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

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| In the Matter of:<br><br>**Seattle Children's Hospital Appeal of OIC's Approvals of HBE Plan Filings.** | **Docket No. 13-0293**<br><br>**SEATTLE CHILDREN'S HOSPITAL'S OPPOSITION TO INTERVENORS' JOINT MOTION FOR SUMMARY JUDGMENT** |

## I. INTRODUCTION AND SUMMARY OF RESPONSE

The Intervenors have failed to meet the required standards to obtain summary judgment dismissal of Seattle Children's Hospital's (SCH's) appeal. First, the Intervenors' standing arguments fail; SCH clearly is "aggrieved" by the Commissioner's actions, which is all that is required to support this appeal. On the merits, the Intervenors' arguments demonstrate the accuracy of SCH's contention that the OIC staff failed to consider or apply the proper standards under the ACA and state law. In this regard, the record establishes multiple genuine issues of material fact, including such issues as whether SCH has refused to contract at generally applicable rates, the frequency of use of single case agreements and the burden that they represent, and the Intervenors' assertions of network adequacy in the absence of SCH. All of these factual disputes preclude summary judgment in favor of the Intervenors.

The Intervenors also fail to establish any entitlement to judgment as a matter of law in their favor. As SCH has already identified in its own pending motion for partial summary judgment, because the OIC failed to consider or apply controlling federal law, and failed to



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601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

consider the harms to patients and to SCH resulting from its failure to require inclusion of SCH as an in-network provider by the Intervenors' Exchange plans, the only summary judgment appropriate here is one in favor of SCH, vacating the approvals and requiring the staff to reconsider in light of the proper standards.

## II. FACTUAL BACKGROUND

### A. Coordinated Care Corporation (CCC).

SCH offered to contract with CCC's Exchange network at rates consistent with SCH's other commercial rates. Supplemental Declaration of Eileen O'Connor Ex. C at SCH000025, SCH000035. CCC, however, informed SCH in May 2013 that it did not intend to enter into a contract with SCH for its Exchange product. Supp. O'Connor Decl. Ex. C at SCH000031. The OIC disapproved the proposed Exchange plans from Coordinated Care Corporation (CCC) on the basis of network inadequacy. As Dr. Fathi's declaration notes, the OIC disapproval was based on CCC's failure to include SCH as an in-network provider. *See* Fathi Decl. ¶ 4. The Hearings Unit is aware that CCC requested adjudication, and prevailed on the question whether RCW 48.46.030 or WAC 284-43-200 require pediatric specialty hospitals to be included in exchange plan networks. [First] Declaration of Michael Madden (dated Jan. 17, 2014) Exs. C, D; *see* SCH Motion for Partial Summary Judgment, at p. 2.

### C. BridgeSpan Health Company.

SCH offered to contract with BridgeSpan for its Exchange plans network consistent with the commercial rates used for other commercial products. Supp. O'Connor Decl. ¶ 8, Ex. D at SCH000110-111, SCH000118. BridgeSpan, however, informed SCH that it would use its "RealValue" network for its Exchange products, and that SCH was not participating in the RealValue network. Supp. O'Connor Decl. Ex. D at SCH000110-111, SCH000116, SCH000120. The OIC approved the BridgeSpan Exchange plans.[1]

[1] The record provides possibly inconsistent evidence as to what information the OIC had at the time of the approval about whether the BridgeSpan Exchange plans included SCH as an in-network provider. *Compare* Supp. O'Connor Decl. Ex. D at SCH000119 (threatening that SCH "will be *suppressed* from the BridgeSpan directory") (emphasis



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601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

**D. Premera.**

Premera informed SCH that it is an "out-of-network" provider as to Premera's Exchange plans. *See* SCH Motion for Summary Judgment, at p. 8. The OIC approved the Premera Exchange plans.[2] To date, the Premera Exchange products have the largest number of enrollees of any carrier on the Exchange. *See* Intervenors' Motion at 5, 8, 10; Supplemental Decl. of Michael Madden Ex. E. Premera estimates that the number of enrollees in its Exchange plans is currently 48,092. *See* Intervenors' Motion, at p. 10.

**E. SCH Action and Summary Judgment Motions.**

SCH timely appealed all three approvals. *See* SCH Motion, at p. 2. SCH and the Intervenors have filed separate Motions for Summary Judgment. The OIC staff have also filed a motion seeking summary judgment relief. *See* OIC Staff's Motion to Dismiss.

## III. ISSUES PRESENTED

1. Have the Intervenors failed to establish that there are no genuine issues of material fact and that they are entitled to judgment as a matter of law on their claim that SCH lacks standing to pursue this administrative action challenging the OIC's approvals of the Intervenors' Exchange plans, where the undisputed evidence demonstrates that the approvals have caused harm to SCH and its patients, and that SCH represents interests within the zone of interests that the federal and state statutes were designed to protect?

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added) *and* Supp. O'Connor Decl. Ex. D at SCH000120 ("SCH was not and is not included in the [BridgeSpan Exchange] network as a *fully and directly* contracted provider") (emphasis added), *with* Supp. O'Connor Decl. Ex. D at SCH000116 (BridgeSpan statement to SCH that because SCH is out of network for BridgeSpan's Exchange members, SCH has "the right to balance bill these members") *and* [First] Madden Decl. Ex. A at p. 3 (OIC response to RFA 4; admitting that BridgeSpan Exchange plans did not include SCH at the time of the OIC approval).

[2] As described in SCH's Motion for Partial Summary Judgment, Premera has expressly stated that its Exchange plans do not include SCH as an in-network provider. SCH Motion, at p. 8. The OIC, however, has denied that the Premera Exchange plans do not include SCH as an in-network provider. Declaration of Michael Madden Ex. A at p. 3 (response to RFA 4). Premera has stated to the OIC that, despite SCH's status as an out-of-network provider with Premera's Exhange plans, SCH "will be prohibited from balance-billing" Premera's Exchange plan members. [First] O'Connor Decl. Ex. A at SCH000104; *compare id.* Ex. A at SCH000197-109.



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601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

2. Have the Intervenors failed to establish that there are no genuine issues of material fact and that they are entitled to judgment as a matter of law on the issue of whether the OIC complied with federal and state requirements in reviewing and approving the Intervenors' Exchange plans, despite the OIC's undisputed failure to consider and apply the federal requirements that the plans must include essential health benefits and essential community providers?

## IV. EVIDENCE RELIED UPON

SCH relies on:

- the accompanying Supplemental Declaration of Eileen O'Connor, together with the exhibits thereto,
- the accompanying Supplemental Declaration of Michael Madden, together with the exhibit thereto,
- the accompanying Declaration of Kelly Wallace,
- the accompanying Declaration of Suzanne Vanderwerff;
- SCH's pending Motion for Partial Summary Judgment;
- the previously filed [First] Declaration of Michael Madden (dated January 17, 2014), together with the exhibits thereto,
- the previously filed [First] Declaration of Eileen O'Connor, (dated January 16, 2014), together with the exhibits thereto,

and the other records and files herein.

## V. AUTHORITY AND ARGUMENT IN RESPONSE

### A. Standard of Review.

Summary judgment under WAC 10-08-135 is appropriate only where "there is no genuine issue as to any material fact and ... the moving party is entitled to a judgment as a matter of law."' *E.g., Locke v. City of Seattle,* 162 Wn.2d 474, 483, 172 P.3d 705 (2007) (quoting identical language from CR 56(c)). A genuine issue of material fact exists where



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Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

reasonable minds could reach different conclusions regarding a material fact. *Wilson v. Steinbach,* 98 Wn.2d 434, 437, 656 P.2d 1030 (1982); *see also Michael v. Mosquera-Lacy,* 165 Wn.2d 595, 601, 200 P.3d 695 (2009). Washington law favors resolution of cases on their merits. *Smith v. Arnold,* 127 Wn. App. 98, 103, 110 P.3d 257 (2005). When determining whether an issue of material fact exists, the court must construe all facts and inferences in favor of the nonmoving party. *Vallandigham v. Clover Park Sch. Dist. No. 400,* 154 Wn.2d 16, 26, 109 P.3d 805 (2005) (citing *Atherton Condo. Apartment-Owners Ass'n Bd. of Dirs. v. Blume Dev. Co.,* 115 Wn.2d 506, 516, 799 P.2d 250 (1990)).[3] Only after the moving party has sustained its burden, the nonmoving party must then set forth specific facts evidencing a genuine issue of material fact for trial. *See* CR 56; *Schaaf v. Highfield,* 127 Wn.2d 17, 21, 896 P.2d 665 (1995).

**B. The record reflects numerous genuine issues of material fact as to the issues the Intervenors raise.**

The Intervenors assert that the issues they raise are appropriate for resolution on summary judgment because no genuine issues of material fact exist. As a preliminary matter, however, the record reflects numerous genuine disputes of material fact:

First, the Intervenors' assert that SCH had "high[]" rates that caused the Intervenors to decline to contract with SCH. *See, e.g.,* Intervenors' Motion, at 7. Other than the unsupported assertions of the Intervenors themselves, there is no evidence that SCH were disproportionate to other providers or other agreements in which the Intervenors participated. SCH has entered into agreements with carriers for other Exchange plans, demonstrating that other Exchange plan carriers have found SCH's rates acceptable. Supp. O'Connor Decl. ¶ 7.[4] SCH offered to

[3] *See also, e.g., Reid v. Pierce County,* 136 Wn.2d 195, 201, 961 P.2d 333 (1998); *Nivens v. 7-11 Hoagy's Corner,* 133 Wn.2d 192, 198, 943 P.2d 286 (1997); *Van Dinter v. City of Kennewick,* 121 Wn.2d 38, 44, 846 P.2d 522 (1993); *Wilson v. Steinbach,* 98 Wn.2d 434, 437, 656 P.2d 1030 (1982).

[4] There is evidence that Premera also acknowledged that SCH's rates were commercially reasonable. Premera communicated to SCH that it included SCH in its "Tier 3" network, which it defined to include facilities "whose severity adjusted cost-per-case is competitive with that of other local facilities." [First] O'Connor Decl. Ex. A at SCH000092-93.



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contract with both CCC and BridgeSpan at standard commercial rates; in the case of BridgeSpan, this represented the rate that it had already entered into with SCH for its other commercial product lines. Supp. O'Connor Decl. Ex. D at SCH000110-111.[5] CCC asserts in the Intervenors' Motion that SCH "would only accept full commercial rates." *See* Intervenors' Motion, at p. 7. Although this may have been unpalatable to CCC, which prior to the Exchange had only done business in Washington as to Medicaid plans ([First] Madden Decl. Ex. C at p. 4), CCC effectively concedes that SCH's rates were accepted rates for non-Medicaid, commercial products.

Second, the Intervenors assert that "single case agreements" are common and lawful,[6] and then argue by extension that neither the OIC nor SCH should be troubled by the use of single case agreements to provide payment for any out-of-network services provided to the over 50,000 (and growing) number of state residents already enrolled in their Exchange plans. *See* Intervenors' Motion, at p. 7. However, SCH has presented evidence that, to this point, the use of single case agreements is very rare, with only 67 completed in during FY 2012, in the context of 351,147 patient encounters during the same time period,[7] a usage frequency rate of only 0.02 percent. *See* Supp. O'Connor Decl. ¶ 10. In particular, as to in-state residents, with the exception of two national carriers for behavioral health services, with whom SCH anticipates

[5] As to CCC, SCH learned in 2013 that CCC had leased the Multiplan Systems commercial network, which seemed to indicate that CCC was willing to pay commercial rates. Supp. O'Connor Decl. Ex. C at SCH000078. Although SCH initially assumed that because of SCH's existing contract with Multiplan, CCC would pay for SCH services at the commercial rates agreed to in that plan, SCH later learned, in September 2013, that CCC did not intend to access the Multiplan network for services to its insureds at SCH. Supp. O'Connor Decl. Ex. C at SCH000078.

[6] This contrasts with CCC's earlier communication to SCH that the OIC had informed CCC in May 2013 that CCC could not use single case agreements ("LOAs") as a "gap filler" in order to establish network adequacy. Supp. O'Connor Decl. Ex. C at SCH000031; *see also* [First] Madden Decl. Ex. C at 17 (documenting OIC assertion that CCC "is not allowed to use 'spot contracts' or 'single payer agreements' to complete its network of providers). *Compare* Supp. O'Connor Decl. Ex. D at SCH000117 (BridgeSpan informed SCH that it intended to obtain any care at SCH for its Exchange insureds through single case agreements, and that "[t]his was a process accepted by the OIC as an alternative mechanism to a direct Real Value contract").

[7] *See* http://www.seattlechildrens.org/about/history/facts-and-stats/ (last accessed Jan. 29, 2014)).



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Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

having provider agreements in the future, the use of single case agreements for services obtained at SCH numbered in the single digits in a one-year period. *Id.*

In contrast to the infrequent use of single case agreements for out-of-network services in the past, in just the first month since the Exchange plans began providing coverage in January 2014, 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. Declaration of Suzanne Vanderwerff, at ¶ 2. To date, in just the month of January, SCH has had to make over 200 such requests to Premera for its Exchange plan members. *Id.* A number of the requests have already been denied, resulting in Premera denying payment to SCH for care SCH provided to Premera's Exchange plan members. *Id.* at ¶ 4.

Third, the Intervenors assert that their networks are adequate because they have included, in the case of CCC, Providence and Swedish in King County, and Providence Sacred Heart and the Shriners Hospital for Children in Spokane;[8] in the case of BridgeSpan, Mary Bridge Children's Hospital in Tacoma, University of Washington Medical Center and Harborview Medical Center in Seattle, Evergreen Hospital in Kirkland,[9] and Valley Medical Center in Renton, and in the case of Premera, "over 87 hospitals," albeit mostly unnamed.[10] *See*

[8] Shriners' services are limited to orthopaedics, burn care, spinal cord injury, and cleft lip/palate. *See* http://www.shrinershospitalsforchildren.org/en/care (last accessed Jan. 29, 2014). It treated a total of 222 inpatients in all of 2012. Supp. O'Connor Decl. ¶ 3.

[9] The Intervenors' assertion that the pediatric hospitalists at Evergreen are also on staff at SCH does not address the scope of services that are offered at Evergreen.

[10] Premera names as examples only Virginia Mason Hospital in Seattle ("VM"), Evergreen Hospital in Kirkland, and Valley Medical Center in Renton. *See* Intervenors' Motion, at 10. Premera's assertion that its network includes 87 hospitals appears consistent with the list of "Heritage Signature" hospitals that it had provided to SCH. [First] O'Connor Decl. at Ex. A at SCH000095. For Seattle and King County, however, the only hospitals Premera included in this list are, in addition to VM, Evergreen, and Valley: Fairfax Hospital in Kirkland, which solely provides behavioral health services; Kindred Hospital (two locations), which solely provides long-term acute care, primarily for Medicare patients; Northwest Hospital (part of the UWMC system); Overlake Hospital in Bellevue, with no pediatric specialties other than for neonates born at the facility; Providence Everett (three locations); Schick Shadel Hospital in Seattle, which solely provides medical treatment for addiction; St. Francis Community Hospital in Federal Way, which has no pediatric specialties other than for neonates born at the facility; and the VA Puget Sound Health Care System in Seattle, providing services solely to veterans. *See id.* SCH has provided evidence regarding the differences between the services provided at SCH and at Evergreen, Providence Everett, UWMC, Valley, and Virginia Mason. [First] O'Connor Decl. ¶¶ 4-7; Supp. O'Connor Decl. ¶¶ 2-6.



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Intervenors' Motion, at 5, 8-10. SCH has, however, presented evidence demonstrating that the services provided at these other hospitals are in no way comparable to the comprehensive inpatient and outpatient pediatric services available only at SCH. [First] O'Connor Decl. ¶¶ 4-7; Supp. O'Connor Decl. ¶¶ 2-6; Decl. of Kelly Wallace at ¶ 2. In the absence of the services that SCH provides, the carriers are not providing and cannot provide the full range of pediatric services to their insureds.

**C. SCH has standing to represent the harms to its patients and to its own ability to provide quality and cost-efficient services.**

Although the Intervenors assert that SCH lacks standing, the evidence and applicable law establish SCH's standing or, at a minimum, raise genuine issues of material fact regarding SCH's standing that preclude summary judgment. Under the RCW 48.04.010 standard providing that standing requires only that a party be "aggrieved" by an act, threatened act, or failure to act by the Commissioner, SCH has established that it has been injured and otherwise aggrieved by the Commissioner's approval of the Intervenors' Exchange plans while failing to consider and apply controlling requirements under the ACA and state law.

Because of the OIC's actions, SCH is now required to provide services to the patients insured by the Intervenors' Exchange plans as an out-of-network provider. *See* Madden Decl. Ex. D. SCH has presented evidence that it has and continues to suffer economic harms resulting from the OIC's decisions, including the current and ongoing administrative burden of processing requests for payment and negotiating single case agreements for patients insured by the Intervenors' Exchange plans, and by the denial of payments for services provided to these patients. [First] O'Connor Decl. ¶¶ 8-12; Supp. O'Connor Decl. ¶¶ 11-15; Vanderwerff Decl. ¶¶ 2-4.



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Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

The Intervenors' assertion that they "will pay" SCH for services provided to these patients[11] is not only shown to be false by the undisputed evidence of their ongoing refusal to enter into agreements with SCH at existing commercial rates, and failing to provide any information about their process, rates, or approval standards for single case agreements,[12] it also ignores their plain assertions in their motion and in their own declarations that they have no interest in or intention of paying SCH at existing commercial rates. Their assertions that they "will pay" SCH for services, in the absence of any additional information as to what rate they will pay, only reinforces the evidence that their intention is to pay SCH at below commercial rates, causing direct economic injury to SCH.

The Intervenors' additional assertion that SCH cannot assert that it has been "aggrieved" based on the harms to its patients ignores the well-established case law that has recognized the ability of physicians to assert the rights of their patients, despite the general rule in other circumstances that parties may not assert the rights of others to establish standing. *E.g., Singleton v. Wulff,* 428 U.S. 106, 108 (1976) (upholding standing of physicians to assert the rights of their patients; "like any general rule, however, this one [preventing parties from asserting the interests of others] should not be applied where its underlying justifications are absent"); *Compassion in Dying v. State of Wash.,* 79 F.3d 790, 795-96 (9th Cir. 1996) (citing *Singleton*; physicians have standing to assert their patients' interests), *rev'd in part on other grounds sub nom. Washington v. Gluckberg,* 521 U.S. 702 (1997). None of the cases the Intervenors cite as to standing addressed the circumstance of physicians asserting the interests of their patients. *Cf. Allan v. University of Washington,* 140 Wn.2d 323, 331-33, 997 P.2d 360

[11] This contrasts with CCC's previous communication to SCH that if any of CCC's Exchange plan insureds received care at SCH, those insureds would not receive any out-of-network benefits. Supp. O'Connor Decl. Ex. C at SCH000059.

[12] Although Intervenors assert that they intend to use single case agreements for any of their Exchange plans insureds who receive care at SCH, neither CCC nor BridgeSpan have provided SCH with any information regarding what process they will use for completing single case agreements, what rates they will pay, or in what circumstances they will require prior approval for treatment as a condition of payment. Supp. O'Connor Decl. ¶¶ 12, 15.



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601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

(2000) (wife of faculty member lacks standing to challenge disciplinary adjudication procedures of university faculty code); *Patterson v. Segale,* 171 Wn. App. 251, 259-60, 289 P.3d 657 (2012) (plaintiffs were "no differently situated than are any other members of the public" and had already settled their claims with the neighboring landowner whose shoreline permit was at issue); *West v. Thurston County,* 144 Wn. App. 573, 183 P.3d 347 (2008) (plaintiff in suit seeking disclosure of public records cannot assert standing for additional contract claim based on alleged contract interests of third parties identified in the documents).

The *Singleton* Court noted several factors that led to an exception to the general rule in the case of physicians asserting standing in order to advocate for the rights of their patients: (1) the "advocate" nature of the underlying relationship (*see, e.g., Youngs v. PeaceHealth,* Wash. St. S. Ct. No. 87811-1 (Jan. 23, 2014), at p. 3 (citing RCW 5.60.060(4); the relationship between a physician is a "'fiduciary one of the highest degree ... involv[ing] every element of trust, confidence and good faith'"); (2) the fact that the patient interests at issue are such that "the physician is intimately involved"; and (3) the limited ability of an individual patient to assert his/her own rights in this context, and (4) the fact that the rights of any individual patient can quickly become moot. *Singleton,* 428 U.S. at 114-17. The *Singleton* Court recognized standing, concluding that "there seems little loss in terms of effective advocacy from allowing [the] assertion [of patient rights] by a physician." *Id.* at 118. All of these factors are similarly present here. SCH stands as an advocate for the interests of its patients in this litigation. The transactions at issue, with the Intervenors and with the OIC, as well as the underlying medical services themselves, are ones in which SCH is intimately involved. As a party, SCH has more resources and ability than any individual patient to assemble relevant data and evidence as to the facts and legal issues in dispute, and therefore is even better positioned than a single patient to present the relevant arguments and evidence here. Although it could be conceivable for a representative class of affected patients to be assembled, the likely "fluid membership" of such a group over the course of litigation, and the fact that the rights asserted would necessarily be



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Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

"representative", makes SCH equally if not more effective as an advocate for such patients' interests. *See Singleton,* at 117-18.

The Intervenors further assert that SCH is not within the "zone of interest" that the legislature intended the OIC to protect. Even if this APA language were considered to apply to the analysis here under RCW 48.04.010, SCH meets the requirement both on its own behalf as well as in asserting representative standing for its patients. The "zone of interest" test "is not meant to be especially demanding." *E.g., KS Tacoma Holdings, LLC v. Shorelines Hearings Bd.,* 166 Wn. App. 117, 128, 272 P.3d 876 (2012) (finding that test was met by party asserting its interest in protecting "the public's enjoyment" of state shorelines) (citing *Seattle Bldg. & Constr. Trades Council v. Apprenticeship & Training Council,* 129 Wn.2d 787, 797, 920 P.2d 581 (1996)). Even the decision the Intervenors cite, *St. Joseph Hosp. & Health Care Ctr. v. Department of Health,* 125 Wn.2d 733, 887 P.2d 891 (1995), is instructive on this issue. The Department of Health asserted that the "zone of interest" test was not met, because the Certificate of Need (CON) statute was intended to protect the interests of the public, not the interests of competing health care providers. *Id.* at 740. The state supreme court disagreed, taking the side of providers in concluding that the CON statute, in recognizing the importance of reviewing need, costs, and financial feasibility "necessarily involves assessing a proposed project's impact on existing providers." *Id.* at 741 ("[b]ecause the Legislature intended to regulate competition as well as control costs, we hold competing service providers to be within the statutory zone of interest").

The OIC's statutory obligation to ensure that health maintenance organizations have made "arrangements with institutions" (RCW 48.46.030) is intended to protect both the consumers and those institutions. The state's insurance code, in requiring that carriers' agreements with providers be preapproved (RCW 48.43.730), further protects the interests of providers in ensuring that those contracts are fairly drafted to protect both parties to the agreements as well as the public's interests. The OIC's own network adequacy requirements,



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601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

WAC 284-43-200, in requiring that the carriers maintain adequate networks, is also necessarily intended to protect the provider participants in those networks—who are otherwise left in the very position that SCH finds itself in providing care to patients while relying on inadequate spot-contracting arrangements for out-of-network care—as well as the carriers who must maintain those networks and the insureds that they serve. The ACA's requirements that carriers establish networks that (1) provide essential health benefits, including pediatric services (42 U.S.C. § 18022(b)(1); 45 C.F.R. § 156.20; 45 C.F.R. § 156.110); and (2) include "essential community providers" in their networks (42 U.S.C. § 18031(c)(1); 45 C.F.R. § 156.230; 45 C.F.R. § 156.235(c)) similarly protect the participants in those networks—who are defined to include providers who "serve predominately low-income, medically-underserved individuals"—as well as the patients that they serve. State provisions that enforce these federal requirements, including RCW 48.43.715 and WAC 284-43-849, protect the same interests.

The *St. Joseph* court noted that "[w]hile an applicant who is denied a CN has both a motive and a statutory right to seek review of the Department's determination, no comparable motivation or statutory authority to seek review exists when the Department grants a CN. Practically, this can be achieved only if competitors have standing." *St. Joseph,* 125 Wn.2d at 742. Similarly here, the Intervenors do not dispute that they have a motivation and right to seek review of an OIC denial of their rate request filings, but no comparable motivation for carriers when the Commissioner erroneously grants the rate request filing. As a practical matter, such review will only take place in an action such as this one, brought by a party with interests genuinely adversarial to the Intervenors. The *St. Joseph* court also cited with approval a similar Kentucky decision in which the court had stated: "'The hospital has the information available to assess the impact of a new program, and if it has no standing to challenge the agency's actions as arbitrary, as a practical matter no one will.'" *Id.* (quoting *Humana of Kentucky, Inc. v. NKC Hosps., Inc.,* 751 S.W.2d 369 (Ky. 1988)).



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601 Union Street, Suite 1500
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T: (206) 622-5511 F: (206) 622-8986

Similarly here, if SCH lacks standing here to challenge the OIC's failure to engage in adequate review of the Intervenors' proposed networks for their Exchange plans, as a practical matter, who will present the challenge? The Intervenors contest SCH's standing in the hope, not that a better plaintiff will come along, but that the OIC's review of the Intervenors' networks will simply go without challenge. The Intervenors' standing argument must be rejected.

**D. The Intervenors have failed to establish that, as a matter of law, they met state and federal network adequacy requirements.**

The Intervenors ask the Hearings Unit to declare that, as a matter of law, they have met federal and state network adequacy requirements. The SCH Demand in this action and its pending summary judgment motion, however, are focused instead on the conduct of the OIC in making its approval decisions regarding the Intervenors' Exchange plans. If the OIC failed to consider controlling authorities in making those decisions, then the function of the Hearings Unit should be to remand this action to the Commissioner's staff for consideration of the controlling authorities.

**1. The OIC's approval of these plans does not preclude review here.**

The Intervenors' contention that summary judgment is warranted here because the OIC has already decided the issue of network adequacy as to each of these plans is without merit. The OIC's approvals are the subject of this action, the action that caused SCH and its patients to be aggrieved, and the fact of the approvals cannot be the final word in an action to challenge the validity of these very approvals. The essential function of RCW 48.04.010 is to provide this forum for review of the validity of the OIC's actions, not to preclude such review. The APA serves a similar function to ensure that agency actions are subject to judicial review before an impartial tribunal.

The fact that this Hearings Unit reviewed in a separate action the adequacy of CCC's network, in an expedited hearing, also fails to serve as a basis to preclude SCH's action. In this action, SCH has timely sought review of the OIC's actions as to each of the Intervenors'



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Seattle, Washington 98101
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Exchange plans. In the CCC action (No. 13-0232), the Hearings Unit reviewed the issues regarding solely CCC's plan, in the absence of input by SCH or other impacted parties, and in the absence of "clear, consistent arguments" by the OIC in opposition to CCC's presentation of evidence and argument. [First] Madden Decl. Ex. D at p. 5; *see also id.* at p. 6 (noting lack of "clearer and more focused arguments, and strong, adequate and consistent evidence" by the OIC), and p. 7 (noting that CCC testimony was "uncontroverted by the OIC", that the OIC "did not object to ... testimony, and presented no testimony of its own" regarding network adequacy, and "changed its own position" on the issue of whether pediatric hospitals were required for network adequacy).

The Intervenors' argument that relief in this action should be precluded by the result in the CCC appeal, which was based on a one-sided and erroneous presentation of facts, is unjust, and without the support of any authority. The proposition that SCH's timely demand for hearing here should be precluded by a ruling in an action in which it did not participate, and was not invited to participate, meets none of the requirements for application of the doctrine of collateral estoppel. *E.g., Clark v. Baines,* 150 Wn.2d 905, 913, 84 P.3d 245 (2004) (rejecting application of collateral estoppel doctrine where the prior proceeding did not provide "a full and fair hearing on the issue in question").[13] Because the CCC action did not address the Premera or BridgeSpan plans, did not present identical issues to this action, including consideration of federal ACA requirements, did not include the participation of SCH or any party with which it had privity, and

[13] The *Clark* court specified that a party asserting collateral estoppel must establish four separate elements:

> The party asserting collateral estoppel must prove: (1) the issue decided in the prior adjudication is identical to the one presented in the current action, (2) the prior adjudication must have resulted in a final judgment on the merits, (3) the party against whom collateral estoppel is asserted was a party or in privity with a party to the prior adjudication, and (4) precluding relitigation of the issue will not work an injustice on the party against whom collateral estoppel is to be applied.

*Clark,* at 913. The fourth element requires the party to establish that the earlier proceeding provided "a full and fair hearing on the issue in question." *Id.*



LAW OFFICES
BENNETT BIGELOW & LEEDOM, P.S.
601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

did not involve effective advocacy in opposition to CCC, its result fails to preclude a full and fair hearing of the issues raised in this action.

**2. The Intervenors' Exchange plans fail to meet federal and state network adequacy standards, and the Commissioner failed to consider the federal requirements before approval.**

The Intervenors err in asserting that, as a matter of law, their Exchange plans meet federal and state network adequacy requirements. As set forth in SCH's own summary judgment motion, the substance of which is incorporated here by reference, Congress has established two separate mandatory network standards: (1) the essential health benefits requirement, and (2) the requirement to include essential community providers. SCH Motion, at pp. 5-6. States have an obligation under both federal and state law to enforce these federal requirements. *Id.* at p. 6. The OIC has admitted that SCH is an Essential Community Provider. [First] Madden Decl. Ex. A at p. 3.

Not only do the Intervenors err in asserting that these requirements have been met, they further err in ignoring the undisputed fact that the OIC failed to consider and apply these requirements in its approval of these networks. Neither the OIC nor the Intervenors have presented any evidence that the OIC considered these ACA requirements in approving these plans. If there had been such evidence, the OIC would have presented it in the CCC action, in its summary judgment motion in this action, or in response to SCH's discovery requests in this action. The CCC decision reflects that the OIC made no arguments there that raised or addressed the federal ACA essential health benefits and essential community provider requirements.[14] This undisputed failure by the Commissioner to consider and apply controlling law requires summary judgment in favor of SCH rather than the Intervenors.

Instead of addressing the Commissioner's undisputed failures, both the Intervenors and the OIC now assert a new argument, not raised in either the CCC action or in prior

[14] Although the record reflects no consideration by either the Intervenors or the OIC of the ACA requirements in either the approval process or in the CCC litigation, neither the OIC nor the Intervenors dispute the applicability of these requirements here.



LAW OFFICES
BENNETT BIGELOW & LEEDOM, P.S.
601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

communications by the OIC. They now assert that a CMS advisory letter and instructions to carriers excuse them from the statutes and regulations requiring compliance with the ACA essential community provider requirements. *See* Nollette Decl. Exs. F, G. This argument is unavailing. First, the CMS letter and instructions do not carry the force of law, and to the extent that they 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. *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 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). In this case, the CMS letter and instructions in fact conflict with the statutory and regulatory requirements, and therefore must give way to the controlling authority. The ACA requires carriers to "at a minimum ... include ... essential community providers, where available" in order to establish network adequacy. 42 U.S.C. § 18031(c)(1); 45 C.F.R. § 156.230. Essential community providers include children's hospitals. The ACA identifies only two exceptions to the requirement to contract with ECPs: (1) where and ECP is not "available" (42 U.S.C. § 18031(c)(1)(C)), and (2) where the ECP "refuses to accept the generally applicable payment rates of such issuer." 45 C.F.R. § 156.235(d).

It is undisputed that SCH was "available" for the Intervenors to contract with for their Exchange plans. The record shows no compliance with these requirements, nor any review by the Commissioner of the Intervenors' compliance with these requirements. Solely in the course of this litigation have some Intervenors asserted high rates as a basis for their failure to contract



LAW OFFICES
BENNETT BIGELOW & LEEDOM, P.S.
601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

with SCH; SCH has presented evidence raising genuine issues of material fact as to those assertions. The CMS letter, in direct conflict with this requirement to contract with available ECPs, negates this plain language and instead, asserting as a reason that "the number and types of ECPs available varies significantly by location," asserts that carriers in federal Exchange plans need only show participation of "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," then identifying six large ECP categories (FQHCs, Ryan White HIV/AIDS providers, family planning, Indian providers, "Hospitals", and "other"). *See* Nollette Decl. Ex. F at pp. 7-9. The category of "hospital" includes DSH, children's, rural referral centers, sole community hospitals, free-standing cancer centers, and critical access hospitals. *Id.* at pp. 8-9. The letter 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 letter 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 hospital in its network. This result violates both the plain language and the spirit of the ACA ECP requirements. To the extent that the Intervenors interpret the CMS letter to exempt them from including SCH as an essential community provider, their interpretation must give way to a plain reading of the ACA itself.

Second, the CMS documents, by their own terms, apply to carrier applications for Exchange plans to be listed on the federal Exchange, and do not address or apply to state Exchange plans. Third, the OIC has failed to assert that it relied on, or even was aware of, these documents at the time that it approved the Intervenors' Exchange plans. SCH's action asks the Hearings Unit to review the adequacy of the OIC's action; it has never asserted that it even considered the federal ACA network requirements, nor that it made use of these CMS documents in reaching its decisions.



LAW OFFICES
BENNETT BIGELOW & LEEDOM, P.S.
601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986

Fourth, the CMS documents in no way preclude the OIC nor this tribunal from imposing higher network adequacy requirements under state law. Finally, the documents do not address or interpret compliance with the separate federal essential health benefits requirement to provide pediatric services. *See* Nollette Decl. Exs. F, G. In the absence of inclusion of SCH in the Intervenors' networks, a high number of essential pediatric services will be otherwise unavailable in network to patients enrolled in the Intervenors' Exchange plans. [First] O'Connor Decl. ¶¶ 4-7; Supp. O'Connor Decl. ¶¶ 2-6; Declaration of Kelly Wallace at ¶ 2.

## VI. PROPOSED ORDER

A proposed order is attached to the Hearing Unit's copy of this pleading.

## VII. CONCLUSION

For the foregoing reasons, SCH asks the Hearings Unit to deny the Intervenors' summary judgment motion.

RESPECTFULLY SUBMITTED this 24th day of January, 2014.

BENNETT BIGELOW & LEEDOM, P.S.

By _____

Michael Madden, WSBA # 8747
Carol Sue Janes, WSBA # 16557
Attorneys for Seattle Children's Hospital
mmadden@bbllaw.com
csjanes@bbllaw.com
601 Union Street, Suite 1500
Seattle, WA 98101
Telephone: (206) 622-5511
Facsimile: (206) 622-8986

## 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 e-mail and mail on today's date addressed to the following:

**Hearings Unit**
Honorable Michael Kreidler
KellyC@oic.wa.gov
Office of the Insurance Commissioner
Hearings Unit
5000 Capitol Boulevard
Tumwater, WA 98501

**Office of the Insurance Commisioner**
Charles Brown
charlesb@oic.wa.gov
Office of the Insurance Commissioner
5000 Capitol Boulevard
Tumwater, WA 98501

**Coordinated Care Corporation**
Maren R. Norton
Gloria S. Hong
mrnorton@stoel.com
gshong@stoel.com
Stoel Rives LLP
600 University Street, Suite 3600
Seattle, WA 98101

**Premera Blue Cross**
Gwendolyn C. Payton
Lane Powell PC
Paytong@lanepowell.com
1420 Fifth Avenue, Suite 4200
Seattle, WA 98101-2375

**BridgeSpan Health Company**
Timothy J. Parker
Carney Badley Spellman, P.S.
parker@carneylaw.com
701 Fifth Avenue, Suite 3600
Seattle, WA 98104-7010

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 29th day of January, 2014.

Julia Crippen
Legal Assistant



LAW OFFICES
BENNETT BIGELOW & LEEDOM, P.S.
601 Union Street, Suite 1500
Seattle, Washington 98101
T: (206) 622-5511 F: (206) 622-8986