



OFFICE OF
INSURANCE COMMISSIONER

FILED

JAN 29, 2014

Hearings Unit, OIC
Patricia D. Petersen
Chief Hearing Officer

In re

Seattle Children's Hospital's Appeal of
OIC's Approvals of HBE Plan Filings.

NO. 13-0293

OIC'S OPPOSITION TO SEATTLE
CHILDREN'S HOSPITAL'S MOTION
FOR PARTIAL SUMMARY
JUDGMENT

I. RELIEF REQUESTED

The Office of the Insurance Commissioner ("OIC"), by and through its staff attorney Charles Brown, requests denial of Seattle Children's Hospital's ("SCH") Motion for Partial Summary Judgment.

II. INTRODUCTION

The OIC Rates and Forms staff review all health plans that must be filed with the Commissioner prior to being sold in Washington, to ensure they meet the requirements of state law and of the Affordable Care Act, 42 U.S.C. 18001, *et seq.* ("the ACA"), Second Nollette Decl., ¶ 2. This includes satisfying the generally applicable requirement of network adequacy. See RCW 48.43.500 *et seq.*¹ In addition, for any plan sold on the Washington State Health Benefits Exchange ("The Exchange"), OIC staff reviews to determine that they meet the standards of a "Qualified Health Plan" ("QHP"), which require coverage of essential health benefits, See RCW 48.43.715, 42 U.S.C.

¹ These requirements are described more fully in the Intervenor's Joint Motion for Summary Judgment, pp 17-18. A network relying solely on spot-contracting or billed charges for the majority of services would not be approved by the OIC.

18022(b)(1), and include sufficient numbers of “essential community providers,” entities that serve predominately low-income, medically underserved individuals. 42 U.S.C. 18031(c)(1).

The OIC correctly applied federal and state law in determining that each of the intervenors’ plans included “coverage” for the required essential benefits. Contrary to SCH’s assertion, the law does not equate “covered” with “part of a contracted network.” As a result, the OIC requires only that carriers ensure that covered service be provided at an in-network price that accrues to the plans maximum out-of-pocket limit. Issuers can accomplish this through a variety of means, including spot-contracting or paying billed charges.^{2 3}

The OIC also correctly ensured that each of the Intervenor’s plans met the federal essential community provider standards, using the automated review tool provided to all state reviewers by the Center for Consumer information and Insurance Oversight (“CCIIO”), under the Centers for Medicare and Medicaid Services (“CMS”).

III. STATEMENT OF FACTS

The Center for Consumer Information and Insurance Oversight, under the Centers for Medicare & Medicaid Services, developed automated review tools to evaluate issuer submissions for the federally facilitated Exchanges. See Second Declaration of Molly

² Paying “billed charges” means that the issuer pays the entire bill received from the provider, and there is no charge to the enrollee. In other words, there is no cost-sharing left over for a consumer to pay. Nollette Decl., ¶ 9.

³ These arrangements are considered within the context of the general network adequacy requirements. A network relying *solely* on spot-contracting or billed charges for the majority of services would not be approved by the OIC.

Nollette, ¶ 3. The tools include an “Essential Community Providers Tool” (the “ECP Tool”), used to evaluate whether issuers meet the regular or alternative standards for inclusion of essential community providers.⁴ Second Nollette Decl., ¶ 4. CCIO’s tools were made available to all state reviewers to use in the review process. Second Nollette Decl., ¶ 3.

The OIC uses the Essential Community Providers Tool to determine whether submitted plans meet the essential community provider standard required of a QHP. Second Nollette Decl., ¶ 5. As part of the required filing, issuers submitted a template listing all the Essential Community Providers (“ECP”) contained in their proposed networks. Second Nollette Decl., ¶ 6. The OIC ran the templates for each of the Intervenor through the ECP Tool using the regular ECP Standard, which approved them as meeting the federal essential community provider standards. Second Nollette Decl., ¶ 7.

Although consumers who receive services from providers that are out-of-network face the possibility of being responsible for higher cost-sharing or for the entire bill depending upon the specific health plan, the OIC has determined that enrollees purchasing QHPs from Coordinated Care, BridgeSpan, and Premera will not be subject to higher costs for SCH’s unique services. Second Nollette Decl., ¶ 8. Each of them has included in their filing documents the statement that for covered services that are only available at Seattle Children’s Hospital, enrollees will be subject to cost-sharing of negotiated in network rates. . Second Nollette Decl., ¶ 9.

⁴ These standards are described in Chapter 7 of the “Letter to Issuers on Federally-facilitated and State Partnership Exchanges,” a copy of which is attached to Nollette Declaration submitted in the OIC’s Motion to Dismiss as Exhibit “F.”

The federal ECP standard also requires that each issuer at least offer a contract to a Hospital that qualifies as an Essential Community Provider in each county in which plans would be offered. For example, in King County, Premera contracted with a Hospital on the federal non-exhaustive list of available ECPs. Premera contracted with Snoqualmie Valley Hospital. Second Nollette Decl., ¶ 10.

IV. ARGUMENT

It is undisputed fact that SCH is an essential community provider, and that SCH provides some pediatric services that are unique in the state. However, contrary to SCH's assertion, the OIC did not fail to consider the fact of SCH's unique services, or the fact that SCH has no contract with the Intervenors. It is simply that neither of these facts mandated disapproval. Nothing in the law dictates inclusion of a specific provider, regardless of their preeminence or sympathetic patient base.

The OIC correctly considered the facts of the Intervenors' submitted plans, and applied the correct legal standards prior to approving them.

A. The OIC correctly applied state network adequacy standards and the federal requirement to include essential covered services in approving the Intervenors' plans.

Adequate networks require that enrollees have access to and choice among providers. RCW 48.43.515. Adequate networks must contain certain *general types* of providers, including primary care, specialists, and chiropractors. *Id.* But there is nothing in state or federal law that requires any specific provider entity to be included, even those that may provide a unique service. SCH is focusing on the issue through the wrong lens.

Viewed correctly, the requirement should be stated this way: every QHP must provide coverage for the essential health benefits required by federal law. OIC's responsibility and care is to ensure that every enrollee in a QHP is entitled to those covered services, meaning that they are provided at an in-network price (or less), and that what enrollees pay for those services accrues to any annual maximum-out-of-pocket limit in the contract.⁵

Practically, this is largely accomplished through network contracts between issuers and providers. However, so long as issuers meet the legal standards for adequacy and covered services, the OIC does not manage their business arrangements for them. Indeed, the substance of issuer contracts with providers is not generally OIC's concern, except to the extent that contracted prices support the filed rates that will be charged to enrollees.

In this case, it is undisputed that each of the Intervenor's plans include coverage for the required essential health benefits. *See* Second Nollette Decl., ¶ 7, *see also* Fathi Decl, ¶¶ 12-13, Johnson Decl., ¶¶ 16-17.

Most of the unique services SCH offers would be considered essential health benefits under the federal law. As a result, issuers must satisfy the OIC that enrollees have access to these covered services, either by contracting with SCH or by some other method. For each Intervenor, based on written statements contained in their filings, OIC was satisfied during the approval and QHP certification process that their

⁵ SCH asserts likely injury to enrollees who will be forced to pay the generally higher out of network prices for any unique SCH services. This truism does not apply to the contractual arrangements reported by the Intervenor's to the OIC.

enrollees would have appropriate access at in-network cost (or less). Second Nollette Decl., ¶¶ 8-9.

B. The OIC correctly considered the required presence of essential community providers in certifying the Intervenors' as QHPs

The OIC correctly considered the presence of essential community providers in Premera's network prior to certifying it as a QHP.

The federal instructions to QHP filers and state regulators allow certification of a QHP that includes twenty percent of a given service area's essential community providers. In certain circumstances, a QHP may be approved with as little as ten percent, when certain exceptions are met. First Nollette Decl., Ex. "F," p.7. Issuers are also required to at least offer a contract to a Hospital that qualifies as an essential community provider in each county in which plans will be offered. First Nollette Decl., Ex. "F," p.7. Second Nollette Decl., ¶ 10.

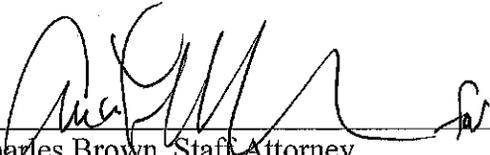
As required, Premera submitted an Essential Community Provider template to the OIC. Second Nollette Decl., ¶ 7. The Premera template did not contain SHC as a contracted provider. Second Nollette Decl., ¶ 7. The OIC ran the Premera template through the CCIIO ECP Tool using the regular ECP standard setting, and it was approved as meeting the federal standards. *Id.* In addition, the OIC verified that Premera has contracted with a King County Hospital contained on the HHS non-exhaustive list of available ECPs. Second Nollette Decl., ¶ 10. As a result, the OIC determined that Premera's plan met this prong of the QHP requirements, without the inclusion of a contract with SCH.

Because Premera's submitted plan meets the QHP's requirement for inclusion of essential community providers regardless of any contract with SCH, consideration of that contract is irrelevant.

V. CONCLUSION

For the foregoing reasons, the OIC staff respectfully requests that SCH's Motion for Partial Summary Judgment be denied.

DATED this 29 day of January, 2014.



Charles Brown, Staff Attorney
Legal Affairs Division
Office of Insurance Commissioner

CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the State of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the State of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing OIC'S OPPOSITION TO SEATTLE CHILDREN'S HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT on the following individuals via Hand Delivery, US Mail and e-mail at the below indicated addresses:

VIA HAND DELIVERY TO:

OIC Hearings Unit
Attn: Patricia Petersen, Chief Hearings Officer
5000 Capitol Blvd
Tumwater, WA 98501

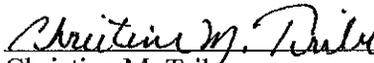
VIA US MAIL AND EMAIL TO:

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SIGNED this 29th day of January, 2014, at Tumwater, Washington.


Christine M. Tribe



FILED

OFFICE OF
INSURANCE COMMISSIONER

JAN 29, 2014

Hearings Unit, OIC
Patricia D. Petersen
Chief Hearing Officer

In the Matter of)	
)	NO. 13-0293
SEATTLE CHILDREN'S HOSPITAL,)	
)	SECOND DECLARATION OF
)	MOLLY NOLLETTE IN
)	RESPONSE TO SEATTLE
)	CHILDREN'S HOSPITAL'S
)	MOTION FOR SUMMARY
)	JUDGMENT

I, Molly Nollette, declare as follows:

1. I am over the age of 18 and make this declaration based on my personal knowledge and in response to Seattle Children's Hospital's Motion for Summary Judgment.
2. I am employed by the Washington State Office of Insurance Commissioner ("OIC") as the Deputy Commissioner in charge of the Rates and Forms Division, the division that is responsible for reviewing and approving or disapproving health plans that must be filed with, and approved by, the Commissioner prior to being offered in Washington.
3. The Center for Consumer Information and Insurance Oversight (CCIIO), under the Centers for Medicare & Medicaid Services (CMS), developed automated review tools to evaluate issuer submissions for the federally facilitated Exchanges. CCIIO made the automated review tools available to all state reviewers to use in the review process.
4. The automated review tools include an "Essential Community Providers Tool" (ECP Tool) to evaluate issuers against the regular or the alternative ECP Standard



as described in Chapter 7 of the “Letter to Issuers on Federally-facilitated and State Partnership Exchanges.”

5. The OIC downloaded the ECP Tool from the System for Electronic Rate & Form Filing (SERFF) website. The OIC uses the tool to determine whether submitted plans meet the required essential community provider standard to qualify as a Qualified Health Plan.
6. Issuers were required to submit completed Essential Community Provider templates as part of the SERFF Binder filing. The OIC “runs” the templates through the ECP tool, which evaluates the information against the federal standard and returns a result: either approved, or not approved.
7. The OIC ran the Essential Community Provider templates for BridgeSpan, Premera and Coordinated Care through the ECP Tool using the “regular ECP standard” setting. Premera’s template did not include Seattle Children’s Hospital as an in-network provider. The ECP tool approved each template as meeting the federal essential community provider standards.
8. Although as a general matter consumers who receive services from providers that are out-of-network face the possibility of being responsible for higher cost-sharing (or for the entire bill depending upon the specific health plan), the OIC has been assured and has determined that enrollees in QHPs from Coordinated Care, BridgeSpan, and Premera will not be subject to higher costs for SCH’s unique services.
9. Premera, Bridgespan and Coordinated Care each stated in their filing documents that for covered services that are only available at Seattle Children’s Hospital, enrollees will be subject to cost-sharing of negotiated in-network rates.
10. The federal ECP standard also requires that each issuer at least offer a contract to a Hospital that qualifies as an essential community provider in each county in which plans would be offered. For example, in King County, Premera contracted with a Hospital on the federal non-exhaustive list of available ECPs. Premera contracted with Snoqualmie Valley Hospital.

11. I declare under penalty of perjury under the laws of the State of Washington that
the foregoing is true and correct.

Dated this 29th day of January, 2014.


Molly Nollette

CERTIFICATE OF MAILING

The undersigned certifies under the penalty of perjury under the laws of the State of Washington that I am now and at all times herein mentioned, a citizen of the United States, a resident of the State of Washington, over the age of eighteen years, not a party to or interested in the above-entitled action, and competent to be a witness herein.

On the date given below I caused to be served the foregoing SECOND DECLARATION OF MOLLY NOLLETTE IN RESPONSE TO SEATTLE CHILDREN'S HOSPITAL'S MOTION FOR SUMMARY JUDGMENT on the following individuals via Hand Delivery, US Mail and e-mail at the below indicated addresses:

VIA HAND DELIVERY TO:

OIC Hearings Unit
Attn: Patricia Petersen, Chief Hearings Officer
5000 Capitol Blvd
Tumwater, WA 98501

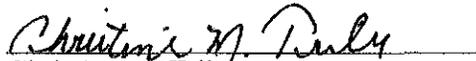
VIA US MAIL AND EMAIL TO:

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SIGNED this 29th day of January, 2014, at Tumwater, Washington.


Christine M. Tribe