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STATE OF WASHINGTON
BEFORE THE WASHINGTON STATE
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of: **Seattle Children's Hospital Appeal of OIC's Approvals of HBE Plan Filings.**	**Docket No. 13-0293** **SEATTLE CHILDREN'S HOSPITAL'S HEARING BRIEF**

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I. INTRODUCTION

The fundamental question presented by this appeal is whether, under the Patient Protection and Affordable Care Act of 2010 ("ACA") and applicable state law as applied to the specific circumstances of this case, covered pediatric services required by Washington Health Benefit Exchange enrollees must be provided by "participating providers" who are part of a "network" of providers reasonably accessible to those enrollees. The evidence will show that, with respect to Seattle Children's Hospital ("SCH"), the answer to that question is yes. Indeed, in an earlier proceeding involving Coordinated Care Corporation ("CCC") in which the same issue was presented, the Commissioner insisted that, for products offered through the Exchange, access to pediatric hospital and specialty services must be provided through in-network providers, and that to do otherwise would violate state and federal law. Nothing justifies a different position in this case.

II. OVERVIEW OF REGULATORY REQUIREMENTS

The ACA authorized states to sponsor Health Benefit Exchanges ("HBE"), through which health carriers may offer "Qualified Health Plans" ("QHPs") to individuals and small employer groups, beginning in January 2014.[1] Washington elected to sponsor an HBE[2] and charged the Office of the Insurance Commissioner ("OIC") with responsibility for review of QHPs for compliance with state insurance and applicable ACA requirements.[3]

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[1] 42 U.S.C. § 18031(b)(1); 42 U.S.C. § 18041(c)(1).

[2] RCW 43.71.010 *et seq.*

[3] RCW 41.71.005(2)(i); RCW 48.43.065(a); RCW 48.53.715.

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One key ACA requirement is that QHPs must cover ten categories of "essential health benefits" ("EHBs").[4] The list of mandated EHBs includes "pediatric services."[5] These services must be provided through "a network that is sufficient in number and types of providers ... to assure that all services will be accessible without unreasonable delay."[6] Another key ACA requirement is that QHPs must "include within their health insurance plan networks those essential community providers, where available, that serve predominantly low-income, medically underserved individuals...."[7] This "ECP" requirement applies to several distinct categories of providers, one of which is "children's hospitals," which are defined as those "whose inpatients are predominantly individuals under 18 years of age."[8] The federal government and the OIC recognize Seattle Children's Hospital ("SCH") as an ECP.

In addition, state law requires "health care service contractors," such as BridgeSpan[9] and Premera/LifeWise,[10] to provide health care services through "participating providers," which are defined as those who "contracted in writing with a health care service contractor to accept

[4] 42 U.S.C. § 18021(a)(1)(B).

[5] 42 U.S.C. § 18022(b)(1).

[6] 45 C.F.R. § 156.230(a).

[7] 42 U.S.C. § 18031(c)(1)(c).

[8] *Id.*, defining ECPs to include health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)], which in turn references 42 U.S.C. § 256(b)(a)(4)(M) pertaining to "A children's hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act [42 U.S.C. 1395ww (d)(1)(B)(iii)]," which contains the cited definition.

[9] BridgeSpan Health Company is part of a "family" of health insurance companies owned by Cambia Health Solutions, the new name (as of 2011) of the holding Company formerly known as the Regence Group. The BridgeSpan plan available on the Exchange uses a network labeled as the "RealValue" network, a network also used by certain Regence BlueShield health plans off the Exchange.

[10] Premera Blue Cross and its affiliate, LifeWise Health Plan of Washington, both use the same network of participating providers for their QHPs. The network for the Premera product is labeled as the "Heritage Select" network, and for the LifeWise product is labeled as the "LifeWise Connect" network.

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payment from and to look solely to such contractor" for payment.[11] RCW 48.43.515(4) further requires all health carriers to "provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted." (Emphasis added). For the 2014 plan year, this requirement was effectuated by former WAC 283-43-200(1), which stated in part, "A health carrier shall maintain each plan network in a manner that is 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."[12]

Altogether, the ACA and state law require QHPs to provide EHBs through a network of participating providers, including available ECPs so long as those ECP providers are, under the ACA, "willing to accept the generally applicable payment rates" of the plan,[13] or under state law, providers are willing "to contract with the carrier under reasonable terms and conditions."[14]

III. FACTS

A. OIC's Review of 2013 Exchange Submissions.

During the spring and summer of 2013, the OIC reviewed a large number of filings submitted by health plans seeking approval to offer coverage through the Washington HBE and non-Exchange market. The OIC was charged with determining whether the filings met new standards under the ACA and state law. The OIC's task, which was extremely time-sensitive, was made more difficult because of significant turn-over of its senior staff. The OIC also has

[11] RCW 48.44.020; RCW 48.44.010(9), (14).

[12] This rule was amended in 2014, but the amendment is not retroactive. Further, insofar as the OIC may contend that the new rule justifies its current position, SCH reserves all rights with respect to such a claim.

[13] 42 U.S.C. §18031(c)(2).

[14] Former WAC 284-43-200.

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acknowledged that it had a bias at this time in favor of approval of plans.[15] As a result, the OIC made a number of critical errors that adversely affected SCH and children enrolled in the BridgeSpan and Premera/LifeWise plans.

As relevant here, on July 31st, the Commissioner announced that he had approved the QHP filings submitted by Group Health Cooperative, Community Health Plan of Washington, BridgeSpan Health Plan, Premera Blue Cross and LifeWise Health Plan of Washington.[16] On the same day, he disapproved the plans submitted by CCC and Molina HealthCare of Washington ("MHW").[17] A major reason for these disapprovals was the failure to include pediatric specialty hospitals in their provider networks.[18] Among the approved plans, Community Health Plan of Washington and Group Health Cooperative included pediatric hospitals (including SCH) in their networks. BridgeSpan and Premera/LifeWise did not include pediatric hospitals in their networks at the time of approval, but the responsible party on the Commissioner's staff – newly appointed Deputy Commissioner Molly Nollette – erroneously believed they did.[19]

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[15] SCH Ex. 176 at 51:25-52:1 (testimony of OIC analyst Jennifer Kreitler) ("[w]e were directed that all carriers should get into the exchange").

[16] Ex. 106.

[17] *Id.*

[18] *Id.*

[19] Ms. Nollette's deposition testimony was as follows:

> Q. So when -- and you were the person responsible for that approval [Premera]?
> A. That final decision, yes.
> Q. And when you made that decision, am I hearing you correctly that you were under the impression that Seattle Children's Hospital was in network before [for] that plan?
> A. Yes.
>
> ***
>
> Q. Did I ask you with respect to the BridgeSpan QHP approval in 2013, what was your understanding as to Seattle Children's network status for the purposes of that plan?
> A. At the time of approval?

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B. The Coordinated Care Hearing.

CCC and MHW immediately appealed the Commissioner's disapproval. CCC's appeal was heard August 26-28, 2013. Much of the hearing focused on the absence of pediatric hospitals from the plan's network. CCC contended that the need for services uniquely available at pediatric hospitals would be very low and that, when needed, those services could be accessed through use of "single case agreements," an arrangement negotiated on a per patient basis between the hospital and the plan. Contrary to its current position, the OIC insisted that, in order to meet state and ACA requirements, CCC's network had to include pediatric hospitals. The OIC characterized CCC's request to use single case agreements to provide covered pediatric hospital services as "unacceptable on its face [because it] poses potential harm to consumers, does not comply with Washington regulation, and is antithetical to the purpose of the ACA."[20] It explained, "the Commissioner does not approve such requests [for approval of single case agreements] for new product offerings, and certainly not to address a lack of a core category of provider," "such arrangements ... are used only when an extraordinarily uncommon specialty provider is needed to treat an enrollee's atypical condition," and "[c]hildren requiring hospitalization ... are not rare or unforeseen medical situations."[21]

On September 3, 2013, the OIC's Chief Presiding Officer issued a decision largely agreeing with CCC's position on single case agreements, as well as other points.[22] Following

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Q. Yeah.
A. I actually thought they were in network. Surprised me.

[20] *Id.* at 12.

[21] Ex. 107 (OIC's CCC Hearing Brief at 9-10).

[22] SCH Ex. 177 (CCC order 9/3/13).

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that decision, the OIC: (1) on September 4th, settled with MHW and approved its plan;[23] (2) on September 5th, approved CCC's plan;[24] and (3) on September 6th, submitted a pleading in the CCC adjudication conspicuously captioned "Motion of Commissioner Mike Kreidler for Reconsideration."[25] In his motion, the Commissioner directly attacked the idea that single case agreements can substitute for in-network status, arguing that the CCC ruling misconstrued the existing network adequacy rule and forced him "to permit Coordinated Care to enter the Exchange with an insufficient network."[26] The Commissioner further stated that Coordinated Care's network was inadequate because it had not been shown to "cover all of the essential health benefits required by law" and that it was error to allow CCC to "provide essential health benefits through non-networked providers."

The Commissioner's reconsideration motion was denied on November 15, 2013.[27] With respect to network adequacy, the Chief Presiding Officer concluded that the omission of pediatric hospitals from the CCC network was acceptable because the plan had submitted uncontroverted evidence that "it can provide 99% of covered pediatric ... services through its network providers," and then chastised the OIC's case, stating, "had the OIC presented clear argument and evidence to support its current position that Pediatric Specialty Hospitals ... must be included then this issue may well have been decided differently."[28]

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[23] SCH Ex. 178; SCH Ex. 179.

[24] SCH Ex. 180; SCH Ex. 181.

[25] Other pleadings submitted by the OIC in the matter were styled as submissions by the "OIC Staff."

[26] Ex. 108 at 11-12.

[27] Ex.109.

[28] *Id.* at 8-9.

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C. Nature and Scope of SCH Services.

SCH will present the evidence missing from the CCC case. This evidence shows that—without SCH—it is impossible to provide 99% or any percentage remotely similar amount of EHB pediatric hospital and specialty services in-network. Therefore, to the extent the OIC seeks to justify its decision based on the proposition that specialized pediatric hospital services can be effectively provided by in-network providers, the facts are to the contrary.

In evaluating this evidence, it is important to understand that, although children in general constitute a healthy population, a significant percentage (up to 18% in Washington according to the Department of Health) has significant chronic health problems.[29] These children consume medical care at a much higher rate and greater cost than healthy children, and many of them require the services of pediatric hospitals and specialists. These children account for the lion's share of services delivered at SCH. Additionally, it is critical to understand the ability and capacity to deliver pediatric hospital and specialty services is not ubiquitous. It is particularly expensive to construct and staff children's hospitals; everything must be "kid-sized" and "kid-friendly," and the staffing needs are greater (e.g. patient/nurse ratios are smaller) than for adult acute care hospitals. Additionally, the level of specialization required to cover the full range of pediatric services is such that major children's hospitals—like SCH—usually are affiliated with medical schools, and therefore incur the additional costs of operating a teaching hospital. In short, in most locations there are not multiple sources of pediatric hospital and specialty services available within a reasonable distance of each other.[30]

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[29] SCH Ex. 182.

[30] SCH Ex. 183.

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This is certainly true in Washington, which has only four licensed pediatric hospitals. SCH is by far the largest, with 323 beds, as compared to 177 at Sacred Heart in Spokane, 82 at Mary Bridge in Tacoma, and 30 at Shriner's in Spokane.[31] Among these hospitals, SCH is the only one that provides the entire range of tertiary and quaternary services for children.[32] Many of these services are uniquely available at SCH, including acute and complex cancer care for children and adolescents; pediatric cardiac intensive care; heart, liver and intestinal transplantation; bone marrow transplantation; care for medically complex children; complex hematology care; and rheumatology. In addition to these unique services, there are many services only available at SCH, Mary Bridge, or Sacred Heart. For example, in 2012, these three pediatric providers performed:

- 100% of cardiac surgeries.[33]
- 93% of all pediatric hematology/oncology treatments.[34]
- 38 other pediatric medical services that no other hospitals in Washington state provided, including bone marrow transplants, chemotherapy, and lymphoma/myeloma/non-acute leukemia treatment.[35]

In comparison to these hospitals, however, SCH sees twice as many inpatients.[36] It also serves patients from nearly every county in the state.[37]

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[31] SCH Ex. 184.

[32] SCH Ex. 185 at 32. Shriner's only provides orthopedic services and does not contract with insurers.

[33] SCH Ex. 63A. SCH performed 182 cardiac surgeries in 2012. *Id.*

[34] SCH Ex. 63A. SCH treated 1,096 pediatric hematology/oncology patients in 2012. *Id.*

[35] SCH Ex. 63A.

[36] SCH Ex. 64 (2012 statistics).

[37] SCH Ex. 64. The comparison is for inpatients under the age of 15. *Id.*

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It is true, as the intervenors will point out, that some acute care hospitals in the area have the capability to provide certain pediatric services. These hospitals are not able to treat the full range of pediatric problems, nor do they have the capacity to serve significantly more pediatric patients. By way of example, hospital inpatient discharges are categorized based on the patient's major diagnosis. These categories are called "APR-DRGs," for "All Patient Refined Diagnosis Related Groups." In 2012, SCH treated patients in 239 distinct pediatric APR-DRG categories (excluding neonates).[38] By comparison, during the same year, other local hospitals recorded the following pediatric APR-DRG statistics (also excluding neonates):[39]

Hospital	**Number of distinct APR-DRGs billed in 2012 (excluding neonates)**
Seattle Children's Hospital	239
Swedish Medical Center	120
Providence Everett	71
Valley Medical Center	62
Evergreen Hospital	60
Virginia Mason	15

Of these hospitals, the BridgeSpan network includes Evergreen (Kirkland) and Valley (Renton), while Virginia Mason, Valley and Evergreen are included in the Premera/LifeWise QHP networks.[40]

[38] SCH Ex. 63A. Treatment of neonates at hospitals often occurs as an adjunct to the mother's delivery of the neonates at those hospitals.

[39] SCH Ex. 63A.

[40] BridgeSpan also includes Mary Bridge Children's Hospital, located in Tacoma, and the University of Washington Medical Center and Harborview Medical Center. The UW hospitals only treat a limited range of pediatric conditions (neonates at UWMC, trauma and burns at HMC), and the pediatricians and pediatric specialists practicing at those hospitals are members of Children's University Medical Group ("CUMG"), the physician group affiliated with SCH, which is also out of network under intervenors' Exchange plans.

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Even those hospitals that have the capability to provide some pediatric services lack the capacity to provide more than a small fraction of required services. Of all hospitals within a 30-mile radius of its Seattle campus, for patients age 0 to 14, in state fiscal year 2012 SCH treated 81% of all pediatric inpatients, over 90% of all high acuity pediatric inpatients, and 75% of all pediatric psychiatric inpatients.[41] The following table illustrates the point:

Hospital	Number of inpatients ages 0-17 treated in 2012	Additional comments
Seattle Children's Hospital	10,499	
Swedish Medical Center	1,631	747 neonates and 119 ages 15-17.
Providence Everett	906	485 neonates and 92 ages 15-17.
Harborview	809	The top APR-DRG for Harborview's patients was burns (for ages 0-1, 1-4, and 5-9) and head trauma with coma (ages 10-14 and 15-17).
University of Washington Medical Center	532	377 neonates, 30 ages 15-17. None in the ages 1-4 or 5-9 brackets.
Valley Medical Center	632	259 were neonates. The top APR-DRG for Valley's pediatric patients was appendectomy (ages 10-14 and 15-17).
Evergreen Hospital	600	Of these patients, 298 were neonates. The top APR-DRG for Evergreen's pediatric patients was appendectomy (ages 5-9, 10-14 and 15-17).
Virginia Mason	19	All of these patients were ages 15-17. The primary APR-DRG for these patients was kidney/UTI.

[41] SCH Ex. 64.

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D. OIC's Belated Realization that SCH is Out-of-Network and Response.

Around the time of the CCC hearing, OIC Deputy Commissioner Molly Nollette, who was responsible for the QHP approvals, learned that SCH was not included in the BridgeSpan or Premera/LifeWise Exchange networks. Having disapproved the CCC and Molina filings for this very reason, and coming at a time when the Commissioner was emphatically insisting that single case agreements were not an adequate substitute for in-network status, this revelation created obvious problems for the OIC in terms of inconsistent decision making and the potentially significant impact of SCH being out-of-network with respect to these much larger plans. OIC sought to resolve those problems, not by reconsidering its approvals in light of the ACA and state network adequacy requirements, but by cobbling together a rationale to defend what it had already done.

In their CCC submissions, the OIC and Commissioner Kreidler took the position that because all QHPs must cover pediatric hospital services, state law and the ACA prohibit delivery of those services through out-of-network providers, except in very limited circumstances. With respect to Premera/LifeWise, however, the OIC struck out in a different direction, adopting a position advanced by Premera. Premera contended that because SCH is "in-network" for its other lines of business, it could utilize what it termed a "benefit level exception" ("BLE") process when its QHP enrollees require services "uniquely available" at SCH. Under its BLE process, Premera said that it would treat SCH as "in-network" if a QHP enrollee required covered services that one of its in-network providers could not deliver.[42] Premera further

[42] SCH Ex. 103. The state's Patient Bill of Rights requires that "[i]f the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers." RCW 48.43.515(4).

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contended that because SCH has a contract with Premera—which also covers LifeWise—for the plans' other lines of business, the hospital cannot "balance bill" QHP enrollees for amounts the plans do not pay.

Despite SCH's statement to the OIC that it does not agree with Premera's position[43]—and despite the substantial additional burdens the BLE process places on SCH and patients' families—the OIC's current position appears to be that the BLE process provides adequate access to covered services simply because it protects enrollees against balance billing. The OIC has taken this position notwithstanding the fact that Premera/LifeWise has told enrollees whose BLEs it granted that they are subject to balance billing.[44] At the same time, the OIC apparently still maintains its earlier position that single case agreements are not adequate, despite the fact that BridgeSpan uses them for services it approves at SCH.

Further, and of critical importance, throughout its attempts to construct a rationale to defend its contradictory positions, the OIC has ignored the available information regarding the scope and need for pediatric hospital services, as well as the capability and capacity of other hospitals and physicians to deliver medically necessary covered services to children enrolled in QHPs. Without this information, the OIC lacked a basis to determine—under the Commissioner's own rationale or the rationale articulated in the CCC decisions—whether the BridgeSpan and Premera/LifeWise networks met state network adequacy requirements or the applicable provisions of the ACA. It also lacked a basis to determine whether the BLE and single case agreement processes utilized by those companies were consistent with the ACA or

[43] Ex. 66.

[44] *E.g.* Ex. 127.

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state network requirements. With accurate information regarding the scope of services and relative capacity of SCH and other hospitals, it will become apparent that the Commissioner's approvals of these QHPs, and the continuing determination that their networks are adequate, were contrary to law and the Commissioner's long-standing interpretation of his own rule.

Additionally, the OIC has been blind to the consequence of allowing BridgeSpan and Premera/LifeWise to market QHPs on the Exchange without sufficient in-network access to pediatric hospital and specialty services. That consequence is known as "adverse selection," where, despite the fact that all QHPs must cover EHBs, the absence of SCH from BridgeSpan's and Premera/LifeWise's lists of in-network providers is likely to drive consumers with children—particularly those whose children have chronic or serious medical needs—to select other plans that include SCH. This effect is almost certainly what intervenors intend. The OIC should not permit it, however, particularly because if an exception is permitted for intervenors, the other plans are likely to seek the same treatment.

E. Adverse Effects of the Premera/LifeWise "BLE" and BridgeSpan "Single Case Agreement" Processes.

During the CCC hearing, the presiding officer was told that use of single case agreements by health plans to provide covered services by out-of-network providers was "common."[45] The experience at SCH prior to 2014 was the opposite: *e.g.*, of 351,147 patient visits (inpatient and outpatient) during FY 2012, SCH completed 67 single case agreements, or 0.02% of total patient encounters. From January 2014 through July 14, 2014, SCH had submitted BLE requests to

[45] SCH Ex. 177.

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Premera/LifeWise relating to 1,069 patient appointments.[46] These numbers have not been decreasing from month-to-month. Premera/LifeWise has approved 84% of these requests, after making a determination that the needed services are not available from "in-network" providers.

The BLE process is not at all like obtaining care from an in-network provider. It is an additional process—on top of the normal process of review for medical necessity, which results in delayed and fragment care. In addition, even after BLE approval, patients' families have been told that they are subject to balance billing and, in some cases, it appears that Premera/LifeWise has applied out-of-network cost sharing (deductible and co-insurance amounts), so that enrollees' financial responsibility is higher than if SCH was an in-network provider. SCH also has experienced significant administrative and financial burdens as a result of the BLE process.

Regarding BridgeSpan, it has a small overall enrollment and apparently very few children. As a result, SCH has sought reimbursement relating to two BridgeSpan QHP enrollees. As to one, SCH and BridgeSpan completed a single case agreement. These agreements take a significant amount of time and effort to negotiate. Despite completion of the agreement, BridgeSpan has not only failed to reimburse SCH, it has denied coverage entirely, leaving the enrollee solely responsible.[47] As to the other, SCH sought reimbursement for an urgent care visit, for which state law requires reimbursement at in-network levels.[48] BridgeSpan also denied coverage and payment for this claim.[49]

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[46] Ex. 54.

[47] Ex. 56.

[48] RCW 48.43.525(1).

[49] Ex. 56.

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IV. ARGUMENT

A. Providing Pediatric Services on an Out-of-Network Basis Violates the ACA.

During the CCC proceedings, the OIC staff and Commissioner strongly expressed the view that the ACA's requirement to cover pediatric services, and specifically pediatric hospital services, cannot be fulfilled through spot-contracts or single case agreements. Although it claims to hold the same view today, it continues to permit BridgeSpan to utilize exactly that device. With respect to Premera/LifeWise, it has seized on the notion that the BLE process can be equated with in-network status, despite the fact that all the arguments it has advanced against single case agreements and for requiring in-network pediatric hospitals apply with equal force to the BLE process.

1. Applicable Law re: Essential Health Benefits.

As noted earlier, the ACA requires QHPs to provide coverage for essential health benefits,[50] including, "Pediatric services."[51] The HHS regulations provide specifically that a QHP issuer must "[m]aintain[] a **network** that is sufficient in number and types of providers ... to ensure that all services will be accessible without unreasonable delay."[52] This requirement is reflected in what federal regulations term the "EHB-benchmark plan."[53] Each state must identify a state "benchmark" plan that meets the EHB requirements.[54] Washington law incorporates this

[50] 42 U.S.C. § 18021(a)(1)(B) [ACA § 1301] ("The term 'qualified health plan' means a health plan that ... provides the essential health benefits package described in section 18022(a)"); 42 U.S.C. § 18022(a) [ACA 1302(a)] ("'Essential health benefits package' means ... coverage that ... provides for the essential health benefits").

[51] 42 U.S.C. § 18022(b)(1).

[52] 45 C.F.R. § 156.230(a) (emphasis added).

[53] 45 C.F.R. § 156.110(a).

[54] 45 C.F.R. § 156.100.

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requirement.[55] Washington's "benchmark" plan is the Regence Blue Shield "Innova" small group plan as offered during the first quarter of 2012.[56] SCH is "in-network" under this plan.

In fact, SCH is in-network for every commercial large group product actually sold to purchasers by Regence and Premera/LifeWise. Premera has tried to sell large group commercial products without SCH in-network, but consumers refuse to buy them. And, perhaps ironically, for the state's Medicaid Managed Care Program serving low income and disabled children, SCH is also "in-network." Only BridgeSpan products offered through the Exchange or Premera/LifeWise's Exchange and non-Exchange individual products exclude SCH.

2. The OIC's changing arguments.

As also noted, during the CCC hearing, the OIC and Commissioner Kreidler took the position that consumers must have the ability to access EHB services through network providers. Specifically, in his motion for reconsideration, Commissioner Kreidler stated that a QHP that does not have a network including pediatric hospitals does not "cover all of the essential health benefits required by law" and that it would be a violation of law to allow a plan to "provide essential health benefits through non-networked providers."[57] Now, however, the OIC seems to be taking the position that EHBs can be provided through out-of-network arrangements, so long as there is what it terms "reasonable access."

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[55] RCW 48.43.715(3) provides: "[T]he commissioner ... must ensure that the plan covers the ten essential health benefits categories specified in [42 U.S.C. § 18022]." WAC 284-43-849 provides: "[E]ach ... health benefit plan offered ... inside ... the Washington health benefit exchange must provide coverage for a package of essential health benefits."

[56] WAC 284-43-865.

[57] Ex. 108.

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There are many problems with this argument. First, as the OIC previously recognized, it defies federal law. ACA regulations state that a QHP must "[m]aintain[] a **network** that is sufficient in number and types of providers ... to ensure that all services will be accessible without unreasonable delay."[58] This regulation closely resembles the OIC's own former network adequacy rule, which rightfully centers on whether a plan has a contracted network of participating providers, who have agreed in advance to deliver covered services to enrollees and look solely to the plan for reimbursement, sufficient in type and number to provide reasonable access without unreasonable delay. The greater problem is—as the OIC itself stated in the CCC case—the use of out-of-network providers to deliver EHB services "is antithetical to the purpose of the ACA."[59]

Consumers with children are less likely to sign up for coverage with a plan that does not include pediatric hospitals in network. Under this adverse selection, consumers with children—particularly medically complex children—are driven to other plans that include SCH. For this reason, the ACA specifically prohibits discriminatory benefit design that discourages enrollments of certain types of patients.[60] The OIC's own witness, Jennifer Kreitler, noted in the

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[58] 45 C.F.R. § 156.230(a) (emphasis added).

[59] Ex. 107 at 12.

[60] 42 U.S.C. § 18022(b)(4)(B) ("[i]n defining the essential health benefits..., the Secretary shall ... not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life"); 42 U.S.C. § 18116(a) (prohibiting discrimination relating to any health program based on age or other protected status); 42 U.S.C. § 18031(c)(1)(A) ("the Secretary shall ...require that, to be certified, a plan shall ... not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs"); 45 C.F.R. § 156.125(a) ("[a]n issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions"); 45 C.F.R. § 156.200(e) ("A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation").

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CCC hearing the ACA prohibits "discriminatory benefit designs that would discourage enrollment by individuals with significant health care needs because [of] an absence of certain specialty providers."[61] In addition, consumers with children who require services at SCH who purchased coverage from BridgeSpan or Premera/LifeWise face a daunting process fraught with greater delay, uncertainty, and potentially higher cost than they would if these services were available in-network. This process further discriminates against children, particularly those with serious or chronic illness, and also negatively affects SCH's ability to serve them.

B. Approval of Intevenors' QHPs Violates the ACA's ECP Requirement.

The ACA requires, in order to be certified as a QHP, the plan "**shall, at a minimum ... include within health insurance plan networks those essential community providers** ... such as health care providers defined in [42 U.S.C. § 256b(a)(4), defining essential community providers to includes children's hospitals]."[62] HHS regulations similarly require that QHP issuers must ensure that their networks "include[] essential community providers."[63] The HHS

[61] Ex. 176 at 166:7-10 (testimony of OIC analyst Jennifer Kreitler); see also id. at 167:15-24.

[62] 42 U.S.C. § 18031(c)(1) and § 18031(c)(1)(C); 42 U.S.C. § 256b(a)(4)(M).

[63] 45 C.F.R. § 156.230(a) provides:

> A QHP issuer must ensure that the provider network of each of its QHPs ...
> (1) Includes essential community providers in accordance with § 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....

45 C.F.R. § 156.235 provides in relevant part:

> (a) *General requirement.* (1) 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 QHPs service area, in accordance with the Exchange's network adequacy standards.
> ***
> (c) *Definition.* Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or

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commentary to the final rule noted "**the intent explicit in [the ACA] that access to essential community providers be *maximized* in QHPs.**"[64] State Exchange plans must comply with these requirements. 42 U.S.C. § 18031(b)(1), § 18021(a)(1).[65]

The ACA and accompanying federal regulations specify two exceptions to the ECP requirement. First, the ECP requirement is operative only to the extent ECPs are available in the plan's service area.[66] Second, QHPs do not have to "contract with" an ECP that "refuses to accept the generally applicable payment rates" of the plan.[67] As discussed below, the evidence will show that neither exception applies here. SCH is entirely willing to accept the plans' generally applicable payment rates, as demonstrated by its in-network status for the Regence and Premera/LifeWise large group products, as well as the fact that it is contracted with every other QHP operating in the Puget Sound area.

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(2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:
(1) Health care providers defined in section 340B(a)(4) of the PHS Act [42 U.S.C. § 256b(a)(4)];...
***
(d) *Payment rates.* Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

[64] 77 Fed. Reg. 18309, 18422 (Mar. 27, 2012) (emphasis added).

[65] 42 U.S.C. § 18031(b)(1) requires states to establish health exchanges that facilitate the purchase of "qualified health plans." 42 U.S.C. § 18031(d)(1)(B)(i) provides that "[a]n Exchange may not make available "any health plan that is not a qualified health plan." 42 U.S.C. § 18021(a)(1) defines "qualified health plan" as a plan that "has in effect a certification ... that such plan meets the criteria for certification described in section 18031(c)" regarding ECPs.

[66] 45 C.F.R. § 156.235(a) ("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 QHPs service area, in accordance with the Exchange's network adequacy standards") (emphasis added).

[67] 42 U.S.C. § 18031(c)(2) ("Nothing in [42 U.S.C. § 18031(c)(1) regarding ECPs] shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan."; 45 C.F.R. § 156.235(d) (same).

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The OIC has admitted that it has ignored these requirements and instead claims to have applied a "safe harbor standard" based on a "tool" prepared by the Centers for Medicare and Medicaid Services ("CMS") for QHPs offering plans through federally operated exchanges. The CMS tool, which applies to federally operated HBEs, assumes that, because "the number and types of ECPs available varies significantly by location," QHPs offered through federal HBEs need include only a certain percentage of ECPs in the plan's service area: *i.e.*, for 2014 plans,

- "at least 20 percent of available ECPs in the plan's service area," with the additional proviso that the carrier must show participation by
- "[a]t least one ECP in each ECP category," with one category identified as "hospitals";[68] and
- The "hospitals" category includes any of the following: Disproportionate Share, children's, rural referral centers, sole community hospitals, free-standing cancer centers, and critical access hospitals.[69]

CMS has not adopted this "tool" as a rule and has emphatically stated that its use by state regulators "is completely optional."[70] The OIC's use of this "tool," if not a violation of law, is completely unwarranted. Administrative "guidance" does not, and cannot, alter the plain statutory language of the ACA.[71] To the extent that the CMS "guidance" and instructions

[68] The six identified ECP categories are FQHCs, Ryan White HIV/AIDS providers, family planning, Indian providers, "Hospitals," and "other." *See* Ex. 110 at pp. 7-9.

[69] Exs. 110 at 8-9, 29.

[70] Ex. 33.

[71] *E.g., Schneider v. Chertoff*, 450 F.3d 944, 958 (9th Cir. 2006) ("the Secretary cannot re-write the law"); *Freeman v. Gonzales*, 444 F.3d 1031, 1041 (9th Cir. 2006) (refusing to follow agency's "untenable interpretation" of controlling law); *NRDC v. Nat'l Marine Fisheries Serv.*, 421 F.3d 872, 877 (9th Cir. 2005) ("we should not defer to an agency's interpretation of a statute if Congress's intent can be clearly ascertained through analysis of the

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conflict with the requirements of federal statutes and regulations for carriers to provide essential health benefits and include essential community providers, they are of no effect.

The CMS "guidance" identifies no other authority for its 20 percent requirement, or for the formulation of its broad categories that purport to show the range of coverage. If the "guidance" were to define what adequate ECP coverage is, then all that a carrier would need to show adequate ECP enrollment, even in King County, would be show participation by one hospital—even just a "free-standing cancer center"—in order to completely fulfill its obligation to have an ECP children's hospital in its network. This absurd result violates both the plain language and the spirit of the ACA's ECP requirements.

The absurdity of the outcomes under the CMS "guidance" is plain here. The OIC has asserted that, when it used the "tool," the Premera/LifeWise plan complied with the requirement to include an ECP hospital in their plans, because they included a single hospital in King County: Snoqualmie Valley Hospital.[72] Snoqualmie Valley Hospital, a 25-bed facility located 27 miles outside Seattle that qualifies as a Critical Access Hospital providing services in rural areas, has almost no capacity to provide pediatric care, and expressly redirects its pediatric patients to SCH. When the OIC used the tool for the BridgeSpan plan, it erroneously included SCH as an in-

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language, purpose and structure of the statute."); *Paralyzed Veterans of Am. v. D.C. Arena L.P.*, 117 F.3d 579, 586 (D.C. Cir. 1997) ("APA rulemaking is required where an interpretation 'adopt[s] a new position inconsistent with ... existing regulations'") (internal citations omitted); *W. Ports Transp., Inc. v. Employment Sec. Dep't of State of Wash.*, 110 Wn. App. 440, 449-50, 41 P.3d 510 (2002) ("[t]he construction of a statute is a question of law reviewed de novo under the error of law standard"); *City of Redmond v. Cent. Puget Sound Growth Mgmt. Hearings Bd.*, 136 Wn. 2d 38, 46, 959 P.2d 1091 (1998) ("it is ultimately for the court to determine the purpose and meaning of statutes, even when the court's interpretation is contrary to that of the agency charged with carrying out the law"); *Waste Mgmt. of Seattle, Inc. v. Utilities & Transp. Comm'n*, 123 Wn.2d 621, 628, 869 P.2d 1034 (1994) ("we will not defer to an agency determination which conflicts with the statute").

[72] Ex. 3; Ex. 36.

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network ECP for purposes of the tool, even though the OIC has admitted that SCH is not in-network.[73]

Additionally, the OIC seems to have further aligned itself with Premera/LifeWise and BridgeSpan by advancing the argument that, in effect, SCH brought this trouble on itself, by "refusing" to contract at lower rates, and therefore should be exempted from the ACA's ECP requirement because it was not "willing to accept the generally applicable payment rates" of the plan[74] or, under state law, "to contract with the carrier under reasonable terms and conditions."[75] The evidence demonstrates the opposite. First, the OIC itself never considered this ECP exception. Second, the argument ignores the fact that four[76] other carriers—Group Health, CHPW, Molina and CCC—have contracted with SCH for their QHPs.

Second, the fact that Premera/LifeWise has been agreeing to provide reimbursement at commercial rates for ER care, ER-to-admit care, and nearly all of the BLE requests, reflects that it has made a business decision that it is more advantageous to both incur the additional expense of the BLE process and to pay SCH at commercial rates for services rendered to its commercial enrollees, than to have SCH in-network and risk larger pediatric enrollment and utilization.

Third, the evidence does not support the contention that SCH is "too expensive." In its responses to discovery on this issue, the OIC relied on the testimony of CCC President Jay Fathi,

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[73] Ex. 35; SCH Ex.183.

[74] 42 U.S.C. §180310(c)(2).

[75] Former WAC 284-43-200. Although this rule was substantially amended in 2014, the new language continues to require issuers to maintain their provider networks in a manner to assure that all health plan services are accessible, changing the "without unreasonable delay" language to "in a timely manner appropriate for the enrollee's condition." WAC 284-43-200(1).

[76] Now five, including the Exchange plans submitted by United Healthcare for inclusion on the Exchange in 2015.

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MD.[77] Dr. Fathi's testimony consisted of a single sentence, asserting without reference to any data that in the summary that SCH "decided to have a strategy around reimbursement that is at the highest level, commercial, for the Exchange."[78] The OIC did not offer, and has not offered, any evidence other than this bald assertion, which was left unchallenged by cross-examination. Neither the OIC nor Premera/LifeWise and BridgeSpan have offered any evidence of how much more expensive these QHPs would be if they included SCH as an in-network provider, or why the OIC should consider that additional expense, if any, unacceptable. SCH also, as discussed above, treats the sickest of sick children in this state, and it is more expensive to provide care to the sickest of sick children.[79] For example, an otherwise healthy pediatric patient undergoing an appendectomy at another hospital may not require the same level of care and services as a pediatric patient undergoing an appendectomy while also diagnosed with a developmental disability, chronic asthma, juvenile diabetes, or another underlying condition. Where SCH provides services not available elsewhere in the community, its rates are commensurate with the quality of service provided.

Finally, the evidence demonstrates that although SCH offered to contract with these insurers at their existing commercial rates; i.e., "generally applicable rates,"[80] the intervenors ignored this offer and simply informed SCH that it was not in their QHP networks, without

[77] SCH Ex. 187 at 4.

[78] SCH Ex. 188 at 28:11-14.

[79] Ex. 63A ¶¶ 9, 14].

[80] Ex. 63A

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further discussion.[81] Despite the express language of the ACA regarding an ECP's refusal to accept "generally applicable rate," the OIC regards these facts as irrelevant.

C. The OIC's Current Position Regarding State Network Requirements Violates the ACA's Discriminatory Benefit Design Prohibitions.

Finally, the planned use of out-of-network services avoids the ACA's and the OIC's prohibitions on discriminatory benefit design.[82] Plans in which SCH has only out-of-network status discourage enrollment of minors, especially those with existing health conditions that are already requiring treatment at SCH. The plans such as the Premera/LifeWise and BridgeSpan that do not show SCH as an in-network provider on the Exchange's website have an advantage that parents of children with known, costly medical needs will choose other plans, which then reduces the amount of services that these plans have to pay for.

D. OIC's Position is Indefensible under State Law.

As the Commissioner himself has previously stated, approval of a QHP in the absence of including SCH in their networks violates the state's own network adequacy requirements. BridgeSpan, Premera, and LifeWise are licensed by the OIC as "health care service contractors" ("HCSCs").[83] HCSCs provide prepaid health care services for their enrollees through

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[81] Ex. 64; Ex. 63A

[82] *See supra* at IV.A.2.

[83] An HCSC, as defined by RCW 48.44.010(9) is a "corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services." At their inception, Blue Cross programs such as Premera were associated with hospitals and Blue Shield programs like Regence were sponsored by physicians.

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"participating providers,"[84] health care professionals and facilities with which they have contracted to provide services.[85] The OIC implements these requirements through its network adequacy rules. Those rules define "network" as "the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group)."[86] "Participating provider" and "participating facility" are defined as those "who, under a contract with the health carrier or with the carrier's contractor or subcontractor, [have] agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person."[87]

The OIC network adequacy rule in place during 2013 required that each health insurer "must maintain" its provider "network ... in a manner that is sufficient in numbers and types of providers and facilities."[88] This language specifically requires that health carriers—specifically HCSCs—must maintain networks of participating providers that are sufficient to provide reasonable access to covered health services. It is not "sufficient"—under the plain language of the statutes and rule—for HCSCs to cover those services without providing access through in-network providers. Until this case, the Commissioner himself has always maintained this position. Also, by requiring that an issuer "must maintain" its network, the regulation reinforces the proposition that network adequacy is not a determination that is fixed in time, solely to be

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[84] RCW 48.44.020.

[85] RCW 48.44.010(14).

[86] WAC 284-43-130(21).

[87] WAC 284-43-130(23).

[88] Former WAC 284-43-200(1).

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reviewed by the OIC on a one-time basis during annual plan review and approval. Third, the rule is necessarily intended to protect the provider participants in those networks—who are otherwise left in the very position that SCH finds itself in providing out-of-network care to patients while relying on inadequate spot-contracting arrangements for payment—as well as the insureds that the networks serve.

State law also imposes significant requirements on any use of out-of-network services. Where health care services "are not ... performed by ... a participating provider," the carrier must make "provision ... for reimbursement or indemnity" that is either "underwritten by an insurance company authorized to write accident, health and disability insurance ... or guaranteed by a deposit of cash or securities."[89] The OIC further requires carriers to pre-file all such agreements with providers:

> A carrier must file all provider contracts and provider compensation agreements with the commissioner thirty calendar days before use. When a carrier and provider negotiate a provider contract or provider compensation agreement that deviates from a filed agreement, the carrier must also file that specific contract or agreement with the commissioner thirty calendar days before use.[[90]]

This requirement protects the interests of providers and patients in ensuring that those contracts are fairly drafted and negotiated in advance to protect both parties to the agreements as well as the public's interests. Negotiating the terms of a single case agreement at the time of patient treatment inevitably causes delay in either patient care or in compensation to the provider.

Additionally, the OIC requires that an insurer's participating provider contracts state that the provider "agrees that in no event ... shall [the provider] bill, charge, ... seek compensation,

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[89] RCW 48.44.030.

[90] RCW 48.43.730(2)(a).

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remuneration or reimbursement from … a covered person."[91] In the absence of a participating provider contract, neither the OIC nor the insurer has a mechanism to prevent a patient from being subject to balance billing, unless the insurer consistently pays the entire amount of the provider's billed charges.

1. Intervenors' networks are inadequate under state law.

The BridgeSpan QHP network includes (within King County) University of Washington Medical Center and Harborview Medical Center in Seattle, Evergreen Hospital in Kirkland, and Valley Medical Center in Renton. In addition to the fact that these hospitals, as noted in the discussion above, provide far more limited pediatric services than a pediatric hospital such as SCH, the pediatric specialists practicing at each of these facilities are, in most cases, members of Children's University Medical Group (CUMG), which is also out of network for BridgeSpan.[92]

The Premera/LifeWise QHP network includes the following hospitals within King County, none of which are pediatric hospitals and none of which provide the essential and comprehensive inpatient pediatric services available only at SCH:[93]

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[91] WAC 284-43-320(2).

[92] SCH and CUMG contract in parallel with each carrier, so if SCH is out-of-network, CUMG is also out-of-network.

[93] *See* Intervenors' Motion, at 5, 8-10. Ex. 64 at Ex. A at SCH000095; Ex. 64 ¶¶ 4-7; Ex. 63A ¶¶ 2-6; SCH Ex. 197 at ¶ 2].

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Hospital	City	Comment
Virginia Mason Hospital	Seattle	(see chart *supra* comparing scope of pediatric services)
Evergreen Hospital	Kirkland	(see chart *supra* comparing scope of pediatric services)
Valley Medical Center	Renton	(see chart *supra* comparing scope of pediatric services)
Northwest Hospital	Seattle	Part of the UWMC system; refers pediatric patients (non-neonates) to SCH
Overlake Hospital	Bellevue	No pediatric specialties other than for neonates born at the facility
Schick Shadel Hospital	Seattle	Solely provides medical treatment for addiction
Fairfax Hospital	Kirkland	Solely provides medical treatment for behavioral health/addiction
St. Francis Community Hospital	Federal Way	No pediatric specialties other than for neonates born at the facility
VA Puget Sound Health Care System in Seattle,	Seattle	Provides services solely to veterans; refers to SCH
Snoqualmie Valley Hospital	Snoqualmie	(see discussion *supra*)

The fact that the insureds from the Premera/LifeWise Exchange plan networks are continuing to seek care from SCH in large numbers, and that Premera/LifeWise is approving nearly all of the BLEs, reflects the absence of these needed pediatric services elsewhere. In the absence of the services that SCH provides, the carriers are not providing and cannot provide the full range of essential pediatric services to their insureds.

2. Intervenors are not complying with the OIC's hold harmless requirements.

The OIC has asserted that the out-of-network services are an acceptable method for QHPs to provide EHB services because the OIC "determined that enrollees purchasing QHPs from ... BridgeSpan and Premera <u>will not be subject to higher costs</u> for SCH's unique

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services."[94] But adherence to this requirement has not proven to be the case with these plans. Premera's own communications with its insureds demonstrate that it considers SCH an out-of-network provider, and is informing its insureds that they remain subject to balance billing.[95] SCH review of payment data has revealed that Premera/LifeWise is at least in some circumstances, if not regularly, imposing higher cost-sharing on patients, and SCH has experienced delays in payment even after BLE approval.[96] After reviewing the evidence, the Order dated March 14, 2014 stated that "it is unclear how the intervenors' assurances in their filing documents with the OIC [promising to hold enrollees harmless] will effectively serve to protect Exchange plan enrollees from this higher cost-sharing or for the entire bill."[97] The evidence will demonstrate that the intervenors have not been acting consistently with these assurances.

E. SCH Patients and SCH Are Aggrieved as a Result of the OIC's Actions.

SCH is entitled to seek and obtain relief from the Commissioner under RCW 48.04.010(1)(b) because it is "aggrieved" by "an act ... or failure of the Commissioner to act." As a direct result of the OIC's actions approving these QHPs and his continued refusal to apply

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[94] SCH Ex. 198 at 3.

[95] Ex. 58. The letters that Premera/LifeWise sent to patients for whom BLEs have been approved, state:

> The non-contracted provider may balance bill you for billed charges. This means that you are responsible for amounts above the allowable charge (the difference between what we allow for the service and the provider's actual charge), in addition to applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies.

[96] Ex. 57, Ex. 59, Ex. 63.

[97] SCH Ex. 199 at 13.

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proper network adequacy standards, SCH patients and SCH have experienced significant harms since January 2014.

Premera/LifeWise. Based on enrollment, the most significant impacts SCH patients and SCH have experienced concern the Premera/LifeWise individual and small group products including their QHPs.[98] SCH has observed the following circumstances that have resulted from patients being required to make use of the Premera/LifeWise BLE process in order to obtain care:

- *Delays in care and medical risks.* The BLE approval process has in many cases caused delays in care. The BLE process has placed and will continue to place the health of children at risk. The testimony from patient families will also reveal that they have experienced tremendous emotional and practical issues as they have had to navigate the BLE process to obtain healthcare for their children. At the time patients do obtain care, they are sicker than they were and require additional or more complex services. This in turn uses more resources, thereby reducing resources available for other SCH patients and impairing the ability of SCH to serve the pediatric healthcare needs of the region. As just one example, the evidence will include the testimony of Jenni Clark, whose two-year-old son's needed hernia surgery was delayed by the Premera/LifeWise BLE process. During the delay, he had to obtain painful ER care to manage his symptoms, at the same time that Premera/LifeWise was referring the family to a single in-network provider who could not perform the surgery. The evidence will also

[98] Individual and small group products offered outside the Exchange are subject to the same EHB and state network adequacy requirements as QHPs. WAC 284-43-849.

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include the testimony of Alexandra Szablya, whose teenage daughter presented to the ER and was determined to need inpatient psychiatric care. Although Premera/ LifeWise advised Ms. Szablya that inpatient care at SCH would be considered out-of-network, SCH ignored Premera/LifeWise's BLE delays and proceeded with the needed care without waiting for the BLE approval process.

- *Fragmented care.* In some cases, where patients have previously received integrated care at SCH, Premera/LifeWise is now requiring patients to obtain some care from in-network specialists and obtain the remainder of their care from SCH specialists. As just one example, patients with complex medical conditions involving multiple specialties, who previously have obtained coordinated care from SCH specialists, are now being sent solely for their outpatient cardiology services to an in-network provider, while still receiving the remainder of their specialty services at SCH.
- *Administrative burden.* SCH has committed at least three new FTEs to managing the BLE exception request for the Premera/LifeWise narrow network products. Additional employees have also been pulled away from other duties to manage this administrative process.
- *Financial burdens on patient families.* Patient families have experienced multiple additional financial burdens. They also have been informed that they are subject to balance billing.[99] This action directly contradicts Premera's communications to the Commissioner, that because SCH is a "contracted" provider, SCH is

[99] Ex. 58.

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prohibited from "balance billing" Exchange and outside market individual and small group plan patients.[100] In addition, patients have been and continue to be improperly subject to out-of-network cost-sharing despite Premera/LifeWise's assurances that the services were approved through the BLE process for processing at in-network rates. Patients also experience additional costs related specifically to the delays in care resulting from the BLE process.

- *Financial burdens on SCH.* SCH has experienced significantly increased costs relating to the administrative burden of the BLE process.[101] Premera/LifeWise continues to make processing errors as to these claims, depriving SCH and its patient families from the benefit of in-network status even after BLE approval. And Premera/LifeWise regularly continues to process the professional fee component of SCH fees as out-of-network services, despite BLE approvals. As a result, SCH experiences lost income because it is not receiving payment to which it is entitled for the services it provides to these QHP-enrolled patients.
- *Other burdens on patient families.* A further issue for these families is the ongoing uncertainty for them regarding whether future care they anticipate receiving at SCH will be appropriately compensated. Now that they are aware that SCH is not an in-network provider, they are more hesitant to seek care at

[100] Ex. 103.

[101] SCH has had to add approximately three FTE positions in order to process the documentation relating to requests for approvals for care provided at SCH to patients insured by Premera's Exchange plans.

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SCH, even for needed care for which Premera/LifeWise must provide coverage, such as emergency care.[102]

BridgeSpan. Although the BridgeSpan QHP product has received very little pediatric enrollment,[103] two patients have received care at SCH in 2014. BridgeSpan has refused payment as to each of these claims,[104] causing harm to both the patients and SCH resulting from its noncompliance with ACA and state law requirements.

F. The Adverse Effects of the OIC's Actions are Redressable.

Intervenors and OIC have suggested that SCH's appeal should be dismissed because, even if approval of the intervenors' QHPs violated the ACA and state law, the problem is not redressable through these proceedings. This suggestion is without merit. This proceeding is being conducted on behalf of the Commissioner, who has delegated full and final authority to the Presiding Officer to make a final decision on his behalf. As such, the Presiding Officer has the same authority—and responsibility—as the Commissioner himself to identify and remedy conditions that are inconsistent with law or harmful to the public interest.

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[102] The ACA identifies emergency care as a separate EHB category of care for which all Exchange plans must provide coverage. In addition, the state's "Patient Bill of Rights" (L. 2000, ch.5, § 22), applying to all state health plans on and off the Exchange, prohibits health insurers from "retrospectively deny[ing] coverage for emergency ... care." RCW 48.43.525(1); *see also* RCW 48.43.500 (noting the "intent of the legislature" that health plan enrollees "[h]ave sufficient and timely access to appropriate health care services, and choice among health care providers." State law further requires that a health insurer "shall cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed," even where that care is provided by a "nonparticipating hospital." RCW 48.43.093(1)(a). The statute further restricts the health insurer from imposing "[d]ifferential cost sharing", *i.e.*, higher levels of co-insurance and deductibles, for the emergency services provided by a nonparticipating provider. RCW 48.43.093(1)(c).

[103] SCH Ex. 190.

[104] Ex. 56.

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In this regard, the Commissioner has broad authority over the health insurance business, with power to review health insurance carriers' insurance products for compliance,[105] and final authority to suspend or revoke an insurer's certificate of authority for, among other things, "fail[ure] to comply with any provision of this code ... or fail[ure] to comply with any proper order or regulation of the commissioner."[106] The enabling legislation for the Exchange "[r]ecognize[s] that the regulation of the health insurance market, both inside and outside the exchange, should continue to be performed by the insurance commissioner."[107]

The Commissioner's authority with respect to network adequacy is not limited to a one-time review or annual checkup. Provider networks are fluid by their very nature. Therefore, the Commissioner has authority to make sure that health carriers not only create adequate networks, but "maintain" them as well.[108] To this end, HCSCs are subject to examination by the Commissioner "as often as he or she deems necessary in order to carry out the purposes of" the state's insurance laws.[109] SCH will present evidence that the Commissioner has exercised this authority to order health carriers to remedy deficiencies in networks previously deemed adequate. In this context, it does not matter whether the result of the hearing is a finding that the

[105] SCH Ex. 191; SCH Ex. 192.

[106] RCW 48.05.140(1); RCW 48.05.030(1) (same). Health care service contractors must apply for and obtain a certificate of registration from the Commissioner. RCW 48.44.015(1). The Commissioner also ultimate authority to suspend or revoke a health care service contractor's registration for specified reasons, including "fail[ure] to comply with any provision of chapter 48.44 RCW or any proper order or regulation of the commissioner." RCW 48.44.160(1).

[107] RCW 43.71.005(2)(i).

[108] Former WAC 284-43-200(1).

[109] RCW 48.44.145(1).

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intervenors' networks were inadequate at their inception or became so later; the Commissioner has authority to remediate in either circumstance.

In this case, the appropriate remedy would be to order that, with respect to the 2014 plan year, medically necessary pediatric services provided by SCH to Premera/LifeWise and BridgeSpan QHP enrollees must be handled as if SCH and its affiliated professionals were in-network providers; *i.e.*, emergency care must be covered in accordance with benefit requirements and applicable law; utilization review must occur in accordance with standards applicable to participating providers[110] and separate BLE or other separate forms of "coverage" reviews for non-emergency medically necessary care eliminated; and cost-sharing must be the same as if the enrollee received services from in-network providers; the plans must submit a form of provider agreement covering these arrangements to the OIC for its review and approval; and the plans must hold their enrollees harmless against balance-billing by paying SCH at the rates specified in the existing contracts with those plans. This package of remedies would protect enrollees, relieve SCH of the unfair burdens of the Commissioner's and plans' actions, and conform to the law.

This remedy would not have any significant impact on affordability of intervenors' plans. To begin with, intervenors' plans have very few pediatric QHP enrollees relative to total enrollment. For the small percentage of enrollees who need care at SCH, Premera/LifeWise is already approving BLEs and saying it will pay for that care at in-network rates. Even if a somewhat greater number will seek care at SCH as a result of this remedy, the increased payments likely will be offset by reduced administrative cost, not to mention the other benefits to

[110] WAC 284-43-410(6)(b)(iv).

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enrollees, providers, and plans for delivering covered, medically necessary care through in-network providers. And, finally, it is not the case—as the plans might have the OIC believe—that their premiums are more affordable because they exclude SCH. To the contrary, their premiums are generally higher than the QHP plans that include SCH in-network.

V. CONCLUSION

Seattle Children's Hospital respectfully requests that the Commissioner, acting through his duly appointed Presiding Officer, determine:

1. Intervenors' QHP offerings for 2014 were approved based on an erroneous belief that SCH was an in-network provider.

2. Under the circumstances presented, omission of SCH from the intervenors' networks violates the EHB and ECP requirements of the ACA.

3. Under the circumstances presented, omission of SCH from the intervenors' QHP networks renders them inadequate under state law.

4. The Commissioner can and should remedy these violations of law by appropriate order.

DATED this 11th day of August, 2014.

BENNETT BIGELOW & LEEDOM, P.S.

By _____

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CERTIFICATE OF SERVICE

I certify that I served a true and correct copy of this document on all parties or their counsel of record on the date below by the method of delivery specified below on today's date addressed to the following:

Presiding Officer		
Hon. George A. Finkle (ret.)	☐	Legal Messenger
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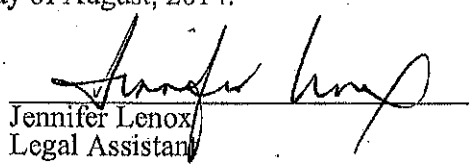
I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

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



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