

BEFORE THE WASHINGTON STATE OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE OFFICE OF INSURANCE COMMISSIONER

IN THE MATTER OF:

REGENCE BLUESHIELD

Authorized Insurers.

NO. G2003-02

Docket No. 2003-INS-0001

INITIAL DECISION AND ORDER

Adam E. Torem, Administrative Law Judge (ALJ), conducted an administrative hearing on May 15, 2003, on this matter. Regence BlueShield (Regence) appeared and was represented by attorney Timothy Parker of the lawfirm Carney Badley Spellman. The Office of Insurance Commissioner (OIC or Commissioner) appeared and was represented by staff attorney Charles Brown.

STATEMENT OF THE CASE

This proceeding arises out OIC's November 25, 2002, disapproval of certain filings submitted by Regence related to its Standard Master Contracts for 2003. OIC ruled that several of Regence's riders involving coverage limitations on treatment and provision of medical supplies for those afflicted with diabetes violated specified provisions of Chapter 48.44 Revised Code of Washington (RCW), *Health Care Services*. Specifically, OIC interpreted RCW 48.44.315(4) to prohibit the imposition of any limitation on the amount of diabetes supplies available to a consumer under an available pharmacy rider. The riders submitted by Regence contained annual maximum benefit limits of \$2,000; therefore, the Commissioner rejected these riders as improper cost-sharing provisions.

FINDINGS OF FACT

1. Regence BlueShield is a health care service contractor as that term is defined in RCW 48.44.010(3). Regence offers various contracts for group and individual health insurance benefit plans in Washington. Prior to offering such coverage, Regence files its contracts and associated riders and forms with the Commissioner.

2. On August 30, 2001, Regence filed several rider forms with OIC, including RBS-46, APP#1, and RBS-46 B, all of which were to take effect for 2002. OIC received these forms the following morning. See Exhibit 6.

3. RBS-56, effective for January 2003, created a *50% Prescription Drugs Copay Rider* which contained the following relevant provisions:

BENEFIT MAXIMUM. Benefits for Prescription Drugs as described below will be provided to an annual maximum of \$2,000.

COPAY. The Member will be responsible to pay the Copay percentage specified below for each prescription or refill obtained under the Benefits of this Section.

Approved Pharmacies and Mail Order Service.....50% of the Allowed Amount

COVERED ITEMS. Prescription Drugs, which are included in the Company's current drug formulary, will be covered when Medically Necessary for the treatment of the Member's illness, accidental injury, or disability covered by this Contract, subject to the provisions described below. Other items covered under this Benefit and requiring a prescription include the following: insulin, insulin syringes, other diabetes supplies.

PHARMACY BENEFITS. Prescription Drugs and other covered items obtained at an approved pharmacy will be provided after the Member has paid the Copay specified above. * * *. Prescription Drugs furnished by an approved pharmacy will be limited to a 34-day supply, except as follows:

(1) Certain drugs, including but not limited to . . . diabetes test strips . . . may be limited to a lesser supply as indicated on the Member's prescription or as determined by the Company.

See Exhibit 2. Thus, the RBS-56 Rider essentially creates a maximum prescription drug benefit of \$4,000 per member, half of which (\$2,000) is paid by the member through the 50% Copay requirement. This benefit applies to all drugs prescribed to a particular member, including diabetes supplies such as insulin and the like.

4. On October 7, 2002, one of OIC's compliance analysts wrote to Regence regarding various issues of potential non-compliance with state and federal guidelines. See Exhibit 1. The letter requested that Regence modify RBS-56's annual \$2,000 maximum benefit for prescription drugs. OIC took the position that this language, at least as applied to insulin, insulin syringes, and other diabetic supplies, violated a law prohibiting reduction or elimination of coverage because of legislation requiring prescription benefits to cover diabetic supplies. See Exhibit 1, page 4.

5. On November 25, 2002, OIC again wrote to Regence indicating that RBS-56 was being disapproved because it contained

inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract.

Among other issues, OIC specifically questioned the rider's limitation on diabetic supplies. OIC indicated that Regence could modify and re-file RBS-56 or request a hearing on the matter. See Exhibit 3.

6. On January 9, 2003, Regence wrote to the Commissioner to request a hearing regarding OIC's disapproval of RBS-56 and its provisions regarding diabetic supplies and treatment coverage. OIC received this correspondence on January 13, 2003. On January 29, 2003, Regence clarified its hearing request by requesting that the matter be heard by an ALJ from the Office of Administrative Hearings (OAH) and asked for a stay of the disapproval, to allow continued sale of the policy until a final ruling could be obtained. OIC received this correspondence the following day and, on February 12, 2003, referred the case to OAH.

7. On February 28, 2003, OIC wrote to Regence to clarify the scope of its disapproval of the annual \$2,000 maximum benefit for prescription drugs. OIC indicated its understanding that the pending hearing contesting disapproval of RBS-56 would also cover various other filings listed in its letter of February 28, 2003. See Exhibit 4.

8. On March 3, 2003, OIC wrote to Regence to deny its request for a stay pending hearing. However, OIC indicated its willingness to approve a revised rider that maintained a general annual \$2,000 benefit limit for prescription drugs, so long as that when exceeded, the limit would not deny ongoing coverage for additional diabetes prescriptions and supplies. See Exhibit 5.

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CONCLUSIONS OF LAW

1. The undersigned ALJ has jurisdiction over the parties and subject matter herein pursuant to RCW 48.04.010(5), RCW 48.44.020, Chapter 34.05 RCW, and Chapter 34.12 RCW.

Submission and Approval/Disapproval of Contract Forms

2. Washington's Insurance Code requires that all "[f]orms of contracts between health care service contractors and participating providers shall be filed with the insurance commissioner prior to use."¹ The Code further provides that

[a]ny contract form not affirmatively disapproved within fifteen days of filing shall be deemed approved, except that the commissioner may extend the approval period an additional fifteen days upon giving notice before the expiration of the initial fifteen-day period. The commissioner may approve such a contract form for immediate use at any time. Approval may be subsequently withdrawn for cause.²

Finally, the Code allows the Commissioner to examine a health care service contractor's individual or group contracts and disapprove any form for a variety of reasons, only three of which are potentially pertinent to this matter:

- (d) If it contains unreasonable restrictions on the treatment of patients;
- (e) If it violates any provision of Chapter 48.44 RCW; or
- (f) If it fails to conform to minimum provisions or standards required by the Commissioner's regulations.³

¹ RCW 48.44.070(1).

² RCW 48.44.070(2).

³ See RCW 48.44.020(2)(d/e/f) (although OIC initially indicated in its November 25, 2002, letter that RBS-56 was disapproved under RCW 48.44.020(2)(a), it did not advance such a position at hearing). The Commissioner enjoys similar powers with regard to contracts used by Health Maintenance Organizations

Regence filed RBS-56 and other associated rider forms with OIC in recognition of these statutes.

3. Regence argues that the Commissioner carries the burden of proving that Regence's forms are unlawful. Further, at hearing, Regence indicated that the Commissioner previously approved its "file and use" forms by taking no action to prevent Regence from implementing the new riders. It appeared that Regence implied that these forms, once approved, should be allowed to retain their continued effectiveness in the marketplace. Although Regence's position is sound on most grounds, this last suggested implication goes too far.

4. I conclude that Regence is correct in its assertion that fifteen days after its submission of RBS-56, the rider was automatically approved for use. However, the Commissioner can *always* withdraw any previous approval when there is cause to do so, whether that approval is expressly provided or automatically implied through elapsed time. Here, OIC's correspondence of October 7, 2002, first expressed concerns with the annual benefit limit contained in RBS-56. OIC's letter of November 25, 2002, left no doubt that the filing was being disapproved and provided specific reasons for the disapproval. I conclude that this disapproval action was "for cause" and therefore authorized by law, subject to Regence's right to request this hearing. Accordingly, the argument that RBS-56 was automatically approved and that the

(HMOs). See RCW 48.46.060(2), -.060(3)(d/e), and -.060(6).

Commissioner can not now revoke that approval must fail.⁴ However, as Regence points out, however, the Commissioner must carry the burden of showing that its post-approval action disapproving RBS-56 is supported by the cause required by statute.

Provision of Prescription Drug Coverage for Diabetics

5. In 1997, when enacting the Diabetes Cost Reduction Act (DCRA),⁵ the Washington Legislature found and declared that:

diabetes imposes a significant health risk and tremendous financial burden on the citizens and government of the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.⁶

⁴ This argument appears to rely on the doctrine of equitable estoppel, suggesting that Regence should be able to rely on the Commissioner's earlier inaction and automatic approval of the filing. Equitable estoppel against the government is not favored; in order to prove such a case, Regence would have to prove all of the elements of equitable estoppel with clear, cogent and convincing evidence. See, e.g., Kramarevsky v. Dept of Social & Health Services, 122 Wn.2d 738, 743-44, 863 P.2d 535 (1993); see also Marquardt v. Federal Old Line Insurance Co., 33 Wn. App. 685, 691-2, 658 P.2d 20 (1983). Before equitable estoppel can be asserted against the government, there must be a showing that it is necessary to prevent a manifest injustice and that the exercise of governmental functions will not be impaired as a result of the estoppel. Here, even if there was some manifest injustice to Regence, I conclude that if the Commissioner is estopped by a previous oversight from ensuring the suitability of an insurance contract, governmental functions would be impaired. This contract review process is one of OIC's essential obligations; the Commissioner can not be estopped from carrying out this duty when a contract or rider is proposed or already in effect. As noted above, the power to withdraw an approval for cause exists as an independent process by which OIC could have taken the actions at issue in this matter. Thus, the statutes governing the Commissioner appear to have been drafted to avoid any requirement that an earlier action or omission would necessarily be binding on OIC if cause arose for a change in position.

⁵ See Session Laws of 1997, Chapter 276.

⁶ See Legislative declaration as contained in Session Laws of 1997, Chapter 276. As relevant to this matter, this language is found at the opening of RCW 48.44.315.

As explained below, the DCRA affected the way that health care service contractors, health maintenance organizations (HMOs), disability insurers, and even state-purchased health care provide coverage for diabetes, including pharmacy benefits.⁷

6. The DCRA set out a minimum level of diabetes coverage for insurance plans:

All health benefit plans offered by health care service contractors, issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For health benefit plans that include coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and

(b) For all health benefit plans, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents the health care services contractor from restricting patients to seeing only health care providers who have signed participating provider agreements with the health care services contractor or an insuring entity under contract with the health care services contractor.⁸

⁷ As pertinent to health care service contractors like Regence BlueShield, the DCRA was codified at RCW 48.44.315. The applicable codes affecting other entities can be found at RCW 48.46.272 (HMOs), RCW 48.20.391 and RCW 48.21.143 (disability insurers), and RCW 41.05.185 (state-purchased health care). Each of these statutes contain essentially identical provisions. All further citations in this *Initial Decision* will refer to Chapter 48.44 RCW because Regence is a health care service contractor; however, it is notable that the subsequent quoted statutory language interpreted herein is found in all of the other cited statutes, potentially extending the reach of this *Initial Decision* to plans offered by other health care providers.

⁸ RCW 48.44.315(2) (emphasis added).

Thus, the DCRA required all plans to provide diabetics with preventive care services, to include training and education on self-care and appropriate nutrition. However, the DCRA did not create a mandate for all plans to include coverage for pharmacy services; it simply required any plans doing so to include medically necessary equipment and supplies used by diabetics within the scope of such pharmacy services.⁹ The parties agree that Regence is *not* required to offer pharmacy services as part of its coverage.

7. The DCRA specifically allowed health care providers to share the costs of diabetes coverage with their plan members:

Coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.¹⁰

Health care coverage may not be reduced or eliminated due to this section.¹¹

The parties to this case question whether or not a maximum benefit limit qualifies as a "customary cost-sharing" provision as contemplated by the DCRA.

8. The Commissioner has adopted regulations in Chapter 284-43 of the Washington Administrative Code (WAC) regarding *Health Carriers and Health Plans*. One of the definitions contained therein explains OIC's view of "cost-sharing" provisions as follows:

⁹ When pharmacy services are offered, there is no question that the entire gamut of diabetes-related pharmaceuticals must also be offered as a "covered service." This case presents a much different question than that recently answered in *Glaubach v. Regence BlueShield*, ___ Wn.2d ___, ___ P.3d ___, 2003 Wash. LEXIS 546, Slip Opinion No. 73415-1 (2003). However, as noted below, some of the reasoning and logic applied in *Glaubach* is equally applicable to this matter.

¹⁰ RCW 48.44.315(3).

¹¹ RCW 48.44.315(4).

"Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.¹²

This definition utilizes three specific examples of "cost-sharing" but does not indicate whether copayments, coinsurance, or deductibles are the only and exclusive forms of cost sharing permitted in Washington.

9. There is no question that annual maximum benefit limits are authorized under Washington's Insurance Code.¹³ However, OIC argues that these limits are not "cost-sharing" and that therefore the DCRA prohibits use of prescription drug coverage benefit limits for diabetes-related drugs and services.

10. The Commissioner's interpretation of the Insurance Code must be given due deference and, as to applicable regulations implementing the Code, perhaps even "great weight."¹⁴ However, OIC's interpretation of statutory language and even self-adopted regulations is not binding.¹⁵

¹² WAC 284-43-130(8). The Insurance Reform Act contains this same definition at RCW 48.43.005(13).

¹³ See RCW 48.44.320(2)(a) that permits coverage for home health or hospice care to include "reasonable deductibles, coinsurance provisions, and internal maximums." See also WAC 284-44-040, which states in pertinent part (emphasis added): "Every health care service contract issued or renewed after December 31, 1974, shall conform to the following standards: (1) A contract shall not unreasonably limit benefits to a specified period of time. For example, a provision that services for a particular condition will be covered only for one year without regard to the amount of the benefits paid or provided, is not acceptable. *Contracts may, however, limit major medical benefits, supplemental accident benefits, and diagnostic X-ray and laboratory benefits to a reasonable period of time. Benefits may also be limited to a reasonable maximum dollar amount,* and, in the case of doctor calls, to a reasonable number of calls over a stated period of time. Further, RCW 48.43.041(1)(b) requires any carrier offering individual health benefit plans to include "prescription drug benefits with at least a two thousand dollar benefit payable by the carrier annually."

¹⁴ Marquis v. City of Spokane, 130 Wn.2d 97, 111, 922 P.2d 43 (1996); see also Federated American Insurance Co. v. Marquardt, 108 Wn.2d 651, 656, 741 P.2d 18 (1987).

¹⁵ Cockle v. Dep't of Labor & Industries, 142 Wn.2d 801, 812, 16 P.3d 583 (2001).

11. When a cost is "shared" between two parties (i.e. Regence and one of its plan members), the term typically means "to divide and parcel out in shares; apportion" and can also mean "to participate in, use, enjoy, or experience jointly or in turns."¹⁶

12. The three examples of "cost-sharing" provided in both statute and rule help to illustrate the Commissioner's approach to defining when a cost is shared. In the case of copayments and coinsurance, it is easy to accept that the insurer and the plan member share the cost involved in providing the desired health care services.

Typically, this type of cost-sharing is not done equally, with the plan member paying only the same fixed fee regardless of the overall cost of the services rendered.

13. For deductibles, the sharing is slightly more difficult to see and it may never occur in certain situations. With a deductible, the plan member incurs all of the initial costs of health care services needed. Only after reaching a threshold level does the insurer become responsible for costs over and above the level of the deductible. Thus some plan members with low annual health care costs might never come to share expenses with the insurer. Even so, RCW 48.43.005(13) and WAC 284-43-130(8) specifically include deductibles as a type of cost-sharing.

14. OIC has argued that because Regence's plan contains a general prescription drug benefit, it must offer unlimited coverage of all diabetes-related drugs and supplies or else be in violation of the statute. OIC has conceded that this unlimited

¹⁶ The American Heritage Dictionary of the English Language, Fourth Edition (2000). Alternatively, Webster's Revised Unabridged Dictionary (1998) defines the verb form of the word "share" as meaning "to have part; to receive a portion; to partake, enjoy, or suffer with others."

coverage for diabetes-related items need not be extended to all other covered items under a given prescription drug benefit (see Exhibit 5, page 3), but OIC can not have it both ways. Annual benefit limits are either "cost-sharing provisions" or they are not.

15. After considering all of the arguments put forth by both OIC and Regence, I conclude that an annual benefit limit is essentially the mirror image of a deductible. Under the annual limit set out in RBS-56, the plan member and Regence share equally in the first \$4,000 of costs incurred for prescription drugs each year. If that level is reached, the plan member must then bear the additional costs incurred thereafter.

16. OIC argues that this arrangement ceases to be "sharing" once the \$4,000 annual benefit limit is reached and instead becomes "cost-shifting." However, under this logic, a deductible would also be "cost-shifting," first toward the plan member who must incur the initial expenses, and then onto the insurer who must incur further expenses. Despite this arrangement, both the statute enacted by the Legislature and the rule adopted by the Commissioner agree that a deductible is "cost-sharing."

17. OIC also argues that the listed examples contained in the statute and the Commissioner's implementing regulation preclude consideration of other cost-sharing provisions that are not specifically listed. However, given the statutory and regulatory language that cost-sharing "may include" the three listed items, I can not agree with OIC's reading of the statute. Nothing in either the law or the rule indicates that the list is exhaustive in nature; to the contrary, the permissive "may" indicates otherwise.

18. Further, OIC argues that Regence's use of a \$4,000 annual benefit limit "places medically necessary diabetic supplies and services beyond the financial reach of some enrollees altogether once the modest cap amount is exhausted"¹⁷ and as such operates as a "coverage termination provision."¹⁸ If the Legislature had mandated coverage of diabetic supplies, this interpretation of the statute might be persuasive. However, as the parties agreed at hearing, the DCRA did not require any health care service contractor or other insurer to provide coverage for these supplies. A careful reading of RCW 48.44.315(2) and its related subparagraphs indicates that any pharmacy benefit offered after January 1, 1998, would have to include diabetic supplies and equipment within the scope of that benefit's coverage. OIC is attempting to make more of this statute than the Legislature ever intended.

19. The major difficulty in accepting the Commissioner's proposition is its ultimate scope. As recently noted by the Washington Supreme Court, this type of reasoning would "not accord with the general flexibility health insurers have to tailor plans to meet different needs and different resources."¹⁹ If diabetics are to be offered any prescription drug benefit at all, health care service contractors (and other insurers) must be permitted to customize their plans to allow for competition in the marketplace and reasonable profitability. OIC's position essentially robs Regence and all similarly

¹⁷ See OIC Staff Trial Brief and Motion to Dismiss, at 12-13.

¹⁸ See OIC Staff Reply Brief, at 3.

¹⁹ Glaubach, __ Wn.2d at __ (*10 in LEXIS version).

situated health carriers of the ability to adapt prescription drug benefits to meet the various needs and resources present in the market.

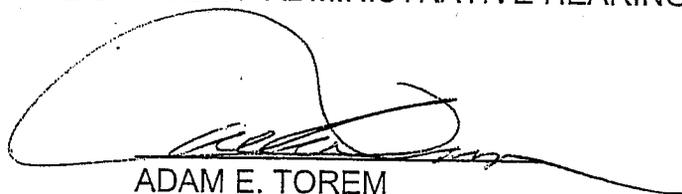
20. Offering a pharmacy benefit remains optional under the DCRA. OIC's approach to RBS-56 can only serve to discourage the offering of such benefits to Washington residents by inappropriately increasing the costs involved in offering such a benefit. At best, this is counterproductive to the express goals of the DCRA. Thus, for all of the above-stated reasons, I conclude that an annual benefit limit is an acceptable cost-sharing provision contemplated by RCW 48.44.315(3) for implementation of the benefits encouraged or required under RCW 48.44.315(2).

ORDER

IT IS HEREBY ORDERED That the Office of Insurance Commissioner's disapproval of Regence's rider form RBS-56 and the prescription drug benefit described therein, specifically including the annual benefit limit, is REVERSED.

DATED at Olympia, Washington, this 13th day of August 2003.

WASHINGTON STATE OFFICE OF ADMINISTRATIVE HEARINGS



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