Level I Burn Services – are accessible to consumers without delay and within a reasonable area, and it permitted under WAC 284-43-200 to arrange for "single payor agreements" in the case that a pediatric specialty hospital is required or a Level I Burn Unit is required. Therefore, by this showing, and by the fact that the Company's plan is substantially similar to its Medicaid network, the Company is not required to have included pediatric specialty hospitals or Level I Burn Units within their provider network.

However, the OIC is correct that the Company's contract language is unclear about the fact that the consumer cannot be subject to balance billing in any situation, whether the provider is one working through an "individual payor agreement" with the Company or whether the provider is a regular Company network provider or whether the provider is a Company network provider through Healthways. The Company must promptly change its contract language in this section to clearly inform the consumer that he is protected from balance billing in all of these situations. Clear language which has been deemed approved by the OIC is found in the Regence contract read into the record at hearing. Further, although the OIC does not require carriers to file their "single payor agreements" with the OIC, in this particular situation, given the OIC's concern, the Company shall promptly provide to the OIC the form of "single payor agreement" which it will use when needed; the form must include a hold harmless clause

complying with applicable rules so that the OIC has assurance that the consumer is protected from balance billing in any of these three situations.

10. The Bronze Product, Specialty Drug benefit includes a $350 maximum "eligible coinsurance charge" before the service is paid at 100%. This dollar amount is a deductible and must be set forth in the policy, rate, and binder as such. The benefit as stated in the policy is misleading per RCW 48.46.060(3)(a0 [sic].

The OIC identified this section as a concern for the first time on July 31, 2013 (apparently of necessity as this language was first included in the Company's filings in its July 25 filing). The OIC argues that the Company seeks to place a $350 deductible on specialty drugs, which deductible does not exist for other drugs and thus is illegally discriminatory against enrollees who have health conditions that require these drugs and is a violation of the community rating requirement, citing RCW 48.46.064 and WAC 284-43-877(9)(c). In addition, the OIC argues that a policy may not include a hidden deductible such as this, which misleads consumers in violation of RCW 48.46.060(3)(a). Once again, the parties do not disagree on the requirements of the rules but only on whether the wording accurately represents the statutory requirements. For this reason, the OIC should promptly review and/or suggest amended language which would meet any remaining concerns that the current language is misleading or does not comply with RCW 48.46.064 or WAC 284-43-877(9)(c).

13. The Pharmacy Benefit Template, Plants and Benefits template and policy do not match. For example, HIOS Plan ID 61836WA0030001 defines it will use Formulary ID WA F003. Formulary ID WAF003 is a 4-tier pharmacy option utilizing copay cost share requirements. The Schedule of Benefits for this Bronze Product defines certain drug tiers are subject to coinsurance [sic]. *WAF003 does not include any coinsurance requirements.*

The OIC first identified this concern to the Company in its July 31, 2013 Disapproval Letter (of necessity as apparently the template was not filed with the OIC until July 25 and up until that time this information had been provided as "TBD"). The OIC advises that this provision can be remedied if the Company changed "co-pay" to "co-insurance" in the three places identified in the contract. [Testimony of Kreitler.] Therefore the OIC should promptly review and/or suggest amended language which would meet any remaining concerns that the current language is misleading or does not comply with applicable rules.

13. The OIC did not present evidence regarding the level of importance or correctability of its concerns, expressed in its July 31 Disapproval Letter, about the Company's rate filing and binder filings. They are these, in total:

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

First, the Company asserts there are no statutes or regulations that require it to include the counties offered in its plans onto a "rate schedule" or in a Rate/Rule Schedule tab, nor did the OIC provide any authority for this requirement. Second, the Company argues that the OIC has had since May 1 to identify this alleged deficiency but raised it for the first time on July 31; and had the Company been notified this was a concern it would have been easily remedied. However, the Company argues that it had already clearly identified the counties that were offered in its plan in its product submission. [Revised Product Submission, submitted July 25, 2013.] The Company also argues that the offered counties were also included in its Form A submissions with the most updated list included in the off-cycle Form A submitted July 25 and as part of its binder submission, and that therefore there should have been no question regarding which counties were included in the Company's plan. Testimony presented by the Company was persuasive and indeed, there appears to be no clear authority for the OIC to require anything further from the Company at this time. The OIC staff actuary who reviewed this rate filing presented no evidence, and little value could be placed on nonspecific evidence from an OIC actuary who had not reviewed this filing and could only testify generally. For this reason, the OIC should promptly review this requirement in light of this Conclusion.

2. You did not provide methodology, justification, and calculations used to determine the contribution to surplus, contingency charges, or risk charges included in the proposed base rates. Furthermore, your definition of "profit" and "contribution to surplus" is inconsistent with WAC 284-43-910(13).

The OIC argues that the Company failed to provide methodology, justification and calculations used to determine the contribution to surplus, contingency charges, or risk charges included in the proposed base rates. However, based upon 1) evidence and argument presented by the Company and its consulting actuary; and 2) evidence and argument presented by the OIC which lacked evidence from its reviewing actuary and presented unclear evidence from another OIC actuary who had not been involved in this review, it is concluded that the Company showed that it has provided methodology, justification and calculations as required. [Testimony of Jason Nowakowski, Principal and Consulting Actuary with Milliman, Inc. in Seattle; Testimony of OIC Actuary Shirazali Jetha.] This concern is of no validity.

3. You did not submit the calculations and justification of the area factors. You mentioned that Exhibit 3 describes the expected reimbursement level as a

percentage of Medicare and rating factors by rating area. However, there is no Exhibit 3 attached to the rate filing.

The Company did attach Exhibit 3 to the rate filing as required. [Testimony of Nowakowski; Testimony of Jetha.] This concern is of no validity.

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

The Company attached Exhibits 4A and 4B to the rate filings as required. [Testimony of Nowakowski; Testimony of Jetha.] This concern is of no validity.

14. The OIC's reasons for disapproval of the Company's Binder filing are included at Nos. 14 and 15 of its Disapproval Letter, as follows:

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

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

In its Hearing Brief, the OIC admits that these objections were "simply technical corrections." [OIC's Hearing Brief, p. 19.] Although the OIC does not cite to any statute or regulation that requires the changes it required in Nos. 13 and 14, had the OIC raised these issues prior to disapproving the filings on July 31, 2013 the Company could have remedied these issues fairly quickly. For this reason, the OIC can require the Company to make these technical corrections, but they cannot be an obstacle to approval of the Company's filings.

15. Based upon careful consideration of the evidence presented, and the arguments of the parties, and upon the above Findings of Facts and Conclusions of Law, it must be recognized that the specific situation involved in this particular review of the Company's filings is unique. This situation involves uniquely short time frames mandated by the ACA for review and approval of the Exchange filings (as opposed, e.g., to the more normal File and Use process of OIC approvals of filings); it involves uniquely complex new federal statutes which were the subject of over 100 new federal regulations, interpretations, reinterpretations and other dictates and changes thereof; and it involves already complex state rules and other uniquely difficult challenges for both the OIC, the Exchange and carriers seeking approval and certification to sell their products through the Exchange. Allowing a window of time for modifications following the submission deadline is well within the OIC's discretion and in full accord with federal rules and the clear goals of both federal authorities and the Exchange. Under the circumstances presented here,

permitting the Company to quickly make modifications as indicated above is reasonable and appropriate. For the OIC to now fail to provide the Company with a short time period, and good communication and cooperation, in order to allow the Company to address the OIC's concerns as identified in its Disapproval Letter (as modified by the Conclusions above) would be to invite a consideration that the OIC might have erred in disapproving the Company's filings on July 31. For the OIC to use its discretion in allowing the Company to quickly make modifications now – so that the Company has the opportunity to gain approval and certification to sell its products through the Exchange for 2014 is reasonable and permissible and would both ensure that the Company is in compliance with applicable rules and ensure the OIC's review process was reasonable under these unique circumstances.

ORDER

On the basis of the foregoing Findings of Facts and Conclusions of Law,

IT IS HEREBY ORDERED that the Washington State Insurance Commissioner shall allow the Company a short period of time, which would still accommodate the Exchange in its responsibilities, in which to make new/amended filings which remedy the OIC's concerns expressed in its July 31, 2013 Disapproval Letter (as modified by the Conclusions above);

IT IS FURTHER ORDERED that it is expected that, beginning on the date of entry of this Order, the OIC will provide prompt, reasonable guidance and recommended language to the Company as appropriate to assist the Company in remedying the OIC's concerns expressed in its July 31, 2013 Disapproval Letter (as modified by the Conclusions above), with the common goal of assisting the Company in obtaining the OIC's reasonable review and approval of its filings in time to be certified by the Exchange for sale in 2014;

IT IS FURTHER ORDERED that the OIC shall give prompt review and reasonable approval of the Company's filings provided the Company has addressed the reasons for disapproval set forth in the OIC's July 31, 2013 Disapproval Letter (as modified by the Conclusions above) to the reasonable satisfaction of the OIC and being guided by the above Findings of Fact and Conclusions of Law above;

IT IS FURTHER ORDERED that in light of the unique circumstances of this matter, this proceeding shall remain open until the Company has made new/amended filings, through the Company's and OIC's communications together, and until the OIC has made determination concerning approval of these new/amended filings. At that time, the parties shall notify the undersigned of the disposition of the OIC's review of the Company's amended/new filings;

IT IS FURTHER ORDERED that, also in light of the unique circumstances of this matter, should the parties have questions about the above Conclusions of Law as they relate to the approvability of any new/amended filings, they may contact the Hearings Unit to discuss the issue, which would involve the parties and the undersigned, in an effort to promptly resolve any

outstanding issues which might otherwise delay prompt settlement of any issues concerning new language and/or the OIC's review and reasonable approval thereof.

ENTERED AT TUMWATER, WASHINGTON, this 3rd day of September 2013, pursuant to Title 48 RCW and specifically RCW 48.04 and Title 34 RCW and regulations applicable thereto.

PATRICIA D. PETERSEN
Chief Presiding Officer

Pursuant to RCW 34.05.461(3), the parties are advised that they may seek reconsideration of this order by filing a request for reconsideration under RCW 34.05.470 with the undersigned within 10 days of the date of service (date of mailing) of this order. Further, the parties are advised that, pursuant to RCW 34.05.514 and 34.05.542, this order may be appealed to Superior Court by, within 30 days after date of service (date of mailing) of this order, 1) filing a petition in the Superior Court, at the petitioner's option, for (a) Thurston County or (b) the county of the petitioner's residence or principal place of business; and 2) delivery of a copy of the petition to the Office of the Insurance Commissioner; and 3) depositing copies of the petition upon all other parties of record and the Office of the Attorney General.

Declaration of Mailing

I declare under penalty of perjury under the laws of the State of Washington that on the date listed below, I mailed or caused delivery through normal office mailing custom, a true copy of this document to the following people at their addresses listed above: Jay Fathi, M.D., Katie Rogers, Maren Norton, Esq., Barbara Nay, Esq., Mike Kreidler, James T. Odiorne, John F. Hamje, Esq., Marcia Stickler, Esq., and Annalisa Gellermann, Esq.,

DATED this 3rd day of September, 2013.

KELLY A. CAIRNS

DECLARATION OF MOLLY NOLLETTE IN SUPPORT OF MOTION TO DISMISS ADJUDICATIVE PROCEEDING

OIC CASE NO. 13-0293

EXHIBIT E

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

Phone: (360) 725-7000
www.insurance.wa.gov

FILED

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Hearings Unit, OIC
Patricia D. Petersen
Chief Hearing Officer

OFFICE OF
INSURANCE COMMISSIONER

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October 31, 2013

Carol Sue Janes, Esq.
Michael Madden, Esq.
Bennett Bigelow & Leedom, P.S.
601 Union Street, Suite 1500
Seattle, WA 98101

RE: Motion for Leave to Intervene in
Coordinated Care Corporation, Matter No. 13-0232

Dear Ms. Janes and Mr. Madden:

On October 24, 2013, the Hearings Unit received your Motion for Leave to Intervene in the above referenced proceeding. As of the date you filed your Motion for Leave to Intervene, it was nearly two months after the time for evidence to be presented at hearing - and indeed even nearly two months since even my Final Order in this case was entered. As reflected in my Notice of Hearing entered August 16, 2013, the hearing in this matter, including presentation of all evidence and argument on the issues involved in this case, commenced on August 26, 2013 and terminated on August 28, 2013. After consideration and review of all evidence and argument presented at hearing, I entered the Final Order in this case on September 3, 2013. Subsequently, the Insurance Commissioner filed his Motion for Reconsideration of this Final Order on September 6, 2013.

Pursuant to the Washington Administrative Procedures Act and most specifically RCW 34.05.443 of the Act, and Washington Rules of Court Civil Rule 24, and cases applicable thereto, had you filed a Motion for Leave to Intervene before the hearing terminated on August 28, 2013,

you would have had the right to present relevant evidence and argument, and conduct discovery, just like either of the two parties involved in this case. Also, as stated in my Notice of Hearing entered August 16, 2013, all administrative hearings before this agency are open to the public and interested parties are encouraged to participate either in person or by telephone free of charge. My Notice of Hearing in this case states: *All interested individuals and entities who have questions or concerns concerning this proceeding should direct them to* [the undersigned's] *paralegal, Kelly Cairns, at the same address.* However, because you filed your Motion for Leave to Intervene after the hearing was terminated on August 28, 2013 - and indeed also after I had entered my Final Order on September 3, 2013 - your right to intervene is affected.

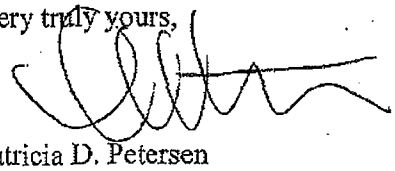
While my Order on Reconsideration is not yet entered, as you know, generally, motions for reconsideration cannot include new evidence, and neither the OIC in its Motion for Reconsideration nor Coordinated Care in its Response in opposition to the OIC's Motion for Reconsideration has attempted to present any new evidence. Both have, however, opposed granting your Motion for Leave to Intervene based upon the above authorities. Along with the parties, my conclusion is it would be inappropriate for me to grant your Motion for Leave to Intervene at this late stage of the proceeding. Again, this is because, briefly, pursuant to Title 34 RCW and the Washington Rules of Court, the Motion for Reconsideration which is before me now is confined to that evidence which was presented at hearing. Essentially, under those rules when interested parties had adequate opportunity to intervene and present argument and evidence at hearing but did not, it is inappropriate to allow such new evidence and argument to be presented on reconsideration. Additionally, it does not appear to me that either the facts or decision in the case law you cited are close enough to the situation at hand to justify granting you leave to intervene now on the basis of that case law.

As above, if you had submitted your Motion for Leave to Intervene at any time prior to, and any time up until termination of the hearing on August 28, 2013, your participation in this case would have been welcomed. However, it was simply filed too late to be granted intervention. My Order on Reconsideration will be entered shortly. It may be that - if this case is appealed to the Superior Court by one of the parties (which would occur after entry of my Order on Reconsideration, if at all) - you may want to consider whether Superior Court rules provide you with the right to file a Motion for Leave to Intervene in the appeal, or to otherwise participate, in that appeal although I suspect your research on this issue might reveal that Title 34 RCW, the Administrative Procedure Act, and regulations limit evidence on appeal to that evidence which was presented in the administrative hearing below.

I am sorry to have to provide this information to you, particularly because, as above, administrative hearings before this agency are open to all interested parties and the public both in person and over the telephone free of charge and statements and evidence, and intervention, from

interested parties are all encouraged. It is just that in this particular situation, pursuant to the applicable rules cited above, your Motion for Leave to Intervene was filed too late and therefore must be denied.

Very truly yours,



Patricia D. Petersen
Chief Presiding Officer

cc (via email):

Jay Fathi, M.D., Pres., Coordinated Care Corp.
Katie Rogers, Vice Pres. of Compliance and Reg. Affairs, Coordinated Care Corp.
Maren Norton, Esq., Stoel Rives LLP
Barbara Nay, Esq., Stoel Rives LLP
Mike Kreidler, Insurance Commissioner
James T. Odiorne, J.D., CPA, Deputy Insurance Commissioner
Molly Nollette, Deputy Commissioner, Rates and Forms Division
AnnaLisa Gellermann, Esq., Deputy Commissioner, Legal Affairs Division
Andrea Philhower, Staff Attorney, Legal Affairs Division