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BEFORE THE STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

In the Matter of)	Docket No. 13-0293
)	
Seattle Children's Hospital,)	ORDER ON SEATTLE CHILDREN'S
)	HOSPITAL'S MOTION FOR
A Washington Not-For-Profit Corporation,)	PARTIAL SUMMARY JUDGMENT
)	
and)	
)	
Coordinated Care Corporation, a Health)	
Maintenance Organization; Bridgespan)	
Health Company, a Health Services)	
Contractor; and Premera Blue Cross,)	
a Health Services Contractor,)	
)	
Intervenors.)	

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NATURE OF PROCEEDING

The purpose of this proceeding was to review, consider and enter the final decision regarding Seattle Children's Hospital's ("SCH") Motion for Partial Summary Judgment. Under the federal Affordable Care Act ("ACA") and state law, the Washington State Office of the Insurance Commissioner ("OIC" or "Commissioner") has the duty to ensure that all individual health care plans intended to be sold through the Washington State Health Care Exchange ("Exchange plans") meet the requirements of the ACA and state law. In July and October, 2013, the OIC reviewed and approved the individual market Exchange filings of Coordinated Care Corporation ("CCC"), Premera Blue Cross ("Premera") and Bridgespan Health Company, a subsidiary of Regence BlueShield ("Bridgespan"). Thereafter, SCH filed a Demand for Hearing to contest the OIC's approvals of these Exchange plans alleging that, contrary to the requirements of the ACA and state law, they do not include SCH in their networks. CCC, Premera and Bridgespan were subsequently granted the right to intervene (hereinafter collectively referred to as "Intervenors" unless otherwise indicated). Pursuant to a briefing schedule agreed to by the parties on November 18, 2013 and so ordered by the undersigned, on January 17, 2014 SCH filed a Motion for Partial Summary Judgment, Declaration of Michael Madden in Support of SCH's Motion for Partial Summary Judgment and Declaration of Eileen O'Connor in Support of Seattle Children's Hospital's Motion for Partial Summary Judgment; on January 29 the OIC filed OIC's Opposition to SCH's Motion for Partial Summary Judgment; on January 30 the Intervenors filed their Intervenors' Joint Opposition to SCH's Motion for Partial

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Summary Judgment; and on January 31 SCH filed the Declaration of Carol Sue Janes in Support of SCH's Motion for Partial Summary Judgment. As agreed to by the parties and properly scheduled, SCH, OIC and the Intervenors presented their oral arguments on SCH's Motion for Partial Summary Judgment on February 3.¹

In its Motion herein, SCH asks for a ruling as a matter of law that the OIC, in its review and approval of the Exchange plan filings of CCC, Premera and Bridgespan 1) failed to consider or apply controlling federal law under the ACA which requires that Exchange plans include pediatric hospital services within their networks unless certain conditions are shown to exist; 2) failed to give required consideration to the fact that a significant amount of pediatric *essential health benefits* required by the ACA to be covered in Exchange plans are available in this state only at SCH; and 3) failed to consider the consequences of allowing these plans to exclude SCH from their Exchange networks. SCH requests, for these reasons, that the OIC's approvals of these three Intervenors' Exchange plans be vacated with direction to the OIC to re-review them based on proper application of the ACA and proper consideration of the fact that a significant amount of *essential health benefits* required by the ACA to be covered in Exchange plans are available only at SCH.

**SEATTLE CHILDREN'S HOSPITAL'S ARGUMENTS IN SUPPORT OF
PARTIAL SUMMARY JUDGMENT – OIC's and INTERVENORS' RESPONSES**

Briefly, SCH states that none of the Intervenors' OIC-approved Exchange plans have contracted with SCH to provide services to plan participants. The OIC admits² that SCH is one of only two children's hospitals located in Western Washington and one of only three in the state, SCH is an *essential community provider* as defined in the ACA, and that most of the services SCH provides are *essential health benefits* required by the ACA to be covered in Exchange plans. SCH asserts that a significant number of essential health benefits required by the ACA to be included in Exchange plans are provided only in this state by SCH ("unique services") and while the OIC admits that some of SCH's services are unique³ it advises in discovery that it cannot determine the amount of SCH's services which are unique.⁴ Intervenors simply assert that their Exchange plans, without inclusion of SCH in their networks, are comprehensive and have been determined to meet the ACA's network adequacy requirements.

SCH argues that because it is the preeminent provider of pediatric specialty services in the Northwest with many of these services being unavailable elsewhere in the Northwest,⁵ it is

¹ Throughout SCH's Motion herein, SCH references and incorporates arguments and evidence presented in the OIC's Motion to Dismiss filed January 15, 2014 and Intervenors' Joint Motion for Summary Judgment filed January 17, 2014, along with the record in *Coordinated Care Corporation*, Docket No. 13-0232. In addition, Intervenors have referenced the *Coordinated Care* record in their arguments. For these reasons, where these sources have been referenced, they have been considered in entering the decision herein.

² Declaration of Madden, Ex. A, SCH's First Requests for Admission to the OIC with Responses dated December 11, 2013; OIC's Opposition to SCH's Motion for Partial Summary Judgment.

³ OIC's Opposition to SCH's Motion for Partial Summary Judgment.

⁴ Declaration of Madden, Ex. A, SCH's First Requests for Admission to the OIC with Responses.

⁵ Declaration of O'Connor, pp. 1-3.

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inevitable that children covered by the challenged Exchange plans will require covered services available only at SCH and when those children require those services they will be able to access those services only 1) by being required to pay the substantially higher out-of-pocket costs of that out-of-network care; or 2) by submitting a request to the Exchange plan for review and possible approval to have those specific covered services provided to that specific child for a specific time period under a "single case agreement"⁶ so SCH would be treated as an in-network provider for that specified situation only. Where an out-of-network provider, and thus a "single case agreement," is required to obtain the covered service needed by the child, SCH asserts, this process would most likely a) result in additional delay awaiting submission of the request from the child or out-of-network provider to the Exchange plan, and the Exchange plan's review and possible approval, which would result in the likelihood that when the child presents for care he or she will be more acutely ill and require additional or more complex services; b) result in lack of clarity as to what services would be included (among many interrelated, interdependent services that could be necessary for the care of the child) the Exchange plan had agreed would be included in the "single case agreement" and what services would not be included (leaving the child's family being required to pay the substantially higher charges for those services the Exchange plan did not agree would be included in the "single case agreement" even those excluded services are also covered services in the Exchange plan's contract); and c) result in financial loss to SCH arising from a substantial expenditure of additional services in preparing, submitting and negotiating "single case agreement" for these patients.⁷ SCH also asserts financial loss to SCH (and the covered patients) would occur because numerous children would seek care from SCH just because it is the only provider of the required covered services, even though SCH is not in the Exchange plans' networks⁸ and even though those children's requests for "single case agreements" might already have been denied.

SCH advises that during the first month the ACA took effect (January 2014) SCH received over 200 requests for "single case agreements" requesting approval for SCH's inpatient and outpatient services for children covered under Premera's Exchange plan alone. Of these over 200 requests, as of January 27, 2014 Premera has approved 21 of them, denied eight of them, and the remainder are still pending Premera's action, which has resulted in delays to SCH in confirming whether appropriate reimbursement will be received for services.⁹ This 200+ number of requests for "single case agreements" relative to the Premera Exchange plan alone is

⁶ "Single case agreements" are also called "spot contracts" or "single payor agreements/arrangements." Hereinafter these arrangements will be referred to as "single case agreements" unless otherwise indicated.

⁷ In order to deal with the volume of requests for "spot contracts" received relative to Premera's Exchange plan in January 2014 to allow covered children to access SCH's services, SCH has been required to hire three additional staff members. Declaration of Suzanne Vanderwerff in Opposition to Intervenor's Joint Motion for Summary Judgment, pp. 1-2.

⁸ E.g., SCH advises that often a child appears at SCH with a need for immediate medical care and has often already received the medical care and treatment and been discharged before SCH has been able to submit a request, negotiate and possibly obtain approval from an Exchange carrier to have that treatment covered as an in-network provider under a spot contract. SCH also states that the average time required for SCH to obtain a spot contract with a health carrier is two weeks.

⁹ Declaration of Suzanne Vanderwerff in Opposition to Intervenor's Joint Motion for Summary Judgment, pp. 1-2.

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in contrast to the total of, essentially, four requests for "single case agreements" it received relative to all of its total of 351,147 Premera and non-Premera patient visits in 2012.¹⁰

Finally, SCH argues that "single case agreement contracting" by definition involves out-of-network care and should not be taken into consideration when determining whether the federal and state standards for network adequacy have been met.

In response, as stated in OIC's Opposition to SCH's Motion for Partial Summary Judgment and during oral argument held February 3, 2014:

1) The OIC asserts that while there are no federal or state statutes or regulations which require the OIC to consider the unique services provided by SCH in reviewing these Exchange plans, the OIC did consider SCH's unique services but determined that these Exchange plans met the requirements of the ACA and state law without including SCH in their networks.

2) The OIC argues that Exchange plans must offer the required health care services in their plans, but they are only required to ensure that the majority of the covered services in their Exchange plans can be provided by network providers.¹¹ The OIC argues that the ACA and state law require Exchange plans to include "coverage" for the required *essential health benefits* but that the required "coverage" need not be provided by network providers. As an example, when a child covered under an Exchange plan requires covered services and there is no network provider who can adequately provide those covered services, the OIC argues that the covered patient (or an out-of-network provider) can submit a request to the Exchange plan for review and possible approval of a "single case agreement" which would allow that specific out-of-network provider to provide certain specific covered service(s) to a specific named covered patient for a specific time period. Health plans' decisions whether to approve or disapprove these requests for "single case contracts" are apparently largely automated, utilizing various data bases. The OIC asserts that health carriers such as Intervenors can meet network adequacy requirements, and thereby have their Exchange plans approved, by advising in their filings that as to covered services which cannot be covered by network providers, they will receive, review and approve/disapprove covered patients' requests for care through this "single case agreement" process, as long as the Exchange plan does not rely on this "single case agreement" process to provide a "majority" of the services covered in their plans: *Contrary to SCH's assertion, the law does not equate "covered" with "part of a contracted network." As a result, the OIC requires only that carriers ensure that covered services be provided at in-network price [sic] that accrues[sic] to the plans[sic] maximum out-of-pocket limit. Issuers can accomplish this through a variety of means, including spot-contracting or paying billed charges. [The OIC allows, however, that These arrangements are considered within the context of the general network*

¹⁰ In 2012, SCH received 28 requests from Washington residents, all but 4 relating to the services of two national behavioral health providers which would be expected to require "single case agreements," and 39 requests from nonresidents. Supplemental Declaration of O'Conner Re: Intervenors' Joint Motion for Summary Judgment, p. 4.

¹¹ OIC's Opposition to SCH's Motion for Partial Summary Judgment, which advises that an Exchange filing which proposes to cover a "majority" of covered services through out-of-network providers would not be approved by the OIC.

adequacy requirements. A network relying solely on spot-contracting or billed charges for the majority of services would not be approved by the OIC.]

3) Intervenor's argue that the decision in *Coordinated Care Corporation*, Docket No. 13-0232, where it was determined that state law allowed limited use of "single case agreements" should be interpreted to mean that *WAC 284-43-200(3)* [and therefore presumably federal law as well] *expressly allows carriers to utilize out-of-network providers for any purpose as long as the consumer is not put in a worse position* and asserts that SCH's *true motivation for its appeal is a desire to maximize its revenue from the Intervenor's' [Exchange plan] members.*

ISSUES PRESENTED

I. In the OIC's review and approval of the Exchange plans filed by Bridgespan, Premera and CCC, was the OIC required to consider and comply with the federal Affordable Care Act, including 42 USC Sec. 18022(b)(1), 42 USC Sec. 18031(c)(1)(C), as well as 45 CFR Sec. 156.020, Sec. 156.110, 156.115, 156.200, 156.230 and 156.235?

SCH argues, and neither the OIC nor Intervenor's dispute, that both the federal ACA and state law impose two requirements on Exchange plans which the OIC was required to ensure were met before the OIC approved them:

1) 42 USC Sec. 18022 requires that the OIC ensure that each Exchange plan it approves includes those essential health benefits set forth in 42 U.S.C. Sec. 18022 (and both state law¹² and the OIC's own recently adopted regulations¹³ also require the OIC to ensure compliance with 42 U.S.C. Sec. 18021). One of these essential health benefits is *pediatric services, including oral and vision care.*¹⁴

2) 42 USC Sec. 18031, CFR 156.230 and .235 also require the OIC to ensure that each Exchange plan it approves includes essential community providers in their networks
....

As a matter of law, it is here concluded that under both federal and state laws, cited above, the OIC was affirmatively required to consider and comply with the federal Affordable Care Act ("ACA"), including 42 USC Sec. 18022(b)(1), 42 USC Sec. 18031(c)(1)(C), as well as 45 CFR Sec. 156.020, Sec. 156.110, 156.115, 156.200, 156.230 and 156.235. These sections of the ACA require the OIC to ensure that each Exchange plan it approves *includes essential community providers in their networks* and that each Exchange plan it approves includes all *essential health benefits*. Of the ten defined essential health benefits, one includes *pediatric*

¹² RCW 48.43.715.

¹³ WAC 284-43-849.

¹⁴ 42 U.S.C. Sec. 18022(b)(1); *see also* 45 CFR Sec. 156.200, 45 CFR Sec. 156.110.

services. All of the other *essential health benefits*, however, relate here as well, and include “at a minimum” (per the wording of the ACA) ambulatory patient services, emergency services, hospitalization, newborn care, mental health and substance use disorder services and behavioral health treatment, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management.¹⁵ The plans must provide these benefits in amounts equal to the scope of benefits provided under a typical employer plan (benchmark plan) identified by the OIC.¹⁶

Second, it is undisputed that SCH is an *essential community provider* as defined in the ACA;¹⁷ that most of the services SCH provides are *essential health benefits* as defined in the ACA;¹⁸ and that some of the services SCH provides are unique in the state.¹⁹

II. In the OIC’s review and approval of the Exchange plans filed by Bridgespan, Premera and CCC, was the OIC affirmatively required to consider and comply with the ACA (42 USC Sec. 18022(b)(1), 42 USC Sec. 18031(c)(1)(C), as well as 45 CFR Sec. 156.020, Sec. 156.110, 156.115, 156.200, 156.230 and 156.235) and failed to do so?

As concluded in I. above, pursuant to federal and state law the OIC was affirmatively required to consider and comply with the ACA cited above. In its OIC’s Opposition to SCH’s Motion for Partial Summary Judgment, the OIC states: *The OIC Rates and Forms staff review all health plans that must be filed with the Commissioner prior to being sold in Washington, to ensure they meet the requirements of state law and of the ACA.... This includes satisfying the generally applicable requirement of network adequacy. See RCW 48.43.500 et seq. [The OIC’s footnote here advises that the requirements for network adequacy are more fully described by the Intervenor’s in their Motion.] In addition, for any plan sold on the Washington State Health Benefits Exchange, OIC staff reviews [sic] to determine that they meet the standards of a “Qualified Health Plan” (“QHP”), which require coverage of essential health benefits, See RCW 48.43.715, 42 U.S.C. 18022(b)(1), and include sufficient numbers of “essential community providers,” entities that serve predominately low-income, medically underserved individuals. 42 U.S.C. 18031(c)(1).*

With regard to this issue, it is unclear what the SCH argues the OIC is required to do in fulfilling its obligation to “consider and comply with” these federal statutes and what the consequences of the OIC’s failure to fulfill this obligation would be. To the extent that the question of whether the OIC failed to consider and comply with the ACA is relevant, however, it involves genuine issues of material fact and questions of law that cannot be decided on summary

¹⁵ 42 USC 18022(b)(1).

¹⁶ CFR 156.110; RCW 48.43.715 OIC must identify benchmark plan with 10 *Essential Health Benefits*; WAC 284-43-849 health plans must provide *Essential Health Benefits*; WAC 284.43.865 Regence BlueShield Inova plan identified as OIC’s benchmark plan.

¹⁷ Declaration of Madden, Ex. A, SCH’s First Requests for Admission to the OIC with Responses; see also, Ex. B, SCH’s First Interrogatories and Requests for Production to the OIC with Answers..

¹⁸ OIC’s Opposition to SCH’s Motion for Partial Summary Judgment.

¹⁹ *Id.*

judgment. However, the following discussion is provided as an aid in clarification of the issues at hearing:

More specifically with regard to its application of the ACA's *essential health benefits* requirements, in its OIC's Opposition to SCH's Motion herein, the OIC asserts that *The OIC ... correctly applied federal and state law in determining that each of the intervenors' plans included "coverage" for the required essential benefits. [However, the OIC argues] [c]ontrary to SCH's assertion, the law does not equate "covered" with "part of a contracted network." As a result, the OIC requires only that carriers ensure that covered service be provided at an in-network price Issuers can accomplish this through a variety of means, including spot-contracting or paying billed charges.* This issue is discussed in IV. below.

More specifically with regard to its application of the ACA's *essential community provider* requirements, in its Opposition to SCH's Motion herein, the OIC asserts that *The OIC also correctly ensured that each of the Intervenor's' plans met the federal essential community provider standards,* The OIC supports its position based upon its Declaration²⁰ that the federal *Centers for Medicare & Medicaid Services (CMS), developed automated review tools to evaluate issuer submissions for the federally facilitated Exchanges[,] that The automated review tools include an 'Essential Community Providers Tool' (ECP Tool) to evaluate issuers against the regular or the alternative ECP Standard ... asserts that [t]he OIC uses the tool to determine whether submitted plans meet the required essential community provider standard to qualify as a Qualified Health Plan[] and asserts that Issuers were required to submit completed ECP templates as part of the SERFF Binder filing. The OIC 'runs' the templates through the ECP tool, which evaluates the information against the federal standard and returns a result: either approved, or not approved. The OIC ran the ECP templates for BridgeSpan, Premera and Coordinated Care through the ECP Tool using the 'regular ECP standard' setting. Premera's template did not include SCH as an in-network provider. The ECP tool approved each template as meeting the federal ECP standards. First, assuming this "tool" is appropriate for state-administered Exchange filing review, by OIC's advice²¹ it was designed only to apply to review of Intervenor's' *essential community provider* compliance (not to their compliance with *essential health benefits* coverage requirements) and there is no evidence presented as to the OIC's application and consideration of Intervenor's' plans' compliance with the ACA's *essential health benefits* coverage requirements. Second, OIC's Declaration is unclear as to whether it used this tool during the times at issue herein, i.e., during the OIC's review and approval of Intervenor's' filings in July 2013. Third, while the OIC declares that SCH was not included in Premera's network at the time the tool was used, there is conflicting evidence as to whether SCH was included in Bridgespan's network at that time.²² Finally, the tool's calculations provide scarce, non-self-evident information and are all undated.²³ Finally, while it may be because this tool applies only to the ACA's *essential community provider* requirements and not to its *essential**

²⁰ Second Declaration of Molly Nollette in Response to SCH's Motion for Summary Judgment.

²¹ Declaration of Molly Nollette in Support of Motion to Dismiss Adjudicative Proceeding.

²² Declaration of Beth Johnson in Support of Intervenor's' Motion for Summary Judgment referenced by SCH during oral argument herein.

²³ Declaration of Molly Nollette in Support of Motion to Dismiss Adjudicative Proceeding, Exs. H, I, J.

health benefits requirements, or there may well be some other explanation, it is curious why, if the tool were run in July 2013, Premera's filing would have been approved yet CCC's filing was initially disapproved.²⁴ In addition, while the OIC designated a benchmark plan as required under the ACA, there is insufficient evidence, at least during the Motion herein, that the OIC applied that benchmark in reviewing and approving Intervenors' Exchange plans.

Relative to the OIC's consideration and application of the ACA *essential community provider* and *essential health benefits* requirements, CCC asserts that *CCC has a comprehensive provider network that is capable of providing all essential health benefits, including pediatric services, without SCH's inclusion;*²⁵ Bridgespan asserts that *On September 4, 2013, BridgeSpan Health Company was certified by the Washington Health Insurance Exchange Board as a Qualified Health Plan. This followed a months-long approval process conducted by the OIC;*²⁶ and Premera asserts that its Exchange members will *have full access to most pediatric services. Premera's network includes Virginia Mason Medical Center in Seattle, Evergreen Hospital in Kirkland, and Valley Medical Center in Renton, among other providers who provide extensive, in-depth, specialty pediatric care and comprehensive pediatric services.*²⁷

III. In the OIC's review and approval of the Exchange plans filed by Bridgespan, Premera and CCC, was the OIC required to give consideration to the unique services provided at SCH, and did the OIC fail to do so?

SCH asserts, and the OIC admits, that SCH is the only pediatric hospital as defined in 42 USC Sec. 256(b)(a)(4)(M) in King County [SCH's First Requests for Admission to OIC ("RFA") at No. 2] and is one of only two children's hospitals located in Western Washington [RFA No. 5]. It is undisputed that there are only three children's hospitals in the state. It is also undisputed that SCH provides some services that are unique in the state and Northwest.²⁸ SCH argues, and it appears to be undisputed, that SCH is the preeminent provider of pediatric specialty services in the Northwest with many of these services being unavailable elsewhere in the Northwest.²⁹ SCH has asserted other significant data concerning the types, residences and

²⁴ E.g., it is unclear the OIC would determine the tool had properly approved Premera's network when apparently the single ECP hospital it included in its network which might qualify to provide the subject ECP provider type, per CMS letter dated April 5, 2013, is Snoqualmie Valley Hospital, which has no more than 25 acute care beds, had no pediatric inpatient discharges in fiscal years 2011 or 2012, has just one pediatrician on staff, and reports that "children with serious injuries and/or sudden onset sickness symptoms are generally transported directly to or transferred to SCH." In addition, it is unclear why, if the OIC ran the tool during its review in July 2013, CCC's filing was disapproved even though it appears to have ECP hospital(s) in its network (and also why this tool was not mentioned during *Coordinated Care*). SCH's Declaration of Carol Sue Janes in Support of SCH's Motion for Partial Summary Judgment; oral argument presented February 3, 2014.

²⁵ Declaration of Jay Fathi, MD, CEO of Coordinated Care Corporation, in Support of Intervenors' Joint Motion for Summary Judgment, at p. 5.

²⁶ Declaration of Beth Johnson, Regional Vice President of Network Management and Contracting Strategy for Regence BlueShield, in Support of Intervenors' Motion for Summary Judgment, at p. 1.

²⁷ Declaration of Rich Maturi, Premera's Sr. Vice President for Health Care Delivery Systems, at p. 1.

²⁸ Declaration of O'Connor, pp. 1-3; OIC's Opposition to SCH's Joint Motion for Summary Judgment.

²⁹ Further with regard to the unique services it provides, SCH asserts that it is the only hospital in the states of Washington, Alaska, Montana, Idaho and Wyoming that provides care across the entire range of tertiary and quaternary services for the pediatric population, including, e.g., pediatric care for medically compromised patients; acute and complex cancer care, including adolescent cancer care; complex hematology care; rheumatology; level IV neonatal intensive care; pediatric intensive care; pediatric cardiac intensive care; heart, liver and intestinal transplantation; bone marrow transplantation, and other highly specialized and unique services, and that many of the state's other hospitals that provide inpatient pediatric services rely upon SCH's services for specialty care or transfer of patients needing tertiary or quaternary care.

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numbers of patients it serves³⁰ along with its Declaration certifying a 23-page List of Unique Services it provides.³¹ SCH advises that, in part due to the significant costs and infrastructure required of a pediatric specialty hospital, there is normally only one in each major U.S. city such as Seattle, with only two in larger cities and perhaps three in the largest urban areas such as Los Angeles and New York.

SCH argues that, although the OIC was required to have ascertained compliance with these requirements before approving them, *it is apparent from the CCC³² record that the OIC staff did not recognize their importance and therefore failed to ask or answer the relevant questions under the ACA. ... Additionally, it appears that the OIC was misinformed or uninformed as to (a) the nature and extent of pediatric services that are available only through SCH, particularly in King County and north; (b) the consequences of allowing spot contracting as a substitute for network inclusion in these circumstances; and (c) whether or not SCH was included in Premera's Exchange plan network. On each of these questions, the undisputed facts are contrary to the assumptions upon which OIC apparently based its decision.*

A. Was the OIC required to consider SCH's unique services? It appears that whether the OIC was required to consider the unique *essential health benefit* services provided by SCH depends upon how much of an impact these unique services would have on the network adequacy requirements of the ACA and state law, which involves a consideration of 1) what amount of unique *essential health benefits* SCH provides; and 2) how often these services are required in order to provide adequate *essential health benefits* to enrollees, considering federal and state network adequacy requirements such as miles from enrollees' residences and other factors affecting, e.g., enrollees' access to care. If there are a substantial amount of unique *essential health benefit* services which are required more than fairly rarely, then to fail to include SCH in the Exchange plans' networks would arguably result in their having inadequate networks. Therefore this issue includes genuine issues of material fact (e.g., as to the amount of unique essential health services, and as to how often these unique essential health services are required) and questions of law which cannot be decided on summary judgment.

B. Did the OIC fail to consider SCH's unique services? As above, it is not decided here whether the OIC was required to have considered SCH's unique services in its review and approval of these plans. Further, the question whether the OIC failed to consider SCH's unique services will also not be decided here on summary judgment. However, the following discussion

³⁰ SCH asserts that it is the only pediatric hospital in King County and provides half of all the pediatric inpatient care in Northwestern Washington, from King County to the northern state border, with the majority of its inpatients coming from outside King County. E.g., in 2012, for patients age 0 to 14, SCH provided 100% of the pediatric kidney and liver transplants statewide, over 90% of the ECMO (lung and cardiac support) statewide, over 90% of the bone marrow transplants, and over 70% of the pediatric cardiac surgeries statewide. In 2012, SCH served patients from 34 of the state's 39 counties, and saw twice as many inpatients under the age of 15 as either of the state's other pediatric providers (Mary Bridge in Tacoma and Sacred Heart in Spokane). Of all hospitals within a 30-mile radius of SCH's facility, for patients age 0 to 14, in FY 2012 SCH treated 81% of all pediatric inpatients, over 90% of all high acuity pediatric inpatients, and 75% of all pediatric psychiatric inpatients. Of the patients requiring inpatient stays at SCH, 77% have significant health care conditions (e.g. brain or bone tumors) or chronic underlying conditions (e.g., diabetes, heart disease, cystic fibrosis, cerebral palsy). Declaration of O'Connor, pp. 1-3. SCH further presents a 23-page list of services it declares are provided in this state only by SCH.

³¹ Declaration of O'Connor, Ex. B.

³²Coordinated Care Corporation, Docket No. 13-0232.

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is offered as an aid in clarifying the issues at hearing: While it appears that during the time it approved Intervenor's Exchange plans there were discussions between the OIC, CCC and Premera concerning whether or not SCH had to be included in these carriers' Exchange plan networks³³ and, as SCH notes, the OIC initially disapproved CCC's Exchange filing on July 31, 2013 based in part on the fact that it had not included SCH in its network,³⁴ it does appear that the OIC was unaware of these unique services at the time it was reviewing and approving these plans through July 2013 and also through December 2013 because in both 1) testimony in *Coordinated Care* referenced by SCH herein and 2) discovery provided by the OIC in December 2013, the OIC acknowledges that it has little or no knowledge about whether SCH provides unique services.

1) Testimony in *Coordinated Care*. As SCH argues, in *Coordinated Care* the OIC did not dispute CCC's testimony that CCC could provide "99% of covered pediatric ... services" without SCH included in its Exchange network. In addition, when asked during *Coordinated Care* to identify what covered services SCH could provide that could not be provided by the providers included in CCC's Exchange network, the OIC testified that the only such services it knew of were Level IV Neonatal Intensive Care Unit and Level 1 Burn Unit care (which were the two types of care which CCC had already disclosed to the OIC in its Exchange filing as being unique services which could not be provided within its Exchange network). The OIC testified that it knew of no other services SCH could provide that could not be provided by the providers included in CCC's Exchange network.³⁵

2) Discovery provided by OIC. When asked to admit or deny much of the above information about type, numbers and residences of the patients that SCH serves, in SCH's First Requests for Admission to the OIC with Responses³⁶ the OIC declares that this information *alleges ... medical statistic[s] as to which the OIC staff has no knowledge or means of obtaining knowledge and which it therefore can neither admit nor deny.* [RFA Nos. 13-16.] When asked to explain its answers in SCH's First Interrogatories and Requests for Production to the OIC with Answers,³⁷ the OIC responded *The OIC has no knowledge or information upon which to predicate a belief whether the statistic[s] alleged in this Request [are] accurate or not.* [Interrog. Nos. 13-16.] Further, when asked to admit or deny whether SCH is the sole provider in the state of Washington of the services identified in Ex. A attached to those Interrogatories (and also included in Declaration of O'Connor, Ex. B, 23-page List of Unique Services) the OIC replied *Denied. The OIC staff has no knowledge or means of obtaining knowledge whether some of the services listed on this exhibit are only available at SCH.*" [RFA No. 17.] When asked to explain its

³³ *Coordinated Care* record; Declaration of O'Connor, Ex. A.

³⁴ *Coordinated Care* record; Decl. of Madden, Ex. A, SCH's First Requests for Admission to the OIC with Responses; Ex. B, SCH's First Interrogatories and Requests for Production to the OIC with Answers.

³⁵ Findings of Facts, Conclusions of Law and Final Order in *Coordinated Care*.

Declaration of Madden, Ex. A, SCH's First Requests for Admission to the OIC with Responses dated December 11, 2013 (hereinafter RFA).

³⁶ Declaration of Madden, Ex. A, SCH's First Requests for Admission to the OIC with Responses dated December 11, 2013 (hereinafter RFA).

³⁷ Declaration of Madden, Ex. A, SCH's First Interrogatories to the OIC with Answers dated December 11, 2013 (hereinafter Interrog.).

denial in SCH's First Interrogatories, the OIC responded *The OIC Staff has no knowledge and no information upon which to predicate a belief as to whether any of the services alleged in this requested admission, let alone all of them, can only be obtained in Washington from SCH. ... [Interrog. No. 17.]*

IV. Did SCH fail to take into consideration the fact that SCH is not an "in-network" provider?

The important issue of whether Intervenors can satisfy their obligations to provide covered pediatric services through "single case agreements" and/or through some other non-network provider arrangement includes genuine issues of material fact and questions of law which cannot be decided on summary judgment. The discussion below is intended to be an aid in clarifying these issues at hearing:

In Intervenors' Joint Response to SCH's Motion herein, Intervenors assert that the issue of whether the OIC considered SCH's unique services is irrelevant because Intervenors can enter into "single case agreements" with any out-of-network providers to provide any covered services when network providers cannot provide those covered services, and thereby satisfy ACA and state network adequacy requirements.

Similarly, in OIC's Opposition to SCH's Motion for Partial Summary Judgment, the OIC argues that while Intervenors' Exchange plans must cover the *essential health benefits* under the ACA and state law, Intervenors are not required to include any specific types or categories of providers in their networks to provide these services. This is because, the OIC argues, the ACA and state law only require Exchange carriers to include "coverage" for the required *essential health benefits* in their plans and this does not mean that they are required to include providers who can actually provide those *essential health benefits* in their networks: *Contrary to SCH's assertion, the law does not equate "covered" with "part of a contracted network."* *As a result, the OIC requires only that carriers ensure that covered services be provided at in-network price [sic] that accrues[sic] to the plans[sic] maximum out-of-pocket limit. Issuers can accomplish this through a variety of means, including spot-contracting or paying billed charges. [The OIC allows, however, that These arrangements are considered within the context of the general network adequacy requirements. A network relying solely on spot-contracting or billed charges for the majority of services would not be approved by the OIC.]*³⁸

Specifically, the OIC argues that when an enrollee requires covered services and there is no network provider who can adequately provide those covered services, that enrollee (or an out-of-network provider) can submit a request to the Exchange plan for review and possible approval

³⁸ Indeed, under the OIC's and Intervenors' reasoning, whether a service is unique or not is irrelevant because it is not required for either unique and non-unique services to be included in carriers' networks.

of a "single case agreement" which would allow that specific enrollee to receive certain specified covered services from a specific out-of-network provider normally for a specific time period. The OIC asserts that health carriers can meet network adequacy requirements, and thereby have their Exchange plans approved, with apparently the understanding that they will accept, review and approve/disapprove enrollees' (and out-of-network providers') requests for "single case agreements" in this manner as long as they do not purport to cover "the majority" of the plans' covered services in this matter. Therefore, OIC urges, while the OIC considered that SCH was not an in-network provider, this issue is irrelevant because Intervenor can meet network adequacy requirements by means of this "single case agreement" process.

Finally, in its OIC's Opposition to SCH's Motion herein, the OIC advises *Although consumers who receive services from providers that are out-of-network face the possibility of being responsible for higher cost-sharing or for the entire bill depending upon the specific health plan, the OIC has determined that enrollees purchasing QHPs from Coordinated Care, BridgeSpan, and Premera will not be subject to higher costs for SCH's unique services. Each of them has included in their filings documents the statement that for covered services that are only available at SCH, enrollees will be subject to cost-sharing of negotiated in-network rates.*³⁹ Even so, SCH advises that it has had little or no communications from Intervenor as to the process of requesting "single case agreements," and it is unclear how the Intervenor's assurances in their filings documents with the OIC will effectively serve to protect Exchange plan enrollees from this higher cost-sharing or for the entire bill.

A. Legal and factual issues concerning single case agreements.

In support of its position, in its OIC's Opposition to SCH's Motion herein the OIC relies primarily on state law:

Adequate networks require that enrollees have access to and choice among providers. RCW 48.43.515. Adequate networks must contain certain general types of providers, including primary care, specialists, and chiropractors. RCW 48.43.515. But there is nothing in state or federal law that requires any specific provider entity to be included, even those that may provide a unique service. ... Viewed correctly, the requirement should be stated this way: every QHP must provide coverage for the essential health benefits required by federal law. OIC's responsibility and care is to ensure that every enrollee in a QHP is entitled to those covered services, meaning that they are provided at an in-network price (or less), Practically, this is

³⁹ *Citing* Second Declaration of Molly Nollette in Response to SCH's Motion for Summary Judgment, at p. 2, which states "Although as a general matter consumers who receive services from providers that are out-of-network face the possibility of being responsible for higher cost-sharing (or for the entire bill) depending upon the specific health plan), the OIC as been assured and has determined that enrollees in QHPs from CC, BridgeSpan, and Premera will not be subject to higher costs for SCH's unique services. Premera, Bridgespan and Coordinated Care each stated in their filing documents that for covered services that are only available at SCH, enrollees will be subject to cost-sharing of negotiated in-network rates."

largely accomplished through network contracts between issuers and providers. However, so long as issuers meet the legal standards for adequacy and covered services, the OIC does not manage their business arrangements for them. Indeed, the substance of issuer contracts with providers is not generally OIC's concern, except to the extent that contracted prices support the filed rates that will be charged to enrollees. ... Most of the unique services SCH offers would be considered essential health benefits under the federal law. As a result, issuers must satisfy the OIC that enrollees have access to these covered services, either by contracting [via "single case agreements"] with SCH or by some other method.⁴⁰

Elsewhere,⁴¹ the OIC focuses on 42 USC Sec. 18031(c)(1) as authority for the proposition that no specific provider or essential health benefit need be included in an Exchange plan's network. 42 USC Sec. 28031(c)(1) requires that, to be certified,

...a[n exchange] plan shall, at a minimum ... (c) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically underserved individuals, such as [through reference to sec. 340B(a)(4) of the Public Health Service Act A children's hospital ...] except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure; [Emphasis added.]

However, aside from those provisions of state law and 42 USC Sec. 18031(c)(1) cited by the OIC above, there are other federal rules which apply to the question of network adequacy. For example, CFR 156.230(a) sets forth the general requirements for network adequacy in Exchange plans:

- (a) *General requirement. A[n Exchange plan] must ensure that the provider network of each of its [Exchange plans], as available to all enrollees, meets the following standards:*
- (1) *Includes essential community providers in accordance with CFR 156.235;*
 - (2) *Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and*
 - (3) *Is consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act. [Emphasis added.]*

CFR 156.235, which also governs network adequacy standards, provides:

⁴⁰ OIC's Opposition to SCH's Motion for Partial Summary Judgment.

⁴¹ *Id.*

(a) General requirement. (1) [An Exchange carrier] must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the [Exchange carrier's] service area in accordance with the Exchange's network adequacy standards.

...

(3) Nothing in this requirement shall be construed to require any [Exchange carrier] to provide coverage for any specific medical procedure provided by the essential community provider.

...

(d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a[n Exchange carrier] to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

As the OIC and Intervenors argue, based upon the Center for Medicaid Services letter⁴² which serves as a guide, it may not be that 42 USC Sec. 18031, strictly as written, requires that each Exchange plan must include in their networks all essential community providers that exist in a given region (regardless of whether or not they refuse to accept generally applicable payment rates). However, clearly the ACA sets forth the above network adequacy requirements which must be met prior to approval and certification of these Exchange plans. It might be that these network adequacy requirements (as opposed to specific wording in the ACA governing inclusion of specific essential community providers), together with consideration of whether or not federal law allows contracting through "single case agreements" to satisfy network adequacy requirements, that might result in a determination that unless SCH is included in these Exchange plans' networks then these networks are inadequate. As above, however, these applicable statutes and regulations, when read together, present genuine issues of material fact and questions of law which cannot be decided on summary judgment.

B. Applicability of *Coordinated Care* decision to issue of single case agreements.

The OIC and Intervenors argue that the decision in *Coordinated Care Corporation*, Docket No. 13-0232, should apply here. The OIC argues that, based upon the Final Order in *Coordinated Care*, *HMOs are allow[ed]...to satisfy [their] obligations to provide essential health benefits through non-networked providers* through "single case agreements." [RFA No. 8; Interrog. No. 8] Intervenors argue that in *Coordinated Care* it was determined that *The Chief*

⁴² CMS letter dated April 5, 2013, which states that there are two standards by which a plan can be evaluated for sufficient inclusion of essential community providers (ECPs): (1) Safe Harbor Standard, whereby the Exchange plan demonstrates compliance with the ECP requirements by having twenty percent of available ECPs in the service area participate in the plan and at least one ECP from each ECP category (Table 1.1 in CMS letter); or (2) Minimum Expectation, whereby compliance with the ECP requirements is demonstrated by having at least ten percent of available ECP's in the plan's service area participate in the network and the Exchange carrier provides a satisfactory narrative justification describing how the network provides an adequate level of service for low-income and medically underserved enrollees.

Presiding Officer has already correctly held that WAC 284-43-200(3) expressly allows carriers to utilize out-of-network providers for any purpose as long as the consumer is not put in a worse position.⁴³

However, while the OIC and Intervenors may have valid arguments to support their positions regarding "single case agreements" for other reasons, the OIC's and Intervenors' arguments that the ruling in *Coordinated Care* authorizes the use of broad "single case agreement" contracting to satisfy network adequacy requirements is misplaced. First, as reflected in the specific wording of the Final Order in *Coordinated Care*, the context under consideration in that case was that "single case agreements" were rare. Second, in *Coordinated Care* neither party raised or argued the applicable ACA rules governing network adequacy.

1) Coordinated Care involved undisputed facts which were different than those contemplated herein. Contrary to the arguments of the OIC and Intervenors herein, *Coordinated Care* does not hold that "single case agreements" may be used to satisfy an Exchange plan's network adequacy requirement, nor does it hold that "single case agreements" are allowed to be used commonly. Not only was there no argument or evidence presented in *Coordinated Care* to dispute CCC's position that it is allowed to contract by "single case agreements" in very limited situations, but the OIC testified that it knew of no services SCH provided that CCC's network providers could not provide⁴⁴ and CCC testified it could provide 99% of all covered pediatric services through its network providers.⁴⁵ The question in *Coordinated Care* was whether state law allowed CCC to use single case agreements at all or whether state law required CCC to include SCH in its network even for the allegedly 1% or less situations where the covered services could not be provided by one of CCC's Exchange network providers.⁴⁶ In short, as the Final Order in *Coordinated Care* clearly reflects, the question was whether state law allows "single case agreements" to be used in even rare situations:

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. ... [CCC] 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 [is] 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, ... [CCC] is not required to

⁴³ Intervenors' joint Opposition to SCH's Motion for Partial Summary Judgment, at p. 2.

⁴⁴ Other than NICU Level 4 and Level I Burn Unit care which were already identified in CCC's Exchange filing, Final Order and Order on Reconsideration in *Coordinated Care*, referenced by parties herein and attached to pleadings.

⁴⁵ Final Order and Order on Reconsideration in *Coordinated Care*, referenced by parties herein and attached to pleadings.

⁴⁶ In *Coordinated Care*, the OIC had initially disapproved CCC's Exchange filing based in large part on the fact that CCC had not included SCH in its network. At hearing, the OIC initially testified that state law prohibited "single case agreements," and CCC cited state law which recognized the possibility of the use of "single case agreements."

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have included pediatric specialty hospitals or Level I Burn Units within their provider network. [Emphasis added.] [Conclusion of Law No. 12.]

As indicated in the above wording of the Final Order, it does not allow carriers *to satisfy* [their] *obligations to provide essential health benefits through non-networked providers* through “single case agreements” as the OIC urges. It also does not *expressly allow* [] *carriers to utilize out-of-network providers for any purpose as long as the consumer is not put in a worse position.*

The context in which this issue in *Coordinated Care* was decided is further illustrated by the testimony of Dr. Fathi, who throughout his lengthy testimony emphasized that CCC's use of “single case agreements” would be rare and would mostly arise in situations the enrollee was out-of-area and so had no access to a CCC network provider who would ordinarily provide those services (or in emergency situations, for the same reason):⁴⁷

1. Dr. Fathi testified that, as to pediatric services, [in setting up its network] *CCC assumed that not many children were going to be on the Exchange.* [Fathi testimony at 1:37.] He testified that there would be only the rare occasion where CCC's network providers could not provide the covered pediatric services, and that “single case agreements” are only used on rare occasions. [Fathi testimony at 1:10.] He testified that CCC could provide 99% of all covered pediatric services through its network providers and would need to enter into a “single case agreement” with SCH only on those very rare occasions when its network providers could not provide this service. [Fathi testimony at 1:13.] The OIC raised no dispute about Dr. Fathi's testimony. Further, the OIC testified that it knew of no other covered pediatric services which could not be provided by CCC's network providers except for Level 4 NICU care and Level I Burn Unit care (both of which CCC had already disclosed in its Exchange filing).
2. Dr. Fathi identified the situations where “single case agreements” would be used as mainly those where the enrollee is out-of-state or in an emergency situation (and if he had been home there would have been sufficient network providers to provide his care). [Testimony of Fathi at 0:30.] He testified *First of all, this* [contracting by single case agreements] *would happen very rarely. ... If it's medically necessary and we don't have a provider in our network then we'll cover that service and the consumer will have no increased burden to pay.* [Fathi testimony at 1:10-1:43.] He further testified that a “single case agreement” is more like a *bill* or an *invoice* where the out-of-network provider simply sends a bill to the Exchange plan, after the service is rendered, and the Exchange plan simply pays it. [Fathi testimony at 1:37.] He further testified that *it would not be wise for carriers to build a plan around a*

⁴⁷ The purpose of referencing Dr. Fathi's testimony in *Coordinated Care* set forth in items 1, 2 and 3 here is not to consider the facts from that case nor to use these statements to decide the issues herein. Instead, these references are used to illustrate the context in which the issue of contracting by “single case agreement” was considered and decided in *Coordinated Care*.

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situation where they felt they would be doing a lot of single payor agreements. That doesn't make a lot of sense. [Fathi testimony at 1:37-1:45.] Dr. Fathi further described the situation where "single case agreements" would be used as being limited to "subspecialty providers" and repeated that [contracting by single case agreements] wouldn't happen very often. CCC will pay for things that are outside the box. There probably won't even be a signed contract; it's an invoice [directly from out-of-network provider to the Exchange plan and not involving the enrollee].

3. As an example of a non-emergent, non-out-of-state situation where a "single case agreement" would be used, Dr. Fathi raised his example of the situation where there is just one network dermatologist in a 50-mile region: should that dermatologist die or move away, and if a person [enrollee] needs dermatology care for some reason, then that person can get dermatology care. My understanding is that these things are not regulated by the OIC. (This "dead dermatologist" example was used and repeated as representative of the rare occasion where "single case agreements" would be used, with presumably all other covered services being provided by network providers.)

As indicated above, the situation under consideration in *Coordinated Care* is clearly different from an Exchange plan, e.g. at the time of filing, attempting to satisfy its network adequacy requirements for provision of up to half of its covered services by simply stating that it anticipates it will contract by "single case agreement" for various required types and categories of covered services.

2) The *Coordinated Care* decision was not based on ACA rules governing network adequacy. Surprisingly, neither party in *Coordinated Care* raised or argued the ACA network adequacy rules which most specifically apply to these Exchange plans. Indeed, as SCH points out, a word search for "*essential community provider*" and "*essential*" and "*community*" in all of the briefs filed in *Coordinated Care* reveals that these ACA central terms were used not once. Neither were the ACA network adequacy rules raised in oral argument in that case. It may be that CCC chose to raise only the state network adequacy rules because the state rules are arguably more lenient (specifically recognizing the possibility of using "single case agreements");⁴⁸ and the OIC may have chosen to argue only the state network adequacy rules because they are more familiar than the very new ACA network adequacy rules which were the subject of many interpretations and reinterpretations up until the July 31, 2013 deadline for approval of the Exchange plans. At any rate, the specific federal statutes provided herein governing network adequacy were not raised or discussed in *Coordinated Care*.⁴⁹

⁴⁸ WAC 284-43-200(3) provides that "In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.

⁴⁹ Indeed, as SCH points out, a search it conducted of all documents filed in that case found not even a single reference to e.g. "*essential community provider*."

AUTHORITY

WAC 10-08-135 governs motions for summary judgment in administrative proceedings. WAC 10-08-135 provides:

A motion for summary judgment may be granted and an order issued if the written record shows that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.

CONCLUSIONS OF LAW

After careful review and consideration of the pleadings of the OIC, SCH and the Intervenor, the authorities cited, and the arguments of counsel presented on February 3, 2013, it is hereby concluded that there is no genuine issue of material fact and SCH is entitled to judgment as a matter of law, and therefore SCH's Motion for Partial Summary Judgment should be granted as to the following issue only:

- As a matter of law, federal and state law require that the OIC ensure that each Exchange plan it approves complies with the federal ACA including 42 USC Sec. 18022(b)(1), 42 USC Sec. 18031(c)(1)(C), as well as 45 CFR Sec. 156.020, Sec. 156.110, 156.115, 156.200, 156.230, and 156.235, as well as applicable state law and regulations.

As to all other issues raised by SCH in its Motion herein, it cannot be concluded that the written record shows that there are no genuine issues as to any material fact or that SCH is entitled to judgment as a matter of law. For this reason, as to these other issues SCH's Motion for Partial Summary Judgment is denied.

ORDER

On the basis of the foregoing activity,

IT IS HEREBY ORDERED that SCH's Motion for Partial Summary Judgment is granted as to the single issue specified in Conclusions of Law above.

IT IS FURTHERED ORDERED that SCH's Motion for Partial Summary Judgment is denied as to all other issues presented therein.

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THIS ORDER IS ENTERED AT TUMWATER, WASHINGTON, this 14th day of March, 2014, pursuant to Title 48 RCW and specifically RCW 48.04; Title 34 RCW; and regulations applicable thereto.



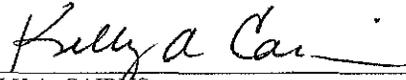
PATRICIA D. PETERSEN

Chief Presiding Officer

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: Michael Madden, Esq., Gwendolyn C. Payton, Esq., Timothy J. Parker, Esq., Maren R. Norton, Esq., Mike Kreidler, James T. Odiome, J.D., CPA, Molly Nollette, AnnaLisa Gellerman, Esq., and Charles Brown, Esq.

DATED this 14th day of March, 2014.



KELLY A. CAIRNS