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STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In re	}	
Seattle Children's Hospital's Appeal of OIC's Approvals of HBE Plan Filings		DOCKET NO. 13-0293
		PREMERA BLUE CROSS' PRE-HEARING MEMORANDUM

I. INTRODUCTION

In this proceeding, Seattle Children's Hospital ("Children's") challenges the Washington Office of Insurance Commissioner's ("OIC") approval of the Premera Blue Cross and LifeWise Health Plan of Washington (collectively "Premera") preferred provider Exchange networks because the networks do not include Children's. Children's argues that the OIC's determination that Premera's plans satisfied the requirements of the Affordable Care Act ("ACA") and Washington law is wrong because its networks do not include Children's as a provider, despite the fact that there is no provision in either the ACA or state law requiring the inclusion of any particular provider.

This dispute turns on competing interpretations of the ACA, Washington law, and federal and state regulations. Thus, all doubts must be resolved in favor of the OIC's interpretations, which are clearly and unambiguously supported by the applicable laws. Children's is basing its argument on an unreasonable interpretation of federal and state law.

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Under state and federal law, an Exchange plan's network is not deficient if it does not include Children's. But even if Children's interpretation were reasonable, it cannot overcome the OIC's alternative, reasonable interpretation.

The statutory scheme, including the ACA, its enabling regulations, and Washington statutes, is specific in its requirements for Exchange networks. The OIC established a state benchmark plan for the individual and small group markets that must include, at a minimum, all of the ten essential health benefit categories specified in Section 1302(b) of the ACA, and established the criteria for certification of health plans for the Exchange. RCW 48.43.715(1).

Further, extensive state regulations implement this federal and state statutory scheme. *E.g.*, WAC 284-43-865.

~~Children's will purport to raise factual issues in attempting to second-guess the OIC's approval of Premera's networks. Although Children's will try to raise purported factual disputes, none of those disputes are material to the issue that the tribunal must decide here. Premera's networks meet and, indeed, exceed the network adequacy requirements.~~

Premera had a process in place to ensure that medically necessary services provided by Children's that are otherwise unavailable from an in-network Premera Exchange provider are available to Premera's Exchange members at an in-network benefit level. This process, called a "benefit level exception" process, enables members to obtain treatment outside Premera's networks if the treatment is medically necessary and unavailable inside Premera's networks. This process ensures that the coinsurance, deductible and other patient responsibility items are treated as an in-network benefit where the member is approved to go to Children's. This process is not new; in fact, it is common in Washington State, and has functioned well for Premera members in the past. Thus, the only issue to adjudicate here is whether the ACA and Washington law permit Premera to provide this access through a benefit level exception process instead of including Children's in its Exchange network.

As will be established at the hearing, Children's allegations fail for two independent reasons. First, the OIC properly found that Premera's networks satisfied the applicable network adequacy requirements because the OIC correctly found that Premera's Exchange plans (i) satisfied Washington's statutory and regulatory requirements; and (ii) satisfied the ACA's requirements. Second, Children's has not alleged any injury that is legally cognizable or that this tribunal can remedy.

The OIC approved Premera's Exchange networks because it correctly concluded that regardless of whether Children's was a part of the networks, Premera would provide its members with access to all medically necessary services by Children's unavailable elsewhere as an in-network benefit. The OIC accepted Premera's proposal that medically necessary access to Children's be provided to its members through Premera's existing contract with Children's and through the benefit level exception process.

Children's cannot cite a single statute or regulation that supports its claim that a tribunal such as this should decertify an Exchange network. Thus, Children's has not articulated a claim for relief that is legally cognizable or susceptible to a remedy available in this tribunal.

II. STANDARD OF REVIEW: THIS TRIBUNAL MUST AFFORD DEFERENCE TO THE OIC'S INTERPRETATION OF APPLICABLE LAWS

There are no material factual disputes to be decided at this stage of the parties' dispute. The parties agree that, when Children's provides medically necessary services to Premera's Exchange members that are not otherwise available in Premera's Exchange networks, Premera has a process in place to ensure that those services are made available to Premera's members as an in-network benefit. The only issue left to resolve is whether the ACA and Washington law permit Premera to provide this access through a benefit level exception process, or whether the law forces Premera to enter into a contract with Children's.

The OIC has concluded that Premera's networks are adequate without Children's, because Premera's members receive any medically necessary services at Children's unavailable elsewhere as an in-network benefit. As a matter of law, all doubts must be resolved in favor of the OIC's approval of Premera's networks. With respect to statutes, "where the agency's interpretation of a statute is at least as plausible as competing ones, there is little, if any, reason not to defer to its construction." *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417-18, 113 S. Ct. 2151, 2161, 124 L. Ed. 2d 368 (1993). With respect to regulations, "[w]hen the meaning of regulatory language is ambiguous, the agency's interpretation of the regulation controls so long as it is 'reasonable,' that is, so long as the interpretation sensibly conforms to the purpose and wording of the regulations." *Lezama-Garcia v. Holder*, 666 F.3d 518, 525 (9th Cir. 2011).

III. WHAT THE EVIDENCE SHOWS

A. The Regulatory Scheme for Approval of Health Benefit Exchange Networks.

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

Under the ACA, Washington has established its own marketplace for residents to apply for and purchase HBE health insurance contracts. *See* 42 U.S.C. § 18031. The OIC is charged by the ACA and state law to establish Washington's marketplace, the HBE; to determine which health plans are qualified to participate in the HBE; and to ascertain that the content of all health plans offered through the HBE meet strict benefit and quality standards. *See* RCW 43.71.005, *et seq.* Among other things, the Exchange is intended to:

- a) **Increase access to quality affordable health care coverage, reduce the number of uninsured persons in Washington state, and increase the availability of health care coverage through**

the private health insurance market to qualified individuals and small employers; . . .

* * *

- c) Create an organized, transparent, and accountable health insurance marketplace for Washingtonians to purchase affordable, quality health care coverage. . . ; . . .
- d) Promote consumer literacy and empower consumers to compare plans and make informed decisions about their health care and coverage; . . .

* * *

- g) **Create a health insurance market that competes on the basis of price, quality, service, and other innovative efforts; . . .**
- h) **Operate in a manner compatible with efforts to improve quality, contain costs, and promote innovation;**
- i) Recognize the need for a private health insurance market to exist outside of the Exchange; and
- j) Recognize that the regulation of the health insurance market, both inside and outside the Exchange, should continue to be performed by the insurance commissioner.

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

Once the Insurance Commissioner (“Commissioner”) finds that a health plan meets federal minimum coverage requirements and satisfies state insuring requirements, the OIC approves it for certification to the HBE board. The HBE board, in turn, analyzes and then certifies the plan as a qualified health plan to the federal Department of Health and Human Services (“HHS”). Among the many requirements established by applicable state and federal

statutes, the OIC must determine that the plan satisfies the requirements of RCW Title 48.

B. The OIC Approved Premera's Plans for the Washington Health Benefit Exchange.

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

On or about July 31, 2013, the OIC approved both BridgeSpan and Premera for participation in the HBE. Ultimately, the OIC approved plans issued by eight health carriers, including Premera, and, in September 2013, the HBE board certified them to HHS as "Qualified Health Plans."

On October 1, 2013, the HBE launched open enrollment, allowing Washington citizens to apply for and purchase individual health contracts effective as of January 1, 2014 – including Premera's plans – through the HBE consumer market place website, wahealthplanfinder.org. Open enrollment through the HBE ended on March 31, 2014. Currently, there are approximately 90,000 Washington citizens enrolled with Premera to receive coverage under the HBE.

C. Facts Related to Premera and Its Exchange Network, Its Approval by the OIC, and Its Performance.

1. The Premera Signature and LifeWise Connect Networks.

Pursuant to the ACA, Premera operates a plan on the Exchange that uses the Heritage Signature Exchange network, and its subsidiary LifeWise Health Plan of Washington operates a plan on the Exchange that uses the Connect Exchange network. Maturi 12. Premera developed these networks in response to the ACA. *Id.* Premera regards the ACA as an unprecedented opportunity for Americans who had previously not been able to afford

health insurance, and so Premera designed plans to make them as cost-effective as possible. Maturi 16-24. The OIC has approved these networks, neither of which include Children's as an in-network provider.

Despite not being part of Premera's Exchange networks, Children's does have an existing contract with Premera. Under that contract, Premera has placed Children's services into "tiers," which dictates the Premera products for which Children's is in-network or out-of-network. While Children's is in-network for some of Premera's non-Exchange products, Children's (relevant to this case) is out-of-network for Premera's Exchange and individual products unless the member seeks a benefit level exception allowing him or her to receive services at Children's at an in-network benefit level. This benefit level exception process that Premera uses for Children's (and many other providers) is well established and customary in the industry. It has enabled members to obtain treatment outside Premera's networks if such treatment is determined to be medically necessary and unavailable inside Premera's networks. Conceptually, this process closely resembles the "prior authorization request" process utilized by Group Health Cooperative and other health maintenance organizations ("HMOs").

Although Children's is not in the Exchange networks, those networks are nonetheless vast. They include over 87 hospitals and over 28,000 providers. For example, since their inception, the Premera networks have included the following hospitals in King County: Virginia Mason, Northwest Hospital, Overlake, Evergreen, Valley, Renton, Snoqualmie Valley, Auburn, St. Francis, and Highline. Maturi 18-19. And the networks continue to grow, with Premera recently announcing that Swedish Health Services will join their Exchange networks effective January 1, 2015. In Pierce County, the Premera networks include the entire Franciscan system. Maturi 18-19.

In developing and maintaining its Exchange networks, Premera keeps close track of the types of services that hospitals provide and the costs of those services. Maturi 19-20.

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Premera's provider relations personnel also keep abreast of new services that hospitals begin to offer or anticipate offering for contracting as well as for network maintenance purposes. *Id.* Premera's data shows that Children's charges substantially higher rates than other hospitals in the region. *Id.*

2. The OIC's Review and Approval of the Premera and LifeWise Exchange Networks.

In the summer of 2012, Premera submitted to the OIC a proposal for a new network it called a "value-based network". Berendt 27-28. Extensive conversations ensued between Premera and the OIC "about what that would look like and how it would work." *Id.* Elizabeth Berendt ("Berendt"), as the OIC's Deputy Commissioner of Rates and Forms, was responsible through her division for the OIC's review and any approval of the Exchange networks. As such, Berendt was directly involved in extensive discussions with Premera regarding its proposed Exchange networks from September of 2012 into the second quarter of 2013. Maturi 14-15.

Premera told the OIC as early as the summer of 2012 that Children's would likely not be in its networks. *Id.* The OIC wanted to know how Premera would provide access to unique services that only Children's could provide, at an in-network benefit level. *Id.* According to Berendt, "At that time the discussion was what would happen if there weren't enough providers or if services were not available and we began to talk about the fact that the company would have to make available services for those types of procedures or treatments that were necessary." Berendt 27:21-28:1.

In assessing insurance plans, the OIC considers various categories of review. Specifically for the 2014 Exchange products, the OIC reviewed "forms," i.e., the policy contract; "rates," i.e., premium rates; the networks; and "the binder". Berendt 21-22. The binder is the shorthand term used by the OIC for its report of the review process to the federal government. *Id.* The binder is made up of required templates that were developed by

the federal government. *Id.*

Berendt did not do any of the actual physical review of Premera's networks. Berendt 31-32; 32:10-15; 20:11-22. However, she was involved in this review process, and contemporaneous documentary evidence establishes that when Berendt left the OIC, she was satisfied that the Premera networks were adequate and had approved them. Nollette 40:24-41:21; Nollette 44:19-46:4; 49-51. At the time of the approval of the Exchange plans, the analyst working under Berendt who reviewed the networks was Jennifer Kreitler ("Kreitler"). Berendt 31-32. Kreitler was responsible for generating the letters back to Premera and any further required interactions with Premera regarding its proposed Exchange networks. Berendt 21:15-25.

Berendt and Kreitler worked closely together. Berendt 31-32. Kreitler would come to Berendt to discuss issues, concerns, and particular problems regarding the proposed networks as they dealt with "the Premera product development." *Id.*

During the review process, Premera explained in detail to the OIC the process that would be available to its members to obtain medically necessary services at Children's at an in-network benefit level where such services were not available in Premera's Exchange networks – the process that has been working as proposed for the first seven months of the operation of the Exchange. Premera explained that in these situations, it had a process in place to be sure that the member would be covered at the in-network benefit level. Maturi 16:9-21. Premera explained that it would use its existing benefit level exception process "so that when a service was either emergency or a service was uniquely needed" – prompted by "medical necessity or unique services reasons" – Exchange members would obtain access to Children's at the in-network benefit level through this process. Maturi 14-15. This meant that Children's would not be able to "balance bill" the member pursuant to the contract between Children's and Premera.

Exhibit 91 is a May 6, 2013 letter from Kitti Kramer of Premera to Berendt that

includes a CD that discloses the make-up of Premera's Exchange networks. The CD also explains, at page 3, Premera's "infrastructure to support preauthorization and benefit level exception process" as a means to provide Exchange members access to out of network services, including those services offered at Children's. Nollette 44:19-46:4; 49-51; *see also* Maturi 14-15. Exhibits 90 and 92 are additional exchanges between Premera and OIC regarding this subject matter.

Based on these communications and the information provided by Premera, Berendt approved the Premera networks. Nollette 40:24-41:21; Nollette 44:19-46:4; Nollette 49-51.

Contemporaneous internal OIC documents known as "SCRUM notes" memorialize Berendt's review and approval of the Premera networks. Nollette 44:19-46:4; Nollette 49-51. Specifically, the SCRUM notes show that by May 28, 2013, the OIC had deemed Premera's network "ok." *See* Exhibit 99 (noting that with respect to Premera's network, "CD under review – almost complete, some tweaking necessary") & Exhibit 100 (noting, with respect to Premera's network, "ok")¹.

Berendt was replaced as Deputy Commissioner of Rates and Forms by Molly Nollette ("Nollette") on about June 25, 2013, and Nollette worked with Kreitler as Berendt had done. Nollette 5:16-25; Kreitler 26-28. The OIC witnesses will testify that at no time did Berendt express any concerns about Children's absence from Premera's networks. Nollette 27:21-24. Therefore, at first Nollette was unaware whether Children's was "in or out" of Premera's networks. *Id.*

Nollette ultimately learned that Premera's networks did not include Children's from Suzanne Petersen Tanneberg, a Children's executive. Nollette 28-29. Ms. Tannenbergs

¹ Berendt claims to remember that she informed Premera that Premera's benefit level exception process would be the "exception" for treatments such as "transplantation," but there is no documentary evidence of these purported communications. Berendt 27:4-28:5. She has taken this position only since she started working as a consultant for Children's. Since October 11, 2013 Berendt has worked as a consultant for Children's; her compensation is \$5,000 per month and the termination date of her contract is December 31, 2014. Berendt 93:10-19.

communication prompted Nollette to instruct Kreitler to again review the Premera networks. *Id.*; Kreitler 26-28. Under Nollette's supervision, Kreitler conducted another review of the Premera networks. As before, Kreitler conducted her review while referencing the binder that the OIC had received from the federal government and was forwarded to Nollette. *See* Kreitler 26-28; Nollette 44:19-46:4. Specifically, Kreitler examined "Provider Network Form A," the "ECP template," and other documents that comprised the binder. *Id.* Provider Network Form A is a data report that identifies which providers are in the network under review, and identifies specialty codes associated with those providers. *Id.* The CMS ECP tool is a computer program developed by the Center for Medicaid and Medicare Services ("CMS") to determine whether a proposed network satisfies Essential Community Provider ("ECP") requirements of the Affordable Care Act. Kreitler 40-48.

In addition, Kreitler and Nollette examined the member handbooks for Premera's Exchange products and specifically "reviewed how the [members'] access [to Children's and Mary Bridge] worked in the handbook." *See* Kreitler 27-28. The OIC staff required Premera to re-draft and redesign the benefit level exception process set forth in its member handbooks for the Exchange product to make it more clear and consumer-friendly.

The OIC does not interpret the ACA as requiring that Essential Health Benefits ("EHBs") be provided by in-network providers. Nollette 10-11. All EHBs must be covered by the Exchange plans, but those services can be provided by out-of-network providers: "access must still be provided to those medically necessary covered services at the in-network cost sharing and without balance billing." Nollette 11. Access to EHBs must be provided "under the same terms as if provided by an in-network provider." Nollette 12. "The coinsurance deductible and other patient responsibility items must be as if it was in network." Nollette 13.

By reviewing prior Premera correspondence from Premera to Berendt, and through her own communications with Premera, Nollette learned that Premera "had a process in place

to provide a benefit level exception,” and “they had contracts in place with Seattle Children’s that they would invoke in case they needed them.” Nollette 43:8-19; Ex. 103. On this basis, both Kreitler and Nollette confirmed Berendt’s approval of the Premera networks. *Id.*; Nollette 64; *see* Kreitler 26-28.

3. Approval of Services at Children’s Under Premera’s Exchange Plans.

From January 1 to mid-July 2014, there were a total of 770 requests from approximately 500 patients for benefit level exception requests with respect to Children’s by Premera or BridgeSpan members. Vanderwerff 65:1-16. Of the 770 requests, 670 or 84% had been approved to receive services from Children’s at in-network benefit levels. Vanderwerff 63:23-64:1-12. If Premera denies a member’s request for a BLE, it sends the member the name of at least one in-network provider who can perform the service. The OIC is satisfied that the process is functioning as it was envisioned by Premera and described to the OIC and in accordance with the ACA and Washington law. *See* Nollette 64-72.

One of Children’s primary arguments against the OIC’s approval of the Premera and BridgeSpan Exchange networks is the alleged administrative burden being placed on Children’s as a result of being out-of-network for both of those carriers’ Exchange networks. However, the OIC does not recognize added administrative burdens to providers as relevant under state law or the ACA in determining network adequacy. Nollette 66:26-67:1.

Nonetheless, Children’s alleges that it has had to devote three full-time-equivalent employees to assisting patients with making benefit level exception requests to their carriers. Further, Children’s alleges that its salaried executives have had to devote time to implementing this process, and that this has burdened Children’s in ways that cannot be financially quantified. Vanderwerff 26-27, 32-33.

While Children’s concedes that the benefit level exception process is not a new process, Children’s complains that the process for Premera and BridgeSpan’s Exchange members has been more time-consuming. Vanderwerff 101-102. However, Children’s

admits that Premera has worked collaboratively with Children's to improve the efficiency of the process. Vanderwerff 26-27; Exhibit 23 (Children's Vice President of Medical Affairs notes in an email to Premera, "your team has done a lot of work to improve the responsiveness and open up lines of communication" and that the benefit level exception process "has improved."). In comparison to the administrative hurdles the entire health care industry – providers and carriers included – has faced in implementing the requirements of the ACA, Children's alleged administrative burdens are, at best, minor and certainly no basis for the extraordinary relief it seeks in this proceeding.

D. The OIC Properly Found That Premera's Networks Satisfied Network Adequacy Requirements.

Children's claims fail because it cannot show that the OIC violated either state or federal law in approving Premera's networks without Children's as an in-network provider. Premera's networks satisfied both state and federal network adequacy guidelines, and therefore the OIC did not err in approving those plans.

1. The OIC correctly found that Premera's Exchange plans satisfied Washington's statutory and regulatory requirements.

Under Washington law, carriers are required to maintain a network "sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay" and that "each covered person shall have adequate choice among each type of health care provider." WAC 284-43-200(1); *see also* RCW 48.43.515(1) ("Each enrollee in a health plan must have adequate choice among health care providers."); RCW 48.43.500(2) (providing that enrollees must "[h]ave sufficient and timely access to appropriate health care services, and choice among health care providers.").

Washington's network adequacy regulation further provides that "sufficiency" and "adequacy" may be established "with reference to **any reasonable criteria used by the carrier**, including but not limited to: 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 technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.” WAC 284-43-200(2) (emphasis added).

In addition, pursuant to the ACA and associated regulations, the Washington legislature passed legislation requiring the OIC to select a state benchmark plan for the individual and small group markets. RCW 48.43.715(1).² The OIC may then only certify health plans for the Exchange that are “substantially equal to the benchmark plan.” RCW 48.43.715(3). Any plan thus certified must include, at a minimum, all of the ten essential health benefit categories specified in Section 1302(b) of the ACA. *Id.*

As a result, Washington’s definition of “essential health benefits” incorporates those ten categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance abuse disorder services; (6) prescription drugs; (7) rehabilitative and habilitative health services; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) **pediatric services**, including oral and vision care. WAC 284-43-865 (emphasis added).

The evidence shows that the Premera networks meet and, indeed, exceed these network adequacy requirements. Testimony from OIC staff and from Premera will demonstrate that Premera set reasonable criteria to build networks that satisfied the statutory and regulatory requirements. Premera enrollees have ample choice among providers and have access to necessary services. Furthermore, the evidence shows that Premera – without the inclusion of Children’s in its networks – includes all ten essential health benefits required by RCW 48.43.715.

Further, to the extent Premera’s Exchange members require Children’s services for

² In the event that such benchmark plan falls short of the requirements of the ACA, the OIC “shall, by rule, supplement the benchmark plan benefits as needed to meet the [ACA’s] minimum requirements.” RCW 48.43.715(2).

medically necessary treatments, Premera's benefit level exception process satisfies Washington's network adequacy requirements. Indeed, the OIC has determined that Premera's benefit level exception process has been functioning as intended since the advent of the Exchange plans.

The evidence shows that the OIC staff diligently analyzed Premera's proposed networks. Indeed, prior to the approval of the networks, the OIC engaged with Premera about certain aspects of the networks to ensure their adequacy. At that time, as the evidence shows, Premera worked with the OIC, addressing each of its concerns. The OIC did not simply rubber-stamp Premera's networks, but instead actively addressed perceived deficiencies within the networks and only approved Premera's plans after a rigorous analysis and review of those plans' networks.

Indeed, the high level of scrutiny applied to the benefit level exception process shows the rigor of the OIC's review. For example, when reviewing the member benefit handbook for the Exchange products, the OIC staff required Premera to re-draft and redesign the benefit level exception process to make it clearer and more consumer-friendly.

Children's argues that Premera's networks are inadequate because they do not include Children's. This claim fails as a matter of fact and a matter of law. First, Washington law and the ACA do not require the inclusion of any particular provider in a network. Second, Children's cannot show that Premera's networks are inadequate.

There is no requirement that a carrier must contract with a provider who has the most experience in providing a certain type of treatment to a certain segment of the population (e.g., pediatric specialty care). Nor is there any requirement that a carrier must contract with specialty providers capable of treating every single type of member condition that may arise. Indeed, the Washington regulations explicitly provide that, although health carriers are prohibited from limiting the scope of the essential health benefit category based on the type of provider delivering the service, "[t]his obligation does **not** require an issuer to contract

with any willing provider.” WAC 284-43-877(5) (emphasis added). Rather, the network adequacy requirements ensure that plans contract with a sufficient number of providers in certain mandated categories so as to provide *adequate* care options for covered services to the population as a whole.

Further, the network adequacy standards do not require that all services be provided by in-network providers. WAC 294-43-200(3) expressly allows carriers to utilize out-of-network providers for any purpose as long as the consumer is not put in a worse position. In other words, for unique services rendered by Children’s to Premera Exchange members, the law allows for a process that provides for such care to be delivered at in-network rates, with in-network deductibles and cost-sharing for enrollees.

Premera will present expert testimony from economist Cory Capps, who will explain why competition among healthcare providers – which hinges upon an ability to exclude from networks those providers who demand high prices (i.e., “selective contracting”) – is critical to controlling healthcare costs. In particular, he will explain why a determination that network adequacy requires inclusion of Children’s would undermine selective contracting, increase the costs of insurance on the HBE, and undermine the access, affordability, and coverage expansion goals of the ACA. He will further testify regarding how value-based networks, such as the Premera networks, allow for affordable healthcare, the very purpose underlying the ACA and the Exchange.

Further, Children’s will be unable to present any evidence that there are EHBs that are not included for Premera members on its Exchange plans. In addition to Premera’s extensive network of providers, Premera’s benefit level exception process specifically provides a mechanism by which its members may receive benefits at an in-network price if no Premera provider within the member’s geographic area provides the appropriate service. Premera has processed several hundred of these requests and has granted the vast majority of them. Vanderwerff 63:23-64:1-12. Indeed, the evidence shows that this process continues to

improve and that necessary benefit level exceptions are granted quickly and efficiently.

2. The OIC correctly found that Premera's Exchange plans satisfied the ACA's requirements.

The evidence shows that Premera's plans similarly meet all federal guidelines, and therefore the OIC properly certified these plans. The ACA authorizes the promulgation of regulations by the Secretary for the certification of Qualified Health Plans ("QHPs"). The Secretary's certification criteria must "include within health insurance plan networks those essential community providers, where available, that serve predominantly low-income, medically underserved individuals . . . **except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure**". 42 U.S.C. 18031(c)(1)(C) (emphasis added).

Thus, even though Children's is an "essential community provider" as determined by the Centers for Medicare and Medicaid Services ("CMS"), that fact does not determine whether Premera's plans were properly certified. The Secretary's regulations do not require the inclusion of every single "essential community provider" ("ECP") in a service area. Instead, 45 CFR § 156.235 provides that: "A QHP issuer must have a **sufficient** number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards." (Emphasis added.)

ECP categories include providers such as family-planning providers and Indian Health providers. One ECP category is "Hospitals." "Hospitals" is defined as "DSH [Disproportionate Share Hospitals] and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals." Thus, while every QHP must include "at least one ECP in each ECP category," there is no requirement that a QHP include any specific ECP provider types, i.e.,

subcategories of ECPs. Indeed, the regulations on this are clear: the requirement to include at least one ECP shall not “be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.” 45 CFR §156.235(d).

The regulatory guidance emphasized that regulators intended to draft the regulation for such a result: “While QHP networks should provide access to a range of health care providers, we are concerned that mandating inclusion of a list of specified provider types would detract from the larger issue of broadly ensuring access to the full range of covered services (that is, essential health benefits).” Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310-01. Moreover, the federal regulation is consistent with the requirements of Washington’s statutory and regulatory scheme governing network adequacy, which require a carrier’s network to include providers of pediatric services (e.g., hospitals) but does not require it to include every provider of those services, nor providers that specialize in providing those services, nor the most sophisticated and experienced provider.

The evidence shows that Premera’s plan easily meets these standards. The network for Premera’s Exchange plans includes at least one ECP from each ECP category. Premera and OIC witnesses will testify that Premera has contracted with several “Hospitals” – the ECP category into which Children’s falls – and therefore is in compliance with these federal standards. A QHP need not include every ECP, only a sufficient number of geographic distributions of ECPs.

CMS has provided guidance on the very question of how many ECPs would constitute an adequate network. In an April 2013 letter to HBE plan issuers – which governed QHPs on the 2014 Exchange, like Premera’s Exchange plans – CMS explained that an application for certification for a QHP would be determined to meet the regulatory standards if:

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at least 20 percent of available ECP's in the plan's service area participate in the issuer's provider network(s). In addition to achieving 20 percent participation of available ECP's the issuer offers contracts prior to the coverage year to: [1] All available Indian providers in the service area, using the model QHP addendum for Indian providers developed by CMS; and [2] At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available.

Even if the network does not include 20% or more of the available ECPs, CMS may still certify the plan as a QHP if it includes 10% or more of the available ECPs, and the issuer provides a "satisfactory narrative justification" describing the adequacy of its networks. Notably, this guidance similarly does not require any minimum number of sub-category providers of ECPs.³

Thus, to preserve its argument, Children's must urge this tribunal to disregard CMS's clear and reasonable standards. See *Seattle Children's Hospital's Opposition to Intervenors' Joint Motion for Summary Judgment* ("SCH's Opposition to MSJ") at 16. However, the OIC's interpretation of its own regulations should not be disregarded simply because Children's disagrees with it. *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417-18, 113 S. Ct. 2151, 2161, 124 L. Ed. 2d 368 (1993) (explaining "where the agency's interpretation of a statute is at least as plausible as competing ones, there is little, if any, reason not to defer to its construction"). Indeed, "[w]hen the meaning of regulatory language is ambiguous, the agency's interpretation of the regulation controls so long as it is 'reasonable,' that is, so long as the interpretation sensibly conforms to the purpose and wording of the regulations." *Lezama-Garcia v. Holder*, 666 F.3d 518, 525 (9th Cir. 2011).

Children's has to show that CMS's guidance is in conflict with the federal and regulatory statutes. But CMS's interpretation is reasonable. It prevents providers, like Children's, from extorting unreasonable rates in the event that plans were forced to contract

³ It appears that the 2015 guidance only applies to plans on the federally facilitated marketplace, whereas the 2014 guidance applied to both federal marketplace plans and state partnership exchanges.

with it. The evidence shows that Premera could not offer its Exchange product to Washington citizens at its current affordable price if it were to contract with Children's to bring Children's in-network for its Exchange plans. Again, Premera's expert, Dr. Capps, will testify regarding how value-based networks maintain affordability, and thus promote the objectives of the ACA.

Premera's plans, which include a vast network which includes over 87 hospitals and 28,276 providers, satisfy the federal regulations regarding ECPs because they include more than 20% of the available ECPs in the service area and at least one ECP from each ECP category in each county in the service area.

E. Children's Has Not Alleged Injury That Is Legally Cognizable or That This Tribunal Can Remedy.

As a fundamental matter, Children's cannot show that it has been "aggrieved" in a way that is legally cognizable or capable of remediation by this tribunal. The OIC allows for hearings to challenge agency action "upon written demand for a hearing made by any person aggrieved by any act, threatened act, or failure of the commissioner to act, if such failure is deemed an act under any provision of [the Insurance Code]." RCW 48.04.010. It is Children's burden to show that based on these standards, it has standing to challenge the agency action at issue. *See KS Tacoma Holdings, LLC v. Shorelines Hr. Bd.*, 166 Wn. App. 117, 127, 272 P.3d 876 (2012). Children's will fall well short of meeting this burden.

Children's cannot show that it has been aggrieved. Washington's Administrative Procedure Act ("APA") defines "aggrieved" for purposes of seeking judicial review of an agency action; a person is "aggrieved" by agency action "only when **all three** of the following conditions are present: (1) The agency action has prejudiced or is likely to prejudice that person; (2) That person's asserted interests are among those that the agency was required to consider when it engaged in the agency action challenged; and (3) A judgment in favor of that person would substantially eliminate or redress the prejudice to that

person caused or likely to be caused by the agency action.” RCW 34.05.530 (emphasis added). “The first and third conditions are often called the ‘injury-in-fact’ requirement, and the second condition is known as the ‘zone of interest’ test.” *Wash. Indep. Tel. Ass’n v. WUTC*, 110 Wn. App. 498, 511-12, 41 P.3d 1212 (2002).

“‘[A] person is aggrieved or adversely affected within the meaning of the APA standing test only when the zone of interest *and* injury-in-fact prongs are satisfied.” *Allan v. Univ. of Wash.*, 140 Wn.2d 323, 332, 997 P.2d 360 (2000) (emphasis in original; internal citation omitted). Far from meeting its burden to establish all three of these criteria, Children’s will fail to satisfy a single prong of the APA’s test. It has neither suffered an injury-in-fact, nor is it in the “zone of interest” of the OIC with respect to the OIC’s review of Premera’s Exchange plans.

1. Children’s cannot demonstrate injury-in-fact.

Children’s will not be able to show either that it has been prejudiced by the OIC’s certification of Premera’s Exchange plans, nor will it be able to show that a judgment from this tribunal will offer it any relief that can redress that purported prejudice.

To establish an injury-in-fact, “the person must demonstrate that he or she is (or will be) specifically and perceptibly harmed by the agency action and, moreover, that this injury will be redressed by a favorable decision by the reviewing court.” *Patterson v. Segale*, 171 Wn. App. 251, 254, 289 P.3d 657 (2012). Thus, Children’s must show at this hearing (1) that it has been harmed by the OIC’s approval of Premera’s Exchange plans and (2) this tribunal may offer it relief to correct this harm. Children’s will not be able to do so.

Children’s cannot show that it has been harmed by the approval of Premera’s Exchange plans that use networks that do not include Children’s. The large majority of services for which Children’s has sought a benefit level exception for Premera’s Exchange members have been granted. To be sure, the whole point of the cost savings arguments in favor of value-based networks is that such networks redirect patients from high priced

hospitals to lower priced hospitals. One implication is that the high-priced hospital has less revenue and profit than it otherwise would. But this is not a cognizable injury-in-fact.

Furthermore, Children's has been compensated for its services at the same rate it receives for its non-Exchange business with Premera. As OIC witnesses will testify, Premera's benefit level exception system has worked: its Exchange members have received unique services from Children's when medically necessary, as Premera has approved 84% of those requests. Regardless, Children's cannot show standing through any injury to its patients – standing is conferred only on the basis of harm to the person or entity purportedly aggrieved, not to third parties. *Allan*, 140 Wn.2d at 332-33 (plaintiff lacked standing where “[s]he has not shown a concrete interest of her own,” instead relying on the interests of her husband); *West v. Thurston Cnty.*, 144 Wn. App. 573, 578, 183 P.3d 346 (2008) (“The doctrine of standing prohibits a litigant from asserting another's legal right.”). Thus, any alleged harm suffered by enrollees and patients, even if it existed, is irrelevant for purposes of determining whether Children's has been “aggrieved.”

It is for this reason that the testimony Children's plans to present from Premera enrollees Alexandra Szablya and Jenni Clark is irrelevant to whether Children's was aggrieved. Likewise, whether other enrollees or patients have been aggrieved is similarly irrelevant for purposes of the standing analysis.

Indeed, the purpose of the ACA is to remedy the fact that many Exchange plan enrollees were uninsured prior to the introduction of the Exchange plans. And, those enrollees who previously had Children's as an in-network provider on their former health plans had the option to select another Exchange plan that did include Children's.

Additionally, Children's complaints about administrative burdens are not cognizable in this tribunal because the OIC does not recognize added administrative burdens to providers as relevant to determining network adequacy under state law or the ACA. *Nollette* 66:26-67:1. Moreover, the alleged burdens are not oppressive. The ACA is a new and vast

regulatory regime operating at the federal and state level that has been an enormous challenge for all participants to implement, and it inevitably involves some administrative burdens.

Finally, Children's cannot show injury-in-fact because a judgment from this tribunal will not redress any prejudice purportedly suffered by Children's. Children's cannot seek damages from this tribunal, and even now, on the eve of trial, it is not at all clear what relief Children's is seeking. Its demand seeks "Reconsideration of the decisions," "Imposition of a stay of the decisions," "Revocation or reversal of its decisions," and "Such other and further relief as this tribunal may grant under its authority." Demand at 3. However, Children's has not addressed what the practical effects of a revocation or a reversal – the ultimate relief it appears to be seeking – would be to the over 90,000 enrollees on Premera's Exchange plans.

Moreover, Children's has failed to show that such relief would address the prejudice that it purportedly suffers due to its exclusion from Premera's networks. Specifically, such a reversal would not lead to a decertification of Premera's Exchange plans, as the OIC does not have the power to decertify QHPs. The ACA requires the Secretary of Health and Human Services (the "Secretary") to "establish criteria for certification of health plans as qualified health plans ["QHPs"]." 42 USCS § 18031(c)(1)(B). The Secretary promulgated a series of regulations concerning the certification process for QHPs. Under 45 CFR 155.1080, the Exchange "must establish a process for the decertification of QHPs." Thus, decertification is a process that is determined and overseen by the Exchange, which is a "self-sustaining public-private partnership separate and distinct from the state." RCW 43.71.020. The Exchange, created by the Washington legislature by RCW 43.71.005 *et seq.*, is not a branch of the OIC, and therefore the OIC cannot compel the certification or decertification of a QHP. Yet, instead of challenging the Exchange's decision to certify Premera's plans, Children's has instead brought this dispute to the OIC, which has no authority over the certification of a QHP.

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2. Children's is not within the zone of interest of the OIC's regulation of HBE plans.

Children's will not be able to show that it is within the zone of interest that the Legislature directed the OIC to consider in promulgating regulations regarding network adequacy and the HBE. In order to have standing before this tribunal, Children's will have to show that its "asserted interests are among those that the agency was required to consider when it engaged in the agency action challenged." RCW 34.05.530(2). This inquiry "addresses the concern that mere injury-in-fact is not necessarily enough to confer standing because so many persons are potentially 'aggrieved' by agency action." *St. Joseph Hosp. & Health Care Ctr. v. Dep't of Health*, 125 Wn.2d 733, 739, 887 P.2d 891 (1995). Thus, "[t]he test focuses on whether the Legislature intended the agency to protect the party's interest when taking the action at issue," and "limit[s] review to those for whom it is most appropriate." *Wash. Indep. Tel. Ass'n*, 110 Wn. App. at 513 (quoting *Seattle Bldg. & Constr. Trades Council v. Apprenticeship & Training Council*, 129 Wn.2d 787, 797, 920 P.2d 581 (1996)).

Children's will not be able to point to a single regulation or statute applicable to this hearing in which the interests of providers are expressly considered – because no such law exists. For instance, network adequacy regulation WAC 284-43-200 is silent on the rights of providers, like Children's, because that is not the intention behind that regulation. The plain language of the regulation shows that it is meant to provide "sufficiency and adequacy of choice" for "covered persons." WAC 284-43-200. Nowhere in the statute does it extend a right to providers to be included in health carriers' networks. Similarly, RCW 48.43 emphasizes that its purpose is to inform enrollees and Washington state citizens. RCW 48.43.001. Along those lines, the ACA, too, notably omits any discussion of protecting or advancing the interests of providers. Like the Washington statutory and regulatory framework, the ACA is intended to protect healthcare *consumers*, not providers. *See, e.g.*, 42

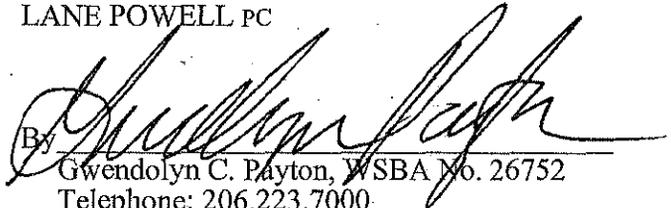
U.S.C. § 18031(c)(1)(B) (requiring that plans “ensure a sufficient choice of providers . . . and provide information to *enrollees and prospective enrollees* on the availability of in-network and out-of-network providers”) (emphasis added).

III. CONCLUSION

For the foregoing reasons, this Court must entirely reject Children’s claimed relief.

DATED: August 11, 2014

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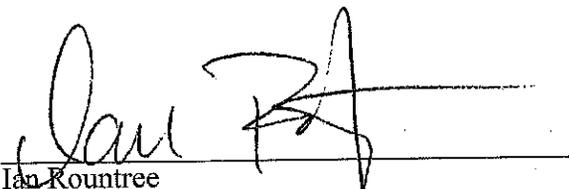
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CERTIFICATE OF SERVICE

I, Ian Rountree, hereby certify under penalty of perjury of the laws of the State of Washington that on August 11, 2014, I caused to be served a copy of the attached document to the following person(s) in the manner indicated below at the following address(es):

<u>OIC HEARINGS UNIT</u> Office of the Insurance Commissioner 5000 Capitol Boulevard Tumwater, WA 98501 Email: kellyc@oic.wa.gov	<u>Seattle Children's Hospital</u> Michael Madden Bennett Bigelow & Leedom, P.S. 601 Union Street, Suite 1500 Seattle, WA 98101 Email: mmadden@bblaw.com
<u>Deputy Insurance Commissioner for Legal Affairs</u> AnnaLisa Gellerman Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255 Email: annalisag@oic.wa.gov	<u>BridgeSpan Health Company</u> Timothy J. Parker Carney Badley Spellman 701-Fifth-Avenue, Suite 3600 Seattle, WA 98104-7010 Email: parker@carneylaw.com
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